DOCTORAL DISSERTATION

Identifying therapeutic change processes in the treatment of complex trauma: the case of play therapist's perspectives.

A Qualitative Study

by

© Ruth Mary Parsons, MSW, RSW

A thesis submitted to the

School of Graduate Studies

in partial fulfillment of the

requirements for the degree of

Doctor of Philosophy

School of Social Work

Memorial University of Newfoundland

May, 2017

St. John's Newfoundland

ABSTRACT

Therapeutic interventions for children have been proven to be effective across all ages and stages of development. However, knowing that therapy works does not account for how or why it works. This question specifically asks, 'what are the change processes within treatment' has been raised historically and continues to be asked today. Knowing more about how and why therapy works with children can provide opportunity for the design and development of programming to meet the specialized needs of children in multiple areas of treatment.

This dissertation utilized the naturalistic inquiry to identify therapeutic change processes within the context of treatment of complex trauma with children. Certified and experienced play therapists that practice in Ontario, Canada were interviewed to discover what therapeutic change processes were utilized in their interventions with children who have experienced complex trauma. The guiding questions for this study were:

1. What practices have play therapists found to be effective in assessment and treatment of children exposed to complex trauma?

2. What practices have play therapists found to be effective in reducing the long-term impacts of complex trauma?

3. What are play therapists' understandings of therapeutic change processes in which they have confidence?

In-depth qualitative interviews were conducted with a purposeful sample of nine certified play therapists, all with advanced training and/or experience in working with

children who experienced complex trauma. All participants reside in the province of Ontario, Canada, and practice in both public and private services.

Thematic analysis was utilized to analyze the data. Three themes emerged from this data: theme 1 – therapeutic tools; theme 2 – building the therapeutic foundation; and theme 3 – working through complex trauma. From within these three themes and their sub-themes, six therapeutic change processes emerged: fostering a renewed ability to attach, fostering a renewed ability to trust, instilling hope for the future, providing age appropriate time and pacing for processing, facing the trauma together, and promoting mental health and resilience.

Additionally, this study's findings show a comprehensive practice model for therapeutic intervention with children who have been exposed to complex trauma and their caregivers. It also highlights the need for creativity and skill in intervening with children.

"The growth in knowledge and in the field of children's mental health in the past fifty years has been phenomenal. Looking back over this development from the viewpoint of 1930, it is clear that social workers are no longer dealing with the same concepts, the same values, or even with the same facts that they were occupied with in 1880. This is not to imply merely that they have moved on to new definitions but that actually… they have, in the process of working, discovered new facts and created new values…."

Virginia Robinson, 1930.

ACKNOWLEDGEMENTS

I first want to thank the participants of my study, who gave so freely of their time and expertise. Your passion for your work as play therapists in the field of complex trauma, and your commitment to the children with whom you work with is truly inspirational.

I wish to thank my advisor, Dr. Dennis Kimberley for his ongoing support, academic expertise, clinical wisdom, and perceptive sense of my academic process as I worked through each individual stage of the dissertation process. I wish to thank my committee members, Dr. Brenda LeFrançois and Dr. Nancy Riedel Bowers, for their expertise, availability and unwavering support and encouragement throughout my dissertation journey. Big "thank you's" as well to Angela Seaward for your support as a peer advisor, and to Jeanette Kerrivan for your tireless editing.

I wish to sincerely thank my large family, both immediate and extended, for their unwavering support throughout my dissertation journey. Together you are a testament that the biggest journeys are never accomplished alone. A huge thank you goes to my spouse who always encouraged me to take on the big challenges, and supported me when I did just that. A big "thank you" goes to each of my three children whose confidence in me made the journey all the more meaningful. And to the newest addition to our family, baby Levi, who became my inspiration towards completion, an especially big "thank you" as well. Thank you to my parents who raised me to believe there was nothing I could not accomplish. And a big thank you also to my ten siblings who have been lifelong cheerleaders for whatever challenges the others took on – you are an awesome group to have in my corner.

DEDICATION

Like a child's footprints in cement, early traumatic events are often preserved for a lifetime. Time does not heal them – it conceals them. To all those children who have been able to break away from the bondage of trauma, and to those who continue towards this goal, I dedicate my work within this dissertation to you. My journey has found purpose in supporting you within your journey.

List of Tables and Figures

Glossary of Key Terms

Child: The *Convention on the Rights of the Child* (http://phn.gc.ca), which was passed by the United Nations in 1989 and ratified by Canada in 1991, defines a child as a person under the age of 18 years unless national law recognizes an earlier age of majority.

Trauma: According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM 5), (American Psychiatric Association, 2013), trauma and stress related disorders follow exposure to catastrophic, aversive, traumatic, or stressful events, and can be quite variable. However "the most prominent clinical characteristics are anhedonic and dysphoric symptoms, externalizing angry and aggressive symptoms, or dissociative symptoms" (p. 265). Trauma can be categorized into one of two types: type I, or single incident traumas, such as natural disasters; or type II, which are multiple or cumulative events or man-made disasters, which involve interpersonal trauma (Terr, 1990).

Complex Trauma: This is a Type II trauma that according to The National Child Traumatic Stress Network Complex Trauma Task Force refers to the "dual problem of children's exposure to traumatic events and the impact of this exposure on immediate and long-term outcomes" (Cook, et al., 2003, p.5). It results from exposure to severe stressors that can be long lasting and weaken a child's personality development and basic trust in relationships (Kliethermes, et al., 2014). Complex trauma can include physical abuse, sexual abuse, emotional abuse, neglect, witnessing domestic violence, exposure to community violence, and medical trauma, most often beginning in early childhood, and occurring within a child's caregiving system (Courtois & Ford, 2009; van der Kolk, 2005), which is normally expected to be a child's source of security, protection, and

stability (Cook, et al., 2005; Courtois & Ford, 2009). Recent additions to sources of complex trauma include community violence and bullying (Finkelhor, et al., 2009).

Play: Play is a child's natural mode of learning, communicating, interacting and relating to others. It is recognized as being necessary for optimal growth and development (Axline, 1947; Landreth, 2012). Play is a protective factor in the lives of children. It helps them process information and experiences for the purpose of understanding. It is through play that a children attempt to understand the rules of the adult world. It is also through play that a child's conscious and unconscious world can be accessed (Boyd Webb, 1999).

Disordered Play: There are specific characteristic behaviours exhibited by maltreated children during play. These are: developmental immaturity; opposition and aggression; withdrawal and passivity; self-deprecation and self-destruction; hyper vigilance; sexuality issues; and dissociation. Two specific themes that recur in disordered play over time are: unimaginative and literal play, and repetition and compulsion (Herman, 1997; White & Allers, 1994).

Play Therapy: The American Play Therapy Association (APT) defines play therapy as the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development (http://a4pt.org).

Play Therapist: Different countries define play therapists according to their own standards. In Canada, a play therapist is a professional masters or medical degreed student, who undertakes study through The Canadian Association of Child and Play

Therapy (CACPT) Program. The CACPT website outlines criteria consisting of: 180 hours of graduate level in-class course work; 2000 hours of supervised clinical practice with children, with 500 of these hours specific to play therapy, under the supervision of a CACPT supervisor or designate; plus 150 hours clinical supervision (https://www.cacpt.com). It is noteworthy that Canada has some of the most stringent criteria for certification in play therapy of all play therapy associations worldwide.

Play in Therapy: This is the use of play and/or play techniques in the therapeutic process, either as an adjunct or in addition to other therapeutic interventions, as identified by Play Therapy International (PTI) (http://www.playtherapy.org).

Therapeutic Play: This is the use of play and/or creative arts to improve the emotional well-being of children. It differs from fully-fledged play therapy in that the person using therapeutic play, such as a Care Worker or a Teaching Assistant, would only deal with conditions at the lower end of the play continuum (PTI) (http://www.playtherapy.org).

Chapter 1: Introduction and Overview

1.0 Complex trauma

For well over a century, social workers have played a significant role in critical areas of human distress (Uehara, et al., 2013). History holds evidence of many notable examples of this, including: a research campaign led by social workers, from 1910-1920, in the newly formed Children's Bureau in the United States of America (USA) which effectively cut infant mortality rates in half; the design and implementation of Federal Programs led by social workers during the Great Depression of 1929-1941, which put millions of people back to work; and the ground breaking development of Assertive Community Treatment models by social workers during the crisis of deinstitutionalization in the mid-20th century, resulting in social transformations that have had impacts worldwide (Uehara, et al., 2013). Since the beginning of the social work profession and throughout its evolution, social workers have also been involved in issues specific to children, beginning with concerns about both children's protection and their mental health, as evidenced by the work of the profession's earliest pioneers and leaders, Jane Addams and Mary Richmond (Addams, 1912; Richmond, 1917). Within this context, social workers have dealt with the impact of child maltreatment, exploitation, and neglect, inclusive of trauma and trauma sequelae (Kimberley & Parsons, 2017; Lanius et al., 2010).

Concurrent with the development of the social work profession, another profession, play therapy, was also developing, beginning with the early work of Anna Freud (Donaldson, 1996; Freud, A., 1976) and followed by the leadership of Virginia Axline (Axline, A. 1947), and Hug-Hellmuth (Hug-Hellmuth, 1920; MacLean, 1986).

Throughout play therapy's years of professional growth and development, many social workers have been involved with applying play therapy as an intervention within the field of children's mental health, for assessment, symptom management, and amelioration of childhood trauma sequelae (Zeig, 1985). In fact today many social workers are play therapists and many play therapists are social workers, interconnecting both professions and the services they provide to children (Boyd Webb, 1999). It is within this interface between the fields of social work and play therapy that this study of complex trauma was undertaken.

Today, in the new era of the 21st century, the social work profession has matured and it faces an altered socio-political context in which enduring social problems demand resolution (Uehara, et al., 2013). The issue of childhood trauma and its sequelae has at long last been acknowledged, yet only recently has its conceptualizations expanded beyond the limits of post-traumatic stress disorder (PTSD) to notions of complex trauma and the related notion of developmental trauma disorder (van der Kolk, 2005; van der Kolk & Pynoos, et al., 2009). At the same time, play therapy has evolved and expanded to include numerous concepts, theories, and practices in the specialized treatment of children's issues, including the many effects of childhood trauma (Boyd-Webb, 1999; 2006; O'Conner, & Braverman, 2009; Gil, 2010).

This study explores play therapy concepts, theories and practices with children exposed to complex traumas and related sequelae in an effort to inform the clinical interventions of social workers who work on a daily basis with this challenging and resilient population. Very few doctoral dissertations in social work specifically address practice or service delivery issues (Anastas, 2014; Anastas & Videka, 2012), however it

was my intention to focus on practice concerns faced by professional social workers, with a view to enhancing practice knowledge specifically within the field of children's mental health. There is a paucity of research in this field (Norton, 2011; Schwean & Rodger, 2013) especially in Canada, where children's mental health needs, although recognized as a right and not a privilege (Kutcher & McLuckie, 2010), are the most neglected part of the health care system (Kutcher, et al., 2010), creating an urgent need to prioritize interventions and services to children (Kutcher & McLuckie, 2010). There is also a need to embed knowledge of trauma and complex trauma into the social work profession where the demand by social workers is increasing for knowledge of trauma and effective interventions to provide help in ways that are currently less known or unrecognized (Kimberley & Parsons, 2017; Stephen & Murphy, 2014). Nowhere is the need for effective interventions more evident than with children and youth clients who are often misplaced within an adult mental health system in terms of the services offered. The problems of children's mental health disorders, inclusive of trauma, becomes markedly more concerning with the recognition of a lack of trained professionals to provide child specific therapeutic intervention with this population (Leckman & Leventhal, 2008). The magnitude of this problem argues for timely age-appropriate interventions by professionals trained specifically to provide therapeutic services to children.

1.1 Statement of the problem

Complex trauma refers to children's exposure to multiple traumatic events, , which most often begins in early childhood, and occurs within a child's caregiving system (Courtois & Ford, 2009; van der Kolk, 2005), which is normally expected to be a

child's source of security, protection, and stability (Cook, et al., 2005; Courtois & Ford, 2009). It is a type of trauma that overwhelms and defines a child, and can include physical abuse, sexual abuse, emotional abuse, neglect, witnessing domestic violence, exposure to community violence, and medical trauma, and the wide-ranging, long-term impact of such exposure. The scope of the traumatic experiences and the developmental sequelae compromise a child's biopsychosocial development and often supports maladaptive patterns of thought, actions, affect regulation, and relationships.

Trauma reminders are often chronic for children following exposure to complex trauma, and therefore the need for early intervention with age and developmentally appropriate interventions are critical in ameliorating harm, supporting resilience, and building strengths. However, clinical intervention with complex trauma utilizing primarily talk therapy has had very limited success with children, which research continues to confirm as being developmentally and neurologically incongruous for children (Boyd Webb, 2011; Davies, 2011; van der Kolk, 2005), as often times children are too dysregulated to attend to talk therapy alone (Taylor, 2013). However, one promising pathway for the treatment of children exposed to complex trauma lies within the active therapies, which, although historically have been applied within the play therapy field, are rarely found within traditional mental health services for children. This study examines practices within play therapy interventions with children, especially within the context of complex trauma.

1.2 Active therapies with children

Mental health begins in childhood and is fundamental to support positive development, including successful personal and social functioning, however access to developmentally appropriate therapeutic services is inadequate (Leckman & Leventhal, 2008). Children who have been traumatized require intervention that is focused on their individual and specific needs. Yet they remain part of a broader population for whom existing treatments and treatment delivery systems are often ineffective (Xenakis, 2014).

In recent years there has been a growing recognition that trauma involves, in part an autonomic, physiological, and neurological response to overwhelming events and/or experiences that create a secondary psychological response (Racco & Vis, 2015; Rothchild, 2000; van der Kolk, 2005). Such recognition has changed how therapists intervene with trauma, and with its symptoms, which are now understood as the body's way of adapting. Within this context, it is being recognized that traditional talk therapies are not meeting the needs of children (Norton, 2011; Taylor, 2013). Traumas and complex traumas can be expected to continue and to rise, based on ongoing issues related to children's well-being and therefore can be expected to intensify the mental health needs of children and youth, which, according to Norton (2011), is now deemed to be a public health concern (MacLeod, 2004; Norton, 2011; Schwean & Rodger, 2013). Based on my experience in children's mental health and in both public and private practice, I agree that this population requires intervention approaches that are congruent with their ages and stages of development as well as being contextually relevant to the individual child's experiences of trauma and complex trauma sequelae.

There is increasing consensus that interventions must not only utilize evidence-based practice with children, but it must also employ techniques that focus on the sensory impact of trauma (Malchiodi, 2014). Such techniques must emphasize the special languages of childhood inclusive of humour, play, storytelling, and metaphor (Terr, 2008). Within the play therapy field, there are a variety of therapeutic approaches that utilize the languages of children as well as creativity, imagination and self-expression. These approaches include art, music, dance/movement, drama, poetry/creative writing, bibliotherapy, guided play, and structured activities such as structured sand tray creations, all encompassed within the context of "play". According to Riedel Bowers (2013), "play can be a catalyst for change and, consequentially, has become a major contributor to the methods of psychotherapy for children" (p.19).

Within play, the creative arts or expressive therapies, known as action therapies (Malchiodi, 2008; Norton, 2011), are used in the context of psychotherapy, counselling, rehabilitation, and medicine (Malchiodi, 2014) to meet the special needs of children. Creative arts therapies have a unique role in the treatment of trauma, as individuals who have experienced trauma are often found to have great difficulty with verbal expression. However such individuals may be able to externalize their trauma experiences through therapy that includes action and movement (Malchiodi, 2014). Externalization of trauma memories is often essential for healing. Utilizing active therapies can support externalization, as well as enhance emotional, neurological, cognitive, relational and social functioning.

Intervention with traumatized children requires clinicians to have an in-depth understanding of childhood development, of complex trauma, and of what has potential

in enabling resilience, recovery, and healthy growth and development. Knowledge of the neurological effects of trauma helps clinicians appreciate that some of the traumata in children's lives are too overwhelming to be processed cognitively, and that for young children especially, immature cognitive development would make processing less likely to be verbalized than somaticized or acted out (Applegate & Sharpiro, 2005). Assessment and treatment of children who have experienced complex traumas must address the complexity, diversity and intensity of symptoms (Gregorowskia & Seedata, 2013), as well as the dysregulation and impairment of all affected domains of functioning: emotional, behavioural, cognitive, somatic and relational (Briere & Spinazzola, 2005; Cook, et al., 2003, 2005; Lanktree, et al., 2012). Thus significant expertise in professional assessment and intervention is required if children at risk are to significantly recover from their trauma (Tomlinson, 2008). With effective child-centred active interventions such as play therapy (Homeyer & Morrison, 2008), children who experience complex trauma and the associated developmental risks may not recover completely but can have increased opportunity to develop resilience, strengths, and adaptive capacity sufficient enough to transcend the chronic and complex impacts of their life experiences that have been influenced by complex traumas.

It is within the interface of the active therapy of play, applied to the risks and needs of children who have experienced complex trauma and associated developmental sequelae that my study seeks to understand and identify change processes that lead to and cause therapeutic change.

1.3 Purpose of the study

The majority of interventions utilized in the field of children's mental health have been adapted from adult models of intervention (Kazdin & Nock, 2003; Leenarts, et al., 2013), many of which have not been studied or researched with children (Gregorowski & Sedat, 2013; Jensen et al, 2010; Kazdin, 2008). Traditional therapies used with adults to treat trauma, including PTSD, are effective in only half of adult patients despite best efforts and practices (Xenakis, 2014). With such a limited effect on adults, the use of such interventions with children raises more concern. According to Kazdin & Nock (2003), there are over 550 such therapeutic models of intervention in use with children, of which very few are identified specifically for trauma.

An exception to this pattern is within the field of play therapy, whereby interventions are developed specifically for children, and are translated into a language that children can understand – the language of play (Kool & Lawver, 2010; Schaefer, 1976). Play therapy evolved from the work of Anna Freud who was one of the earliest pioneers in children's mental health treatment, beginning in the late 1800's (Donaldson, 1996). There is considerable literature on play therapy history (Axline, 1947; Freud, A., 1976; Groos, 1901; Klein, 1976; O'Conner & Braverman, 2009; Schaefer, 1976), development (Carroll, 2000; Lebo, 1952; Miller, 1976; Schaefer, 1976), efficacy (Boyd Webb, 2011; Drewes, 2009; Ray, Bratton, et al, 2001; Riedel Bowers, 2013), approaches (Allan, 1997; Carroll, 2000; Drewes, 2009; Gil, 2010, 2011) and applicability to children's mental health issues (Gil, 2010, Goodyear-Brown, 2010; Malchiodi, 2014; Schaefer, 1976). There is also significant research on play therapy outcomes (Baggerley & Bratton, 2010; Fitzgerald et al, 2012; Gil, 2006; Leblanc & Ritchie, 2001; O'Conner &

Braverman, 2009; Riedel Bowers, 2009). There is also considerable research into children's trauma and complex trauma (Boyd Webb, 2006; Fitzgerald et al, 2012; Green & Myrick, 2014; Myrick & Green, 2014; Norton et al, 2011; Vicario et al, 2013). However, there is a paucity of research into the processes for influencing change within the play therapy process (Kenney-Noziska, Schaefer & Homeyer, 2012; Schaefer, 1993). In fact, there is very little research into the processes of change within child therapy processes in general (Jensen et al, 2010; Kazdin, 2003; Weersing & Weisz, 2002), thus limiting what is known about promising therapeutic services for children.

Although significant evidence indicates that some therapy for children is effective, child therapy research specifically has neglected attempts to understand how or why it influences efficacious change (Kazdin, 2003), leaving these fundamental questions still to be answered. This neglect of critical questions about children's therapy and the very limited understanding of how it works is a result of many years of inattention to the special challenges of psychotherapy with children and adolescence, in favour of the study of adult psychotherapy (Kazdin, 2003). My study aimed to increase understanding of potentially influential change processes within play therapy practices, structures and content, which are transferable through social work within child and youth mental health service, policies, programs and practices. It focused on developing clear, in-depth and relatively broad knowledge about play therapy theories, concepts, and practices perceived by certified play therapists to have been helpful with children who have experienced complex trauma. These children have a significantly high rate of clinical challenges and therefore are of high priority for intervention (Kazdin, 2003).

One foundation of the field of play therapy is rooted in the belief that children do

not free associate and therefore are unable to benefit, in any significant way, from talk therapy (Klein, 1976). Early pioneers in the field transcended this adult concept of free association by using play activity, or equivalent activity, for children (Donaldson, 1996). From its inception, this field developed its methods to accommodate the active, creative, playful and otherwise expressive world of childhood. Play therapy ingeniously undertakes the considerable effort of child psychotherapy in the appealing guise of play (Boyd Webb, 1999). Current scholarship suggests that active therapies within therapeutic contexts enable significant change in neuropsychological and neuro-social functioning and therefore facilitates the achievement of therapeutic goals (Boyd Webb, 2006; van der Kolk, 2005).

Children who have been traumatized require intervention that is focused on their individual and specific needs. My interest in complex trauma and the potential of play therapy in children's mental health developed from my experiences in the field of child and youth mental health, in both public and private practice. This includes experience in the application of play in therapy to children who have been maltreated, specifically those who have experienced complex trauma. Within my practice, interest in child therapy process and content expanded to the structural elements of change associated with child-centred interventions, such as therapeutic play rooms, and play therapy resources that support change and are made available to children in the therapeutic setting. In my experiences, I have discovered that there is little research into 'what works?' in child therapy, especially with younger children to preteens. While there is some research and some evidence of treatment effect, there is more related to older children and teens than there is related to younger children (Fonagy et al, 2015) of treatment that can produce

clinically significant change and sustained developmental improvements. This issue of what contributes to therapeutic change in children was also raised by Virginia Robinson in 1934, Virginia Axline in 1947, Kazdin, 2002, Herman, 2008, and later by Kenney-Noziska, Schaefer, & Homeyer in 2012.

The question of 'what works?' is the precise focus of process research, which speaks to research on processes of change in children's therapy, with a focused interest in where the influences for change in play therapy are found within the context of children dealing with complex trauma. Process research is extremely relevant to clinical practice, as according to Kazdin (2003), practitioners need to understand incremental and moment-to-moment patterns over time in order to map the process of change. If we understood the basis of therapeutic change we might more readily optimize the effectiveness and benefits of treatment (Kazdin, 2003). When we understand the elements of change, treatments can then be strengthened by use of more of these influencers or by attention to the application of activities that enhance the process (Kazdin, 2002). Change process research focuses on the interrelationship of treatment events and influences on client change during treatment (Doyle, 2011). Process researchers are challenged to improve the efficacy of the theories of change they seek to validate, and thereby enable the discovery of unexpected findings in their research (Smith & Grawe, 2003). From a social work perspective, study of clinical intervention would look at the dynamic interplay among structure (e.g., the use of the family dolls only after a period of joining with a child in play and followed by a process of creative play), content (e.g., the use of dolls depicting family members with implied role content), and processes, and the interplay of structure, content and processes influences desired, required and needed changes.

Process research is an area that has been neglected, especially in relation to therapeutic intervention with children (Jensen, et al., 2011; Kazdin, 2003). In fact, according to Kazdin (2003) the processes through which therapeutic change is achieved are rarely studied at all. This paucity of research to understand therapeutic change and the processes through which relative changes are achieved, reflect a significant problem, especially in child and adolescent therapy, which is not knowing what works, and therefore being susceptible to using approaches that may not be effective (Kazdin, 2002). Additionally, without knowing how treatment works, practitioners and researchers are limited in their abilities to meet the emergent requirements for evidence-based practice (Kazdin, 2003).

The strength of process research lies in its firm footing within clinical practice (Doyle, 2011; Shulman, 2015a), an area in which social work has had significant experience. This is evidenced by the early division of social work into two schools: the diagnostic school which was based on the assumption that people were a product of their past, and the functional school which stressed relationship and change (Dunlap, 2011). The functional school of thought was initiated by social worker Otto Rank, and promoted by pioneers Jessie Taft, Virginia Robinson, Charlotte Towle, Ruth Smalley, and Helen Harris Perlman (Dunlap, 2011). In fact, social work is distinguished from other disciplines by its focus on induced change (Doyle, 2011), which is studied within process research. Process research attempts to specify the active ingredients of therapy, which enable client change. Influencers of personal and social change themes preoccupied some very early social work scholars, contributing to both the development (and later the near abandonment) of focus on process in social work research. Process focus was the

impetus for the creation of the *Journal of Social Work Process* (1937-1969) by pioneers of functional social work, Virginia Robinson and Jessie Taft (Doyle, 2011). Robinson, along with another social work pioneer, Florence Hollis, emphasized the importance of measuring process (Doyle, 2011; Hollis, 1969). However, despite their efforts, the focus on process, which remains very important to social work today, (as evidenced by such journals as *Family Matters*) has continued to have a low profile in the profession (Doyle, 2011). The shift in focus away from process research was influenced by a push towards a more scientific base. As part of this, the influential Russell Sage Foundation put forth seed funding into several schools of social work doctoral programs to promote integration of social science and social work, thus leading the profession away from a preoccupation on casework processes to focus on outcome studies which took priority as the profession grew (Doyle, 2011). This study initiated some balanced attention to process.

Within the field of social work (Doyle, 2011), and its neighbouring disciplines of psychotherapy (Kazdin, 2003), psychology (Gennaro, 2011), and play therapy (Kenney-Noziska, Schaefer & Homeyer, 2012), there have recently been calls to action, to move forward with research to ask the question of 'What happens during the therapeutic process in order to produce change?' in an attempt to understand the dynamics of change processes within these fields. My area of interest lies within this identified need for further study of therapeutic processes, structures and content, as well as associated influences on helpful child-centred changes. While respecting the intentions and values of evidence-based practice, my study sought to go beyond this and beyond best practices as well, to understand the practice wisdom of play therapists, based on their expertise which comes from practice experiences. Although exceptions can be found, very few studies of

the views of experienced professional therapists have been conducted (McLeod, 1990; Palmstierna & Werbart, 2013), inclusive of certified play therapists. This highlights a significant gap in literature and therefore a significant gap in the understanding that practice-based wisdom may hold promise for future interventions (Reid, 1994), specifically with children who have experienced complex trauma. My study respects evidence-based scholarship and brings much deserved attention to the process and structure of helpful interventions, as well as the supporting therapeutic content. These foci are justified both theoretically and conceptually in applied practices where the activities of active therapy may supersede the focus on outcome.

The study of efficacious therapeutic processes, also referred to as processes of therapeutic change, has received little attention in research, possibly with the exception of common factors studies. Nowhere is this inattention more prevalent than in the study of interventions for children and youth. In fact, according to Kazdin & Nock (2003), there are no studies to show how or why treatment actually works. Theories of what works in psychotherapy tend to focus on the therapists' contributions; however, as stated above, surprisingly few studies of skilled therapists' experiences or views of successful change have been conducted (Palmstierna & Werbart, 2013). Common factors research however is a promising movement (Sprenkle, et al., 2009), which I examine as it relates to, or may be adapted to, the assessment and treatment of children and youth with mental health risks in general and complex trauma in particular.

The term 'common factors' refers to a set of conditions that are likely influential related to improvement occurring, and therefore is 'common' to therapeutic improvement (Doyle, 2011). Common factors are conditions and processes taking place in and among

practitioners, clients, and others involved, which are used directly and indirectly through participation in therapy, in promoting enhanced functioning on the part of the client (Cameron, 2013). These conditions and processes are essential in facilitating change work on the part of the client. Common factors include relationship variables, such as belief in the client, the working alliance, empathy, and expectancy (Kazdin, 2003; Wampold & Budge, 2012), all of which have been found to be robust predictors of outcome (Cameron, 2013; Wampold & Budge, 2012). Common factors are, in a sense, necessary to deliver particular treatments for particular disorders, but the "specific ingredients do the heavy lifting" (Wampold & Budge, 2012, p. 602). These specific ingredients exert an influence along with the common process factors, especially for clients with more severe and complex disorders. My interest focused on learning about the 'active ingredients' representing both specific treatment techniques and common factors, knowing that one is not likely to be delivered without the other, as they work together to make psychotherapy effective (Doyle, 2011; Wampold & Budge, 2012).

In this study I focused on the issue of active ingredients of therapeutic change by developing clear, in-depth and relatively broad knowledge about play therapy theories, concepts, and practices perceived by certified play therapists that have been helpful with children who experienced complex trauma. Studies are vital in this area of factors believed to contribute to needed and desired therapeutic influences, to bridge the gap between research and practice (Kazdin, 2008; Smith & Grawth, 2003), so that practice can be informed by research findings based in part on practice wisdom, observations and interpretations that have promising potential for clinicians who wish to influence positive changes in the interest of traumatized children, especially within the context of complex

trauma and associated sequelae. Understanding processes of therapeutic change is a pathway towards improved treatment.

1.4 Significance of the problem

A growing body of literature has linked adult mental health, addictions, relationship difficulties, poor parenting, and other social functioning issues back to unresolved childhood trauma, often contributing to a lifetime of seeking services (Dass-Brailsford & Myrick, 2010; Davies, 2011; Majer et al, 2010). Adult mental health and addictions issues are identified as major contributors to the exorbitant cost of health care in Western Countries (Divine & Kimberley, 2012; Roemer, 2011; Schwean & Rodger, 2013). Mental health alone is identified as the biggest drain on economic productivity in the workplace and costing Canadians alone over $14 billion a year (Schwean & Rodger, 2013). As well, mental health disorders are evident in many social problems in Canadian society including suicide, poor education, poor employment outcomes, involvement in the criminal justice system, compromised well-being, and family problems and breakdowns (Schwean & Rodger, 2013). In my social work career I have met many individuals with parenting capacity compromised by addictions and mental health issues that more often than not, are associated with parental experiences of childhood trauma.

Epidemiologic data indicate that close to 20% (more than 14 million youth) in the USA and 13% - 18% of Canadian children and adolescents (more than 1 million youth) suffer from a mental disorder (Robson, 2010), and about 75% of these do not receive treatment through our current mental health care systems (Schwean & Rodger, 2013).

Children and adolescents are increasingly being diagnosed with psychopathology, with approximately 21% of youth in the United States ages 9 through 17 having a diagnosable mental illness with some degree of impairment (Manpreet et al, 2012; Singh & Chang, 2012). In social work, even if a child presents with many interconnected issues that do not result in diagnostic labels, there are often concerns with compromised social and personal functioning, an example being that of a parentified child.

Currently in North America a large percentage of children in care are on psychotropic medications – a higher percentage than ever in history, making it difficult for children who are offered therapy to benefit from it, given the numbing impact of antipsychotic medication (Chubinsky & Hojman, 2013; Wang et al, 2004), leading towards the belief that the use of psychotropic medications in children is a global public health issue (Wang et al, 2004), and supports the concept of 'psychiatrized children' (LeFrançois & Coppock, 2014). Little is known about the neurobiological effects of psychotropic medications on the developing brain of children and adolescents (Cook et al, 2005; Courtois, 2008; Singh & Chang, 2012; Whitaker, 2012). Most medications are usually first tested in adults after which they may be evaluated in children, (Crimson & Argo, 2009). The use of medication in children and adolescents has expanded well beyond evidence-based findings (Chubinsky & Hojman, 2013). Symptoms are often treated before they are understood, a practice in keeping with the model of practice in child and youth mental health services, which is a medical model (LeFrançois, 2008). However, prevention, early intervention and biopsychosocial treatments are advocated for, even though little is known of the processes that underlie treatment (Shing & Chan, 2012).

Kessler, et al., (2005) have noted, that mental health conditions identified in children and youth typically continue into adulthood, with one-half of all lifetime cases of mental disorders having onset by age 14, and 75% by age twenty-four (24). According to Meyers (2011), only a small proportion of maltreated children receive protection services and support. Unaddressed childhood problems tend to persist, leading to substantive distress and impairment throughout adulthood (Kutcher, Hampton, & Wilson, 2010; Straussner & Fewell, 2011). Epidemiological data reveals that the great majority of mentally ill adults were first mentally ill as children (Kessler, et al., 2005).

Because systems for collecting data on child maltreatment vary considerably in countries all around the world, and because numerous cases of maltreatment go unreported, estimates of the global burden of maltreatment remain elusive (Klika & Herrenkohl, 2013). The World Health Organization (WHO) classifies child maltreatment as a global public health issue (Kessler, et al., 2010), emphasizing concerns expressed in recent years that the continued neglect of the mental health needs of children and adolescents is unacceptable and must stop (WHO, 2005). In a study completed by the WHO in 2010 across twenty-one (21) countries, childhood adversities accounted for 29.8% of all disorders across these countries (Kessler, et al., 2010). This has led to recognition that eradication of childhood adversities can reduce adult mental health disorders significantly.

In Canada alone, where youth exhibit the highest distress levels within the population and where few of these receive mental health services, mental disorders ranked seventh out of twenty (20) disease categories for which cost estimates were published in 1996/97 (Schwean & Rodger, 2013). In these estimates, treating mental

health was the most expensive of the top five children's health conditions, costing an estimated CAD $7,312.90 for the treatment of one child (Pepler & Bryant, 2011; Roemer, 2011). The cost of caring for children or youth with mental disorders has been examined in the USA also, and the annual health expenditure finding for mental health among school-aged children was US $2,224 per child (Pepler & Bryant, 2011). According to one estimate, the lifetime cost of nonfatal child maltreatment incidents exceeds $210,000 per victim when services for law enforcement and child welfare involvement, medical treatment, hospitalizations, and loss of productivity are factored in (Klika & Herrenkohl, 2013). My concern with such figures lies in determining the benefits to children within the context of predictable lifetime social and economic costs.

Teicher & Samson (2013) stated that maltreated children are more likely to suffer psychiatric disorders over the course of their lifetime, inclusive of bipolar disorder, anxiety disorders, posttraumatic stress disorders, substance abuse, personality disorders, and psychosis, all differing in diverse but clinically significant ways from other individuals with the same psychiatric diagnosis. Such disorders are evidence of the high degree of complexity for maltreated children. These are in addition to the developmental consequences of child maltreatment, which are, in many cases, severe and long lasting (Davies, 2011; Klika & Herrenkohl, 2013). According to the 2008 Canadian Incidence Study of reported child abuse and neglect, 32% of all substantiated cases of child maltreatment consisting of interactions of emotional, physical, and sexual abuse (Public Health Agency of Canada, 2010). One study (Spataro, et al., 2004) showed a nearly fourfold increase in contacts with mental health services by child sexual abuse groups as compared with the general population. Such maltreated individuals were more than three

times more likely to be diagnosed with an anxiety disorder or an acute stress reaction and had almost five times the rate of a primary diagnosis of personality disorder. However, statistics reveal the very disturbing findings that the most serious cases of children with mental health concerns are not receiving services (Jenson, et al., 2011), despite unequivocal knowledge of the negative developmental impacts and intergenerational transmission of unresolved abuse issues (Liberman et al, 2011; Stephen & Murphy, 2014). Play therapy for children who have experienced maltreatment and who live with post trauma effects may be able to be provided in ways that improve child-centred benefits.

The study of childhood trauma reaches far beyond childhood, into the adult world, and into the lives of tomorrow's children (Tomlinson, 2008; Stephen & Murphy, 2014). It is now recognized that the effects of trauma go far beyond the health care sector, into quality of life of its victims and their families, affecting the functioning of all on many levels other than occupation, and then passing on the untreated effects to future generations (Stephen & Murphy, 2014). One of the most disturbing findings about child maltreatment is its strong intergenerational pattern (Liberman et al, 2011), whereby abused children carry forward abusive tendencies, especially into parenting of their own children. In addition, victimization can lead to re-victimization, putting already victimized children in harms way (Kohn, 1987).

A recent explosion in literature has highlighted the specific and unequivocal connection between childhood abuse and mental health disorders in adults (Levenson & Grady, 2016), which increases exponentially in cases of complex trauma and developmental trauma (Cook et al., 2003; Felitti, et al., 1998; Silberg, 2013b; Spataro, et

al., 2004; Terr, 1990). The more severe and complex posttraumatic outcomes frequently are associated with a life history of multiple interpersonal victimization experiences, often beginning with extended childhood abuse and neglect, and associated disruption of the parent-child attachment system (Briere & Spinazzola, 2005; Davies, 2011; Silberg, 2013b). Attachment describes an emotional bond intended to promote and preserve closeness and safety between children and caregivers (Breidenstine et al, 2011; Schaefer & Emerson, 1964), which can be compromised by traumatic experiences and destroyed by complex trauma experiences. Having been denied their birthright of being both protected and nurtured, children who are severely traumatized at the hands of their own caregivers may, without treatment, go on to abuse and harm others, or may become significantly inadequate parents, and can therefore, continue the cycle of abuse and neglect (Tomlinson, 2008). This may happen in cases whereby a child internalizes aspects of inadequate parenting and in doing so identifies with the abusing parent(s) (McMahon, 2009). These are the disenfranchised and vulnerable young people whom society has most failed to protect and the consequences for them as individuals, and for society as a whole, can be devastating (Tomlinson, 2008). It is these children and their trauma related symptomology that is of special interest to this author.

According to Spataro, et al., (2004), any doubts about whether there are true associations between childhood abuse and significant disturbances of mental health both in childhood and in adult life, can be answered unequivocally in the affirmative, further stating it is time to turn our attention to investigating the factors that mediate and potentially ameliorate the damage that abuse inflicts on children. If we were to understand how potentially successful child-centred interventions work to ameliorate

children's symptoms of complex trauma and associated risks, and enable the building of adaptive resilience and strengths, then we could use this knowledge to enhance direct social work practice, program development, and program delivery to this population.

1.5 Research question(s)

In 1994, Sherman and Reid produced a seminal work addressing the needs and interests of a wide range of social workers. In doing so they identified the need for more study and analysis of what goes on within the actual process of practice, specifically the clinical change process. Change process research remains one of the key directions in which researchers can add to the development of effective treatments by conducting research on the change processes or mechanisms of change, with the guiding question: 'How does treatment achieve change' (Kazdin, 2003). This direction, coupled with my interest in the change process, and my experiences in therapeutic work with children and youth, specifically traumatized children, led me to the following research questions:

1. What practices have play therapists found to be effective in assessment and treatment of children exposed to complex trauma?
2. What practices have play therapists found to be effective in reducing the long-term impacts of complex trauma?
3. What are play therapists' understandings of change processes in which they have confidence?

In relation to these questions, I described and analyzed theoretical frameworks, key concepts, and key practice activities identified by certified play therapists addressing the needs of children within the context of complex trauma. Such knowledge can be used

to inform social work practice and play therapy with children and youth who have experienced trauma.

1.6 Research approach

Within the active therapies, specifically play therapy, lay change processes, and based on these processes theories of change can be used to seek an understanding of what specifically causes therapeutic change. My study focused on the practice-based evidence and the practice wisdom of certified play therapists, using the qualitative method of the naturalistic inquiry to explore and seek understanding of potentially influential therapeutic change processes, in which certified play therapists have confidence. The choice of qualitative research approach is congruent with the focus of my study as it is best suited to promoting a deep understanding of an issue as viewed from the perspective of the research participants, while emphasizing exploration, discovery, and description (Bloomberg & Volpe, 2008). Within qualitative research the methods of the naturalistic inquiry identified as a natural fit for my research.

The naturalistic inquiry is compatible with social works' client-centred traditions (Germain & Gitterman, 1996; Pieper, 1994; Pieper et al, 1999). It utilizes the researcher as the major instrument of study, and thus employs the professional skills of clinical social work which is to explore, observe, follow cues, capture subtle nuances of meaning and behaviour, and "to describe adaptive and dysfunctional patterns as well as processes of change" (Germain & Gitterman, 1996, p. 449). The rationale for using the naturalistic inquiry is guided by the importance of an emergent design acknowledging that perceptions of reality are multiple and constructed. As such the naturalistic inquiry seeks

to provide a deep understanding of individuals, their perceptions, and the meanings they attach to social life (Lincoln & Guba, 1985).

1.7 Overview of chapters

Chapter two conducts literature analysis of both historical and contemporary writing, which explores, summarizes, and synthesizes available literature on the issues of trauma and complex trauma, and play therapy as a developmentally appropriate intervention. Chapter three focuses on the research methodology and method used in this study. It discusses how the research questions were answered, including who was interviewed, how they were selected, how they were informed and protected, and how the data was analyzed. Chapter four presents an organized synthesis of data collected during the interview process with individual participants. Chapter five analyzes the findings and arrives at interpretations of the data, including meaning and conclusions related to practice processes in play therapy within the context of children who have experienced complex trauma and associated sequelae. Chapter six summarizes the study, its findings, and the implications and consequences of the research, including limitations of the study and its findings.

1.8 Researcher's statement

Transparency and reflexivity of a researcher's background, values, and interests that may inform or bias the research process contributes to a qualitative research study's degree of rigour and the reader's judgment of the study's trustworthiness (Sandelowski & Barroso, 2002). Professionally, I have worked in the

field of child and youth mental health services as a frontline clinician for over 12 years, (1999-2011) prior to which I worked for 8 years as a youth court worker within the Field of youth corrections. I presently work as a clinical social worker in a Provincial Youth Addictions Treatment Center. My primary role within each of these positions was the provision of clinical social work services to children, many of whom were victims of trauma, often complex trauma, which adversely affected their abilities, behaviours, mental well-being, family relationships, self-esteem, and age-appropriate progression through their developmental stages. Based on my work I began to observe notable patterns in my child clients, such as age-stage disparities, fear, lack of trust, and inability to enter into a therapeutic alliance in 'talk therapies'. I began exploring alternate and more clearly child-centred orientations and became more aware of the need for increased optimized congruence of treatments with age and stage developmental readiness.

Within my work experiences, I was privy to the traumas suffered by many children and youth, and because of this I sought out specialized training which was child-centred, age-appropriate, reflective of best known practices, applicable to the many issues faced by my child/youth clients. Based on my search I discovered child-centred potentials in the field of play therapy. Training in this field was offered through The Canadian Association of Child and Play Therapy (CACPT) to masters-trained clinicians as a specialty area in working with children/youth, including those children who have experienced multiple traumas that compromised their development. I was accepted into CACPT's summer institute in Ontario, Canada, and over the next three summers (2007-2009), I attended their on-site training program at King's College, University of Western Ontario. This training in play therapy methods has been invaluable to me and my clients

in my continued work with children, especially those who have experienced complex trauma.

Based on my training in play therapy, I have been instrumental in developing and delivering training programs within my employment to many clinicians who work with children, including those who manage children's mental health programs. In addition, I have been successful in the development and implementation of fully equipped 'play rooms' in offices throughout my employer's health region. Based on my training, knowledge and practice experience, I have been sought out by clinicians who work with children, to provide supervision, direction, and support, most notably with cases of complex childhood trauma.

In addition, I have been an active private practitioner since 2007. Within my private practice I provide services based on referrals from agencies I am affiliated with, and from individual referral sources. In this practice, my services to children and youth especially have been sought out. I have also provided consultation in the area of therapeutic services to children, through my private practice.

As with all research, it is understood and acknowledged that both this researcher and the studies participants are subject to bias that according to Fusch & Ness (2015) present both intentionally and unintentionally. It is also understood and acknowledged that it is the task of this researcher to mitigate my own personal biases, recognizing the importance that the interpretation of the phenomena presented is that of the participants and not that of the researcher (Fusch & Ness, 2015).

Chapter 2: Literature Review

2.0 Introduction

Complex trauma has only recently been acknowledged as an underlying factor in significant maladaptive behaviours presented by many children in social work clinics, medical clinics, hospitals, and in school settings. However, the behaviours related to such trauma are not new, and have historically been treated by professionally trained play therapists, utilizing play as the primary language of children. It is the experiences of play therapists within the process of therapy, and their understandings of the changes taking place within that therapeutic process that is the focal point of this study.

In chapter 2 this researcher sought to explore, summarize, and synthesize available literature on the issues of trauma and complex trauma, within the context of play therapy as a developmentally appropriate intervention. These themes laid the foundation to support my study, which sought to identify and understand the change processes within the play therapy process of treating children who experienced complex trauma. Identifying these change processes holds promise for informing the practice of clinical social work with children.

2.0.1 Organization of selected literature analysis.

The chapter begins with my theoretical framework, inclusive of theory, concepts and practices, which guided the development of my study of complex trauma and the use of play theory as a potentially effective intervention to ameliorate symptoms. I reviewed literature that traced the development of the concept of complex trauma, and then

completed an in-depth review of the historical and political context of childhood, child abuse, and therapy with children. I then focused on theory and research in the field of play therapy, from historical approaches to modern day approaches. This review and critique of literature were then combined with my own clinical experiences and insights to present my conceptual framework, which guided the design and conduct of my study. The chapter concludes with an introduction to my qualitative study, which utilized the naturalistic inquiry method of study with a selected sample of certified play therapists.

2.0.2 Integrated theoretical themes "framework".

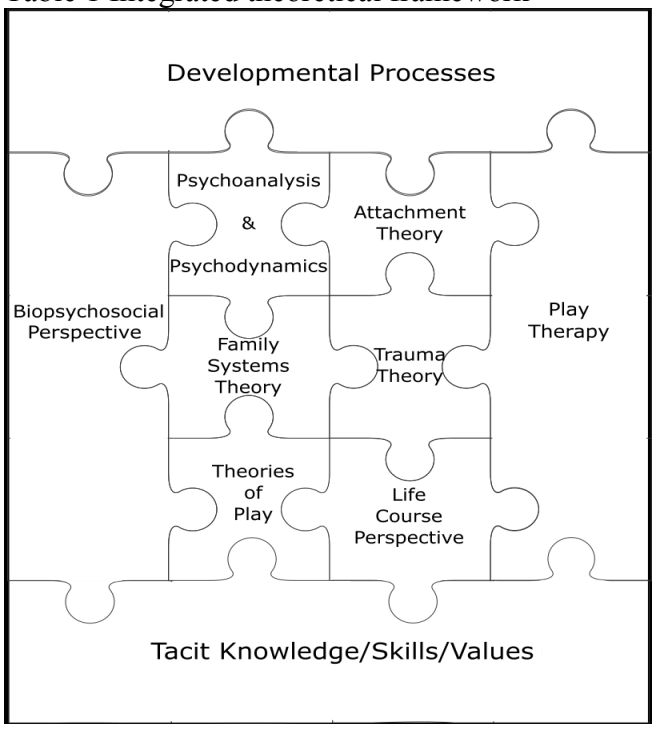
Social workers require a broad range of theoretical perspectives, concepts, practices, facts and contexts of client situations, to guide their clinical interventions. They also need the ability to integrate these themes into a comprehensive and coherent intervention framework, whereby different theoretical perspectives may be used together in a targeted way, especially for ameliorating complex issues (Livesley et al, 2016) to develop relevant and functional perspectives to guide the search for understanding and informed action (Payne, 2016; Shulman, 2015a). As highlighted by Fitzgerald et al (2012), children's mental health clinicians often utilize integrated frameworks as unitary theoretical orientations which are often insufficient for addressing traumatic experiences and their sequelae with due respect to their complexity (Gil, 2006; James, 1989). The intra and interpersonal characteristics … of recurrent trauma at an early age … integrates conceptualizations and treatment strategies … from behavioural, psychodynamic and attribution theories … teaching adaptive behaviors (Gallegos & Hillbrand, 2016).

A theoretical framework assists in the integration of theory and research, thereby informing research. In developing of a multi-theory integrated framework, this researcher combined a group of selected theories and approaches as outlined in Table 1, and in doing so adopted an eclectic paradigm whereby the theories and approaches utilized shared parts of their assumptions and explanations of change (Poulter, 2005), therefore sharing functional linkages referred to as "unformalized linkages" (Poulter, 2005, p. 211). Theoretical integration such as this seeks to combine case relevant components of multiple theories to create an effective model that follows the principles of therapeutic change, providing an integrative approach (Livesley et al, 2016) based on processes of change, which is the focus of my research.

According to Poulter (2005), the integration of theories into eclectic frameworks "often leads to the achievement of intuitively satisfying results" (p. 206). The eclectic theoretical integration utilized in this dissertation is congruent with the complex needs of children faced with complex trauma and its sequelae to address the issue of complex trauma with children and youth (Kimberley & Parsons, 2017: Turner, 2017). Turner identifies a multi-theoretical approach as an interlocking framework, as each approach is connected to the other(s) by concepts and practices not available in any unitary approach. My eclectic multi-theory framework for integration is a combination of theories, concepts, and perspectives, which are further integrated into the practice literature dealing with play therapy and developmental sequelae. These include; psychoanalysis and psychodynamics; attachment theory; family systems theory; trauma theory; theories of play, and life course perspectives. In addition, developmental processes, biopsychosocial perspectives, play therapy, and this researchers tacit knowledge, skills,

and values which inform this researchers clinical interventions with children, and which when combined within this multi-theory approach, provides a transtheoretical framework for this study, that respects the complexities of the lives of children addressing multiple and repeated traumas. While this framework is integrated and muli-theoretical, as represented in Table 1, it is understood that in practice the boundaries of each frame will shift from common themes to unique themes for each child, as the boundaries are fluid based on the needs and risks of each child and the play therapy context. The following is a discussion of the framework approaches, both individually and as they intersect with one other, from philosophical, historical, contextual, and application viewpoints.

Table 1 Integrated theoretical framework



2.0.2.1 Psychoanalysis and psychodynamics.

Sigmund Freud, known as the father of psychoanalysis, introduced psychoanalysis in 1896, from which he produced a structure of the mind that was divided into three parts: the id, ego, and superego (Freud, 1965; Higdon, 2012). A key concept of his theory was that of the unconscious, an obscure part of ourselves that we have difficulty getting in touch with, which specifically underlies trauma and trauma work. He also introduced the concept of defence mechanisms (Freud, 1965), which operate on the unconscious level to protect the ego. Although all people use defenses as ways of protecting themselves from anxiety by keeping impulses and threats from consciousness, (Goldstein, 2011) not all defenses are protective and in fact can become harmful. Among the mechanisms identified by Freud and later refined by his daughter Anna in her publication of *The Ego and the Mechanisms of Defence* (1937) were: repression, denial, regression, projection, introjection, reaction formation, displacement, dissociation, and sublimation. The following is an overview of these defence mechanisms, and their role in protection following a traumatizing event based on a review of the work of both S. Freud (1965) and A. Freud (1937).

Repression, one of the most important defences keeps uncomfortable and painful memories such as traumatic memories at bay, by repressing or blocking them from conscious awareness when their reality is too painful to contemplate. (i.e. women who get in touch with and disclose sexual abuse only after their abuser dies). Denial is used as protection from realities that are just too hard to believe (i.e. a mother who learns her spouse has abused her child). Regression enables a person to retreat to an earlier stage of development that may offer an illusion of adaptation versus maladaptation (i.e. a child

who has been fully toilet trained for many years' regresses to enuresis/encopresis after a traumatic experience such as sexual abuse). Projection serves to project onto others one's own particularly 'bad bits' and then abhor them in the other person (i.e. a child who insists on blaming her sibling for hurting her, yet she had self-harmed). Introjection is the opposite of projection, whereby a person takes the good or bad habits of others and makes them their own (i.e. a young girl rationalizes her father's abuse by saying that's it's his way of showing her love). Reaction formation is the changing of a painful unconscious thought to its opposite (i.e. he hurt me to teach me what I needed to know). Displacement is utilized when the object of anger and fury is not available so that feelings are then projected to those present (i.e. a female abuse victim who hates 'all' men). Dissociation is the detachment from physical or emotional experiences (spacing out). Sublimation is our unconscious way of diverting socially unacceptable instinctual urges (such as anger and aggression) from their target to socially acceptable goals (i.e. sports, arts).

Together these defence mechanisms form the foundation of psychoanalytic theory and represents one of the most important avenues for the treatment of those traumatized by their own past (Freud, 1937; Freud, 1965; Shapiro, 2009). Evolving from psychoanalytic theory and its focus on past events is psychodynamics, also known as a school of psychotherapy. Psychodynamics retains key features of psychoanalysis but focuses more on immediate problems than past problems. Psychodynamic models are based on the idea that change comes with understanding of the psychological forces that motivate a person to act, and the idea that behaviour and feelings in the present are responses to experiences from the past (Barth, 2014).

Although aspects of Freud's work have often been challenged, there are key features of his work, such as defence mechanisms, that remain cornerstones of modern day therapy. For example, in my practice with children, an understanding of each of the psychoanalytic defence mechanisms is important in order to see beyond a child's initial behavioural presentations to their underlying issues. However, psychoanalysis has been subjected to considerable critique and debate. According to Higdon (2012), a major critique has been that none of Freud's theories could be tested because unconscious processes could not be measured. Another has been that psychoanalysis was very male oriented, both in its ideas and its practitioners, including those of Freud himself who according to history did not understand the psychology of women. However, women's roles in late 19th century as being secondary to males, subservient, and the property of their husbands, has to be considered when reviewing Freud's work (Higdon, 2012). Noteworthy as well, is that at the time psychoanalysis was developed, access to therapy was primarily dependent on wealth. Most theorists of the time were relatively affluent, usually with middle or upper class backgrounds, and had a different view of society than the working-class. Practices, particularly in child-rearing were based on what these theorists experienced: nannies, boarding schools, babies separated from mothers in separate cots and in separate rooms, and babies weaned in their first year. This was not the experience of the poorer groups in society. Yet, the psychoanalytic theories that were developed were intended to have universal application (Higdon, 2012).

The identification of defensive routines in the treatment of children's complex trauma is imperative to the success of intervention. Children unknowingly use a number of defences, and in various combinations, which can in turn present as behaviour

problems (e.g., projection). All too often children are referred for counselling based on changes in behaviour, and it is that specific change in behaviour that becomes the focus of treatment. Knowledge and understanding of the function of children's behaviours especially following abuse and trauma enables social workers to look beyond the behaviour. Even in situations where there is no disclosure of abuse or trauma, defensive mechanisms serve a function, and it becomes imperative to treatment that social workers understand their underlying purpose. Applying functional school thinking, thoughts and actions may be adaptive or maladaptive, but both serve a function.

2.0.2.2 Attachment theory.

Attachment theory developed from the joint work of John Bowlby, Mary Ainsworth, and her student Mary Maine, and "has proven to be useful in understanding the developmental consequences of risk, resilience, and trauma on children, including the emergence of psychopathology" (Page, 2011, p.40). Bowlby formed the basic tenets of attachment theory from his work with children orphaned following World War (WW) II. Ainsworth later tested and expanded Bowlby's theories with studies on young children exposed to 'Strange Situations' (Ainsworth et al, 1978; Bretherton, 1992; Bowlby, 1969; Page, 2011). Mary Maine explored the relationship between attachment and infant play and found securely attached children engaged in more exploration and interactive play (Main, 1981). Social workers as well recognized the fit of attachment theory with their professions historical person-in-environment perspective, and thus its fit with their practice of working with both children and adults (Bennett & Nelson, 2011). Social work's contribution to attachment research, with families (both traditional and non-

traditional), parents, couples, adults, children, children at risk, and children in care have added significantly to findings that attachment plays a significant role at all ages and stages of development (Bettmann & Jasperson, 2011).

Attachment, which has its origins in evolutionary theory, speaks to the quality of the bond between children and their primary caregivers. Attachment theory is based on the belief that a secure attachment is vital for emotional stability, and children develop secure, lasting and stable attachments based on the patterns of attachment or detachment exhibited by primary caregivers (Bowlby, 1969). Life experiences can alter attachment, positively or negatively as seen when a caregiver inflicts abuse. A trauma-bond relationship is one whereby children lose their natural curiosity and spontaneity from fear of the truth and avoiding reality (James, 1994). Attachment theory as it relates to trauma work presents a paradox in that children are dependent, independent and interdependent. This is often seen in my work whereby a child who is in-care fearfully maintains a dependence on their abusive parent believing them to be the only person who can truly protect them. In conjunction with this, they may be told they can independently make choices about visits with their abuser, all the while being in a constant state of confusion and struggle between their loyalties and their desires.

Although widely accepted as clinically significant with respect to trauma and child development, challenges have been made to early attachment theory. Criticisms of Bowlby's work lie in his belief that mothers as primary caregivers have to provide continuous caregiving for at least the first two years of a child's life (Bowlby, 1969). Challenges to this claim come from working mothers, who are exclusive caregivers in only a small percentage of societies. It has been found that by eight months the majority

of children have formed attachments to more than one person and that a primary attachment need not be the birth mother (Davies, 2011; McLeod, 2007). Another challenge to the early model is that it did not take into account 'shame' (observable by the second year of life) which was later addressed by therapists attending to the dynamics of shame in relation to abuse (Kaufman, 1989). Relationships between shame and posttraumatic symptoms have come to be identified as a central issue in the treatment of trauma survivors (Harper & Hoops, 1990; Herman, 2007).

The use of attachment theory is fundamental to working in the area of children's complex trauma in order to comprehend not only the strength and power of attachment, but also the effects to a child when attachment is damaged or destroyed. It is within the attachment relationship that complex trauma approaches what can be termed 'irreversible damage'. When a child's protector becomes their abuser, confusion, fear, disbelief, and negative behaviours begin, all aimed at physical and emotional survival. According to Brisch (2012), and Cloitre, et al., (2011), a major component of treatment has to aim at healing attachment-related injuries.

2.0.2.3 Family systems theory.

There is a significant overlap in attachment theory and family systems theory. Both accept ideas of circular causality and multigenerational transmission of relationship patterns, and both have patterns of interaction that closely parallel each other (Davies, 2011). Family systems theory seeks understanding of the individual as part of a family inclusive of all the roles, boundaries, relationships, interrelatedness, interconnectedness, and interdependence (Andreae, 2011). Pioneers of family systems theory include Virginia

Satir (1987), a key social work theorist, known as the mother of family therapy, and Murray Bowen (1978), a psychiatrist, who suggested that disorders were associated with multigenerational transmissions of patterns of relating. Both Satir and Bowen emphasized individuation, while Salvador Minuchin (1985), another key figure, focused on family structure and saw dysfunction as a consequence of rigid transactional patterns and boundaries. Family systems theory helps us comprehend that family members are an interactive group, and that the actions of one member unavoidably influences the others. In my practice, I often see children who feel like outsiders in their family of origin, or in their new family, where interactivity is dismissed. However, because a child's boundaries are fluid and intertwined with the outside world, particularly the family, we cannot be sure what is inside of children and what is outside (Lieberman, 1982). A major critique of the family systems model comes from the feminist perspective, as being too paternalistic, with too much attention paid to the mother's contribution to symptom development within the family system, as in such models, mothers are often pathologized as being overinvolved, fused, and undifferentiated (Brown, 1999). Other critics of this approach take issue with its broad focus, which may be too in-depth for those who look to resolve problems only within the nuclear family. Notwithstanding the above, most play therapists would conclude that the influence of family dynamic in child development is often paramount.

In spite of the critiques, it is within family systems theory that therapists can comprehend clinically important elements of family functioning. This includes Bowen's (1978) concepts of individuation, differentiation, and triangulation. It is within these elements that interpersonal abuse may remain unchallenged and/or undisclosed, resulting

in complex trauma symptoms (Reyes & Asbrand, 2005) that remain long after the abuse has stopped. Trauma, attachment, and self-regulation, according to Mikulincer & Shaver (2016) converge across developmental stages and across generations.

2.0.2.4 Trauma theory.

The study and public awareness of trauma as it is known today, has had three major historical predecessors, each of which were supported by identified political movements (Herman, 1997). The first was the study of hysteria in the late 19th century, the study of which grew out of the republican, anticlerical political movement in France. The second was that of shell shock also known as combat neurosis, which was studied in England and the United States following WWI and the Vietnam War. The third was that of sexual and domestic violence, which grew from the feminist movement in West Europe and North America (Herman, 1997). Our present understanding of trauma is built on a synthesis of findings from studies of these predecessors. In fact, Judith Herman (1997) combined these concepts by stating, "Hysteria is the combat neurosis of the sex war" (p. 32). As such it would appear that the study of trauma has come full circle.

The study of assaults against women inevitably led to a rediscovery of the sexual abuse of children, notably the abuse of children by those whose job it is to keep children safe, now known as complex trauma, an issue that has often garnished attention, but according to Herman (1997) is quick to return to the safety of secrecy as it is too reprehensible for society to sustain attention to it for a long period of time. History is full of examples of issues such as the abuse of children, first demanding awareness by society, and then fading from the consciousness of that very same society.

Lenore Terr, a clinical psychologist who conducted the first longitudinal study of traumatized children described psychic trauma as occurring when "a sudden unexpected, overwhelming intense emotional blow or a series of blows assaults the person from outside" (Terr, 1990, p.8). Herman (1997) stated "the very 'threat of annihilation' that defined the traumatic moment may pursue the survivor long after the danger has passed" (p. 50). Children are traumatized whenever they fear for their lives or for the lives of someone they love. In such situations, the human brain will release a series of hormones causing the defensive response of flight, fight or freeze (Coates, 2013) to protect the self from harm. This response is a protective device that only goes wrong if one is exposed to too much danger with too little protection (Bloom, 1999). When children are repeatedly exposed to danger, their bodies become unusually sensitive so that even minor threats can set off a sequence of physical, cognitive, and emotional responses, as if they were biologically built-in (Pynoos, 1999). If children are subjected to a significant number of experiences, or traumas, whereby it is learned that nothing they can do will effect change, then they stop trying. This learned helplessness could change their ability to regulate their emotions, or to recognize and escape from danger. Their thinking becomes severely impaired. Emotional memory is activated, and trauma is engraved into their brain (van der Kolk, 2005). A child will disassociate as a defensive routine to self-regulate intense negative emotions and to numb feelings when nothing else can be done (Schore & Schore, 2008; Silberg, 2013b).

Stein (2007) studied the links between heinous criminal behaviour and childhood trauma. She found that the people she studied with histories of complex trauma, who committed atrocities on other human beings, often took responsibility for their crimes,

but had no recall of the crime itself. She has suggested that the crimes were perpetrated during times of dissociation, lending support to the role of childhood trauma in shaping violence and suggests that the prevention of violence can be found in the roots of trauma, where it is hidden in plain view. Miller (1983) identified this association in earlier writings on hidden cruelty in child rearing and the roots of violence. Miller had no doubt that behind every criminal act was a hidden personal tragedy, and by examining criminal events and the backgrounds of the offender closely, she believed we might be able to do more to prevent crimes.

Critiques of trauma theory holds that it is much too aligned with the medical model which is now linking childhood trauma with adult mental illnesses, and therefore trauma is being treated pharmacologically despite limited evidence of the effectiveness of same (Breggin, 2008, 2014; Mills, 2014), and despite mounting evidence of the violation of children's rights in doing so (LeFrançois & Coppock, 2014). This alignment can often result not only in diagnosis and treatment with psychotropic medications, but in diagnostic mislabeling (Herman, 1997) and possible mistreatment. There presently exists a growing debate about the efficacy and safety of many drugs used with children, and with resultant "psychotropic childhoods" (Mills, 2014).

Notwithstanding critical analysis of trauma theory, a clinical understanding of this theory enables clinicians to change the discourse in treatment from 'what's wrong with you' to 'what has happened to you' (Bloom, 1999). In doing so, understanding of trauma is reframed as a series of experiences so detrimental to a child that normal developmental functions have been disrupted (Steele & Malchiodi, 2012). According to Rabaia et al (2014), the ultimate meaning given to a traumatic event is shaped by cultural and societal

norms, which influences the reactions of the victims, and whether or not they seek treatment. Fundamental changes to both the discourse and understanding of trauma theory are key to accessing underlying issues that support the negative behaviours most often presented by children in therapy. Briere and Scott (2015) present a balanced summary of the strengths, weaknesses, and potential of current trauma theory and practices without succumbing to a narrow medical model.

2.0.2.5 Theories of play and play therapy.

Theories of play and their development are rooted as far back as Plato, the Greek philosopher who is credited with the statement "You can discover more about a person in one hour of play, than in a year of conversation" Plato (c.427BC –c.347BC). As fitting as this quote is, research shows it has been misattributed to Plato, yet is often found in literature on play. However, it captures the concept that a child plays through situations very much like an adult talks through situations (Erikson, 1976). Theorists such as Piaget, Erikson and Vygotsky agree that children use play for self-teaching. Piaget believed play was a way of accommodating and assimilating reality (Piaget et al, 1962) while Erikson (1963) saw play as a safe place to work out conflicts, by exploring and manipulating ideas in social relationships. Vygotsky (1978) saw play as an influential factor in child development. As children's cognitive processes expand, play becomes more complex with rules, moral judgment, and language development, therefore it is through play that children learn the rules and expectations of the adult world. Psychoanalysts such as Anna Freud and Melanie Klein used this knowledge to develop psychoanalytical therapy with children, the basis of modern play therapy (discussed in

detail in section 2.10), which is dedicated to healing children. Critics of play theory and play therapy challenge that it is based predominantly on practice based evidence, and has yet to establish itself through evidence based research (Phillips, 1985). Others critique the methods used by those providing play therapy stating there is no evidence to prove their value (Carroll, 2000). Yet, despite these criticisms, the field of play therapy has continued to grow and develop, in part because its basic foundation requires child-centredness in its structure, processes and contents.

The use of play with children has strong historical roots, based in the belief that children learn and grow through play. Play becomes increasingly more complicated as children grow and expand their selection of toys, or tools, to use in everyday functioning, most notably in working out problems. These tools can be strategically utilized by therapists in helping children model attachment patterns, work through trauma experiences, and demonstrate patterns of effective relationship, in ways that are familiar, increasingly effective, comforting and potentially meaningful to children in terms of identity, resiliencies, and capacity building. The other advantage of play therapy is that it works with what a child gives the therapist within a therapeutic moment on pathways to recovery that are not fixated on adult-oriented attainment goals. When the therapist signals understanding and safety, and joins with a child in the play process, that child may come to increase his-her sense of safety and trust.

2.0.2.6 Life course perspective.

According to Bengston & Allen (1993), the life course perspective is a relatively recent perspective that developed over the past 40-50 years, which looks at the impact of

history and social change on individuals. “Scholars who write from a life course perspective and social workers who apply the life course perspective in their work rely on a handful of staple concepts: cohorts, transitions, trajectories, life events, and turning points” (Bengston & Allen, 1993, p.11). This perspective, previously known as” life cycle” (Germain & Gitterman, 1995, p.21) was influenced by the human development tradition, developmental psychology, and family development theory, each of which applies to families over time (multiple-clocks assumption) with the basic themes of time, context, meaning, and how individuals are influenced by each other (Bengston & Allen, 1993). Time includes family experiences, family transitions, and historical events. Meaning is focused on processes and change within both individuals and families. Within social work, this model is integrated into the interactional model of Shulman (2015b).

Application of the life course perspective to complex trauma gives required attention to intergenerational issues and interdependence of lives (Hutchison, 2007). Complex trauma most often has generational roots, and understanding the connections of these roots across time spans is important for early therapeutic intervention (Liberman et al, 2011). The life course perspective searches for patterns in human development, which is a huge challenge (Bengston & Allen, 1993), given the heterogeneity of complex trauma. However, it has been critiqued as a perspective of the more affluent countries as it has not been used in systematic study on a global level, and thus its cultural sensitivity is called into question (Afuape, 2011). A promising development is that publications representing global cultural perspectives on social work practice, child protection, and child welfare are increasing (Welbourne & Dixon, 2013).

With the recognition that complex trauma is passed from one generation to the

next, primarily through parenting styles, the life course perspective becomes an imperative knowledge base for therapists who work with traumatized children. Such children are victims not only of the abuses inflicted by caregivers, but they are at very high risk of developing both maladjusted behaviours and protective features, which together will have a significant impact on them throughout their lives, and into their future, especially as parents of the next generation of children.

2.0.2.7 Developmental processes.

Issues inherent in childhood development include the dichotomies of nature-nurture, stability-change, and continuity-discontinuity, each having influences in the lives of all children. Cognitive developmental stages are key as well, as these enable children to assimilate and accommodate. These stages are: sensorimotor (birth to 2), pre-operational (2 to 7), concrete operations (7 to 11), and formal operations into adolescence and beyond (Piaget et al, 1962). These stages are thought to develop consecutively, each one more complex than the last, with progression through these stages dependent on many factors. However these stages are thought to be interrupted by trauma, causing a child's chronological age and their cognitive age to differ greatly. This gap is often seen in adolescents with a history of trauma who present as immature, slow to comprehend, and often having a verbal ability that masks their cognitive ability, thus confusing the therapeutic process. Eric Erikson's eight-stage theory outlines basic conflicts that occur through each stage of development, from trust/mistrust at birth to 18 months, to integrity/despair from 65 to death (Erikson, 1963). Knowledge of these conflicts during

the developmental stages in childhood and how each is impacted by trauma are key to providing effective interventions.

Developmental theory is based on knowledge that integrates maturational, transactional, and ecological perspectives. To assess children accurately, a practitioner must be aware of the steps, timing, and tasks that characterize the different stages of development. Children think differently than adults and the younger they are the more cognitive divergence we see, therefore making assessment of children much harder than that of adults (Davis, 2011). This model comes under criticism in that theories of childhood development are often interpreted as truths, and therefore alternate views are rarely considered (James & Prout, 1997b). Childhood may be viewed as a socially constructed concept, and therefore it varies across all cultures and societies, making it difficult to identify a single concept that fits all children. According to James & Prout (1997b) comparative and cross cultural analysis reveals a variety of childhoods rather than a single universal phenomenon of childhood, confirming their belief that it is biological immaturity and not childhood that is universal. A further criticism of the model lies in its adherence to age related stages of development. This is challenged by the knowledge that chronological age and developmental stage, which normally develops in a parallel process, can be interrupted, depending on a number of factors, most notably trauma. As a clinician I have to interpret a child's developmental stage by their overall presentation and thus their development, in comparison to the expectations of their chronological age. This is informed by knowledge that because of traumatization, children often do not progress through the developmental stages in a chronological way, as do their peers who have not experienced trauma.

A child's level of development influences all aspects of their lives including their ability to engage and interact. Assessing a child's development is vital in counselling as a therapist needs to know children's chronological age with its cultural expectations, plus their developmental age and its limitations. Using this knowledge, therapeutic intervention has to then be offered in a way that respects a child's age and their ability to benefit from therapy given that trauma is a dividing factor between the two. Without such knowledge, therapy may be compromised because of its incompatibility with the contextualized needs of a traumatized child.

2.0.2.8 Biopsychosocial perspective.

This is a framework for understanding how internal and external influences affect individual adjustment. The biological and psychological aspects of this perspective relate to the individual while the social aspect captures the effects of the family, the community, and the wider social culture, and societal structure and organization. The processes within each interact, influencing the occurrence of emotional or mental disorders, and the inclination towards resilience, or the ability to function adaptively despite stressful life circumstances. Therapy expands beyond the individual to recognition of systemic factors that can both create and ameliorate problems (Corcoran & Walsh, 2009; Shulman, 2015a). The biopsychosocial perspective has become a key assessment tool in children's mental health services. It had its beginnings as psychosocial perspective, developed from the writings of Mary Richmond, (Richmond, 1917) and later refined by the work of social worker Florence Hollis (Hollis, 1969) who insisted on the inseparability of social components, thus articulating the psychosocial approach (Hollis, 1969; Robinson &

Kaplan, 2011). The psychosocial perspective later included biological influences to become the biopsychosocial model. Critiques of this model see it as another euphemism for psychosomatic illnesses, which has the potential to be exploited to limit medical or government services to clients (Robinson & Kaplan, 2011). Others challenge that it does not have a theoretical framework thus is not a true scientific model, and therefore is not a model of clinical practice, especially in mental health (Alvarez et al, 2012). In my own experience, its all-encompassing extensive focus is a vital tool for thorough assessment, which is paramount to effective intervention. It has proven to be a very inclusive tool in the assessment and treatment of children referred for therapy. It has the capacity to gather knowledge and perspective about a child from many divergent viewpoints, and is invaluable in integrating and synthesizing information. It is through such synthesis that traumatized children are seen in terms not of the trauma they experienced, but the effects of that trauma. It is the effects of the trauma that require immediate intervention as the effects underlie the protective mechanisms that became the reason for referral to therapy. The interconnectedness and interactions among these elements are observed and analyzed through biopsychosocial assessment. In making observations and guiding transactions in play therapy contexts, attention to biological factors, psychological factors, social factors, and their interactive influences, respects the complexity that a child has experienced and is experiencing; this gets far beyond reducing a child's issues to his/her behaviours.

2.0.2.9 Researchers tacit knowledge, skills, and values.

Tacit knowledge is the grand total of one's professional experience. It includes a multitude of inexpressible associations, which give rise to new meanings, new ideas, and

new applications (Lincoln & Guba, 1985). Given the complexity of practice research, the use of tacit knowledge is of significant value, especially in the search for processes underlying therapeutic intervention, known as process research, which has emerged as an area of social work in need of more research (Anastas, 2014). In tandem with this researchers tacit knowledge, the addition of social work practitioner skills developed over the course of practice, and social work values (CASW, 2017) this research study focused attention on the corresponding tacit knowledge, skills, and values of the study's participants in their therapeutic interventions, with the intention of understanding 'what works' in their practice of provision of interventions to children exposed to complex trauma. Such practice is seen as being discursive and embodied, highly contextualized at various levels, and affected by things that are unconscious and unknown (Longhofer & Floersch, 2012). Thus this researcher endeavoured to obtain knowledge that could not be understood independently from the researcher and the study's participants, therefore capturing 'practice wisdom' that may otherwise be lost (Kazdin, 2008).

2.0.3 Application of the theoretical framework.

A synthesis of each of these perspectives with associated theories and concepts, provides a mutually influencing and integrative theoretical framework, which informs my clinical work with children, particularly in the area of trauma work. This framework, inclusive of theories of psychoanalysis, attachment, family, trauma, play, life course, developmental and biopsychosocial perspectives, play therapy, and this researcher's tacit knowledge, has evolved from my practice experience, and has enabled me to consider key components of a child's development, their internal structures, their environments,

and their supports, to intervene effectively. This integrated interlocking framework is what I used to guide my dissertation, and its research of practices, interventions, and change processes, identified by play therapists in their treatment of complex trauma. While my framework is based primarily on earlier theories, and therefore requires constant re-evaluation to incorporate new material when relevant, these theories have been the subjects of continuous scholarship, development and applications.

Using this context-relevant integrated theoretical framework, I explored the area of childhood interpersonal trauma, a Type II trauma (Terr, 1990), also known as complex trauma, which implies multiple exposures and developmental impacts of an interpersonal nature. This is an area in which clinical social workers have crucial roles, not only in identifying trauma, but also in the provision of effective, age, stage, and developmentally appropriate therapeutic interventions directly to those children affected. Joseph & Murphy (2014) argue that trauma is a unifying concept for the profession of social work, which deals with trauma on a daily basis. Social workers provide trauma services within a wide range of contexts, across all ages and social groups, leading to awareness of trauma sequelae, the effect of this sequelae upon its victims, and to the development of skills required for effective trauma practice.

2.1 Theoretical progress: trauma to complex trauma

This section reviews the many forms of trauma that affect children. The various types of studies undertaken to learn about these traumas and their effects will be reviewed. Following this, a review of literature on complex trauma will be undertaken. This review will incorporate development of the concept of trauma, its impacts, and long-

term sequelae. It will also consider early social work within the field of trauma, and the entry of trauma into the Diagnostic and Statistical Manual of Mental Disorders (DSM).

2.1.1 The epidemiological study of trauma.

Trauma is an overwhelming shock that creates substantial, lasting damage to an individual's psychological development, creating in victims, feelings of helplessness, vulnerability, loss of safety, and loss of control (Herman, 1997; Hindman, 1989; James, 1996; Terr, 1990). Trauma in children has the potential to negatively impact their mental, physical, and cognitive development so much so that the prognosis of meeting age appropriate developmental milestones becomes very unlikely. Even more concerning is the likelihood that as adults, these children will be overrepresented in hospitals, mental health institutions, community mental health programs, addictions treatments, detention centers and prisons (Briere & Scott, 2015).

The study of trauma has to be categorized in order to identify the many types of traumas and how they are inflicted. The United States National Center for PTSD (Fairbank, 2008) categorizes epidemiologic studies of child and youth trauma into four categories, as follows:

(1) General studies: these were established to estimate the prevalence and impact of a range of traumas in general populations of youth. Findings show widespread exposure to a broad range of traumatic experiences including criminal victimization.

(2) Disaster studies: high estimates of psychiatric symptoms are prevalent in studies of children exposed to various types of disasters including; terrorist attacks, hurricanes, earthquakes and tsunamis.

(3) Child maltreatment studies: these establish the incidence of child maltreatment, including sexual and physical assault. In United States in 1994, there were over one million substantiated cases. In 2005, there were 900,000 substantiated. These figures do not include those not reported, or reported and not substantiated, or those reported and recanted by children out of fear.

(4) Studies of at-risk children and youth: these studies focus on populations identified as at-risk, including juvenile offenders, children in foster care, abused and neglected children, and children with multiple adverse experiences.

It is important to recognize that within these categorizations, there is the likelihood of overlap as trauma can be represented in any and all of these studies. However, together they represent the overall epidemiology of traumas experienced by children. Of the various types, complex trauma, which can be represented in both child maltreatment studies, and children at risk studies, has many complicating factors not included in the other types of studies. Specifically, complex trauma entails breaches to relationships that were built on the basis of trust, protection, and attachment, all factors that must be optimally restored for the successful treatment of complex trauma.

2.1.2 Conceptualizing complex and developmental trauma.

According to the *Diagnostic and Statistical Manual of Mental Disorders 5*, (5th ed., American Psychiatric Association, 2013), "trauma and stressor related disorders are specific to exposure to a traumatic or stressful event" (p.265). More specifically posttraumatic stress disorder relative to adults, adolescents, and children over 6 years, is defined as "exposure to actual or threatened death, serious injury, or sexual violation" (p.

271). For children under age 6, the same definition applies, however with more detailed diagnostic criteria.

Two types of traumas are articulated: Type I, or single incident traumas including natural disasters, and Type II or man-made disasters, inclusive of interpersonal trauma (Terr, 1990). *Complex trauma* is a Type II trauma. It is a relatively new concept that evolved from the term psychological trauma. It has been recognized as a multifaceted problem that disrupts functioning on a systemic level involving both the body and the mind (van der Kolk, 2005). For three decades the concept of psychological trauma expanded to include increasingly complex symptomologies. The notion of complex trauma does more justice to the experiences and the sequelae for children in care, but trauma, historically studied only in adult populations, has been studied more from a children's perspective, only in recent years - however social workers have been aware of developmental sequelae since the early 1900's (Addams, 1912).

The definitions of childhood complex trauma have been many, however each definition takes into account the same key characteristics which are; a child's exposure to severe stressors from ongoing abuse, beginning in childhood and repeated over time, and perpetrated by a caregiver whose role it is to protect children (Boyd Webb, 1999; Bussey & Wise, 2007; Cook et al. 2005; Mannarino & Cohen, 2011; Steele & Malchiodi, 2012; Terr, 1990; van der Kolk, 2005). Complex trauma is a multifaceted problem that disrupts children's personal and social functioning on many different levels, including biological (e.g., hypervigilance), psychological (e.g., dissociation) and social (e.g., compromised attachment and relationships). These levels of trauma and their impacts have a powerful effect on children's physical and mental health throughout their lives, especially as young

adults and as adults many years later. Such harmful impacts are evident in my practice experiences whereby adults with mental health and addictions issues predominantly disclose histories of childhood sexual abuse, supporting Knight's (2015) finding that adult survivors of childhood trauma account for the majority of clients seeking treatment.

The impacts of complex trauma include increasing situational risks as evidenced by the fact that people with histories of trauma, abuse, and neglect make up almost the entire prison population in the United States (van der Kolk, 2005). It is also evidenced in the field of psychiatry, for which the patient-client population is over-represented with adults who experienced trauma as children, and then went through a lifetime of diagnostic labels that were rooted in their early childhood experiences (Sinason, 2011). This is in keeping with epidemiological studies, which show that children exposed to trauma are vulnerable to a range of psychological, behavioural, and emotional problems, social maladjustment and academic failure (Allnock & Hynes, 2011). Statistics on childhood trauma support its prevalence but also support the multiple types of victimization, or polyvictimization, which predict the highest rates of trauma symptoms (Mannarino & Cohen, 2011).

Such evidence is testimony to the lasting effects of childhood trauma, and highlights the dire necessity of early intervention with developmentally appropriate interventions, which could change the negative trajectory of traumatized children's futures. It has been within my own work with traumatized children that I have developed an interest in researching interventions that go beyond traditional talk therapies, which are now known to be less than effective with children. Children learn through their natural language of play, which helps them to explore, and to express emotions including

pain (Pehrsson & Aguilera, 2007; Schaefer & O'Conner, 1983). One developmentally and neurologically appropriate form of intervention can be found within the field of play therapy whereby certified play therapists intervene with high-risk children, who have experienced complex trauma (Reyes & Asbrand, 2005). In my experience with the use of play in therapy, I have witnessed its powerful effects. The activities give 'voice' as they speak children's language and offer opportunities for expression of their traumatization, while providing opportunities for children to master their traumas, and to regain hope for their future.

Most traumas begin at home as the vast majority of people (almost 80%) responsible for child maltreatment are children's own parents (van der Kolk, 2005). When trauma stems from within a child's caregiving system beginning early in childhood the traumatized child will organize their behaviour around the expectation of, or prevention of, abandonment or victimization while keeping the abuse a secret (Herman, 1997). For example a child who becomes aggressive to protect himself cannot simply stop acting out when the danger has passed. S/he remains in hypervigilant mode, which is most often misread by caring adults as an aggressive personality. Similarly, a child who tells a lie as a way to protect himself from an abusive parent cannot stop lying simply by being removed from that home, nor can a child who is taught to steal as a way to please adults stop doing so because of removal from this environment. These apparently unreasonable patterns have their own logic but are still very difficult for caregivers to comprehend. Ignorance of the effects of trauma on a child may lead to labels such as: oppositional, rebellious, unmotivated, detached, and antisocial. In addition, it can also lead to stigmatization for behaviours that are meant to ensure survival (van der Kolk,

2005). In my experience, the majority of mental health or behavioural management referrals on children in care are for behavioural issues such as aggression, defiance and lying, which did not subside following removal. It is important to recognize that in social work practice history, the functional school recognized this paradoxical pattern of function in apparent dysfunction (Dunlap, 2011; Jani & Reisch, 2011; Towle, 1957).

Initially, clinical exploration of the more direct effects of trauma was prompted by studies of war veterans. Traumatized soldiers from WWI were diagnosed with war neuroses, including the phenomena labeled shell shock (Bailey, 1918). Work with these veterans propelled the field of social work into a recognized specialty prompting the development of a new education curriculum to prepare social workers to treat returning veterans in WWII (Bransford & Bakken, 2003). It was the diagnosis of Vietnam veterans that contributed to the formulation and inclusion of posttraumatic stress disorder (PTSD) in the DSM, 3rd ed. (APA, 1980). At the same time there was an increased societal awareness of violence against women and children, which specifically highlighted the trauma of child abuse and its post-trauma effects (Herman, 1997).

Clinical exploration of psychological trauma continued, with increased knowledge and practice wisdom from the vantage point of trauma as experienced by children and as impacting mental health and development. Subsequently, researchers found that the effects of child abuse trauma, although fitting a posttraumatic model, also evidenced differences in breadth, depth, and developmental impacts (Cook et al, 2005). Changes were proposed for DSM-IV to reflect these findings by adding a new category of developmental trauma disorder (Cohen, Mannarino & Anthony, 2010). However DSM-IV-TR (2000) instead included a lengthy definition of a traumatic stressor but with

more specific criterion than its predecessor. Gil (2010) criticized this definition as being too limiting, too incomplete, or too misleading. It was also criticized for the limited acknowledgement of the differential effects of trauma on children and youth. Thus PTSD remained primarily an adult diagnosis until May 2013, when DSM-5 was released, in which childhood trauma was more clearly recognized and articulated. However, publication of DSM-5 has sparked debate, thus increased the ongoing research into our understanding, assessment, and treatment of trauma. Scholarship that expands ahead of various iterations of the DSM, informs policy and practice. In this latest revision, PTSD symptom criteria are elaborated and expanded to reflect the different effects of trauma on children, including reduced diagnostic thresholds for children under six years old (Wakefield, 2013). A critical component of progress will be the dissemination of research findings to those best placed to intervene with traumatized children as well as those working with traumatized children contributing to the research findings. I would suggest the majority of those would be social workers, both in clinical practice and in child protection, which are at the frontline of services for children. These social workers are in prominent positions to implement practice-based evidence, and expert practice wisdom interventions, which eventually evolve into evidence-based practices. A feedback loop needs to be acknowledged and is required in this field so that not only does research and practice inform policy but policy also informs practice, and wise practice informs research, policy, and the practice of others.

Recognition of the needs of high-risk children in DSM-5 will change the discourse of complex trauma, a major step in reframing the issue. The diagnostic criteria changes will focus attention on identifying high-risk children and promoting reflective

clinical exploration and research for developmentally appropriate interventions. In doing so the days of treating complex trauma in children with medication and dismissal will, hopefully, become a thing of the past. In my clinical experience attending to behaviour and reducing behaviour related problems, medicating without benefit of psychotherapies such as talk therapy or active therapies (e.g., play therapy), or dismissal of the presenting issue as not being significant, have more often been the norm than the exception, within the medical field. Take the case of a traumatized child, age 8, who attempted suicide. The psychiatric response was a one-time treatment of Ativan, and return home with no follow-up. The psychiatrist specifically stated there were no symptoms of PTSD, despite my well-informed insistence. Using DSM-5, this child would have met the specified criteria for diagnosis, thus changing the course of his treatment, and perhaps the predictable symptomatic and developmental trajectory of his future.

The use of PTSD as a diagnosis for trauma is not without its critics. One of the major criticisms is that of its use towards the medicalization of trauma as a condition to be treated pharmacologically, rather than as a normal response to overwhelming experiences (Burstow, 2003; LeFrançois, 2006; LeFrançois & Coppock, 2014, Mills, 2014; Singh & Chang, 2012). Some see trauma as being adaptive, and are concerned that the western world has pathologized responses and adaptations to abnormal and abusive experiences (Afuape, 2011; Burstow, 2003). Such views see trauma as an opportunity for individuals to develop resilience, resistance, posttraumatic growth and recovery (Brom et al., 2009). Of these, resilience has received significant attention. Resilience is the capacity to rebound from adversity, strengthened, and to become more resourceful (Bussey & Wise, 2007, p.8), a concept that can be strengthened by protective factors in a

child's life. Resilience is often credited with the successes many victims of traumatic experiences have later in their lives. Other critics of the changes in the DSM-5 fear the potential to increase the prevalence rates of PTSD (Jones, 2011). Still others, such as Cohen, Mannarino & Anthony (2010) say the DSM-IV diagnosis, with revisions, could work well, supporting their position by highlighting established treatments for child PTSD, under conditions where risks are high and needs are often left unmet. Starting with the needs of children and contextual relevance, social workers and play therapists have an opportunity to be child-centred as opposed to diagnostic theory-centred.

Within the conceptualizations of trauma, complex trauma has been identified as one of the most debilitating types, given that it occurs within the confines of a child's interpersonal relationship with a caregiver. The resulting sequelae have highlighted the need for continued and ongoing study into finding effective interventions for treatment that respects complexity. This need was supported with the release of DSM 5 (2013) in which the needs of high-risk children were recognized, as was the need for effective therapeutic interventions. Far too many children do not get the help they need while they are young enough to ward off the effects of trauma and thus are unable to change the predictable trajectory of trauma effects (Perry, 2009).

2. 2 Historical and political context

This section will review literature concerning the historical and political context of complex trauma by first of all reviewing the history of childhood and how it has been conceptualized and re-conceptualized throughout its development. Depending on the historical timeframe, the political will, and the value of children, the view held of children often changed to realign with societal pressures, and pressures from those who

were able to keep the best interests of children in the forefront.

The study of trauma calls to attention the experiences of oppressed people, and therefore is an inherently political enterprise. Because subordination of children especially has been so deeply embedded in our culture, the use of violence against them (and against women) has only recently been recognized as a violation of human rights. By the late 1800's social work as a movement advocated for children's protection and for the end of child labour, as well as for the end of the sexual exploitation of children as seen in the writings of social work leader and Nobel Prize winner, Jane Addams (Addams, 1912), in *A New Conscience and An Ancient Evil.* Years later it was the feminist movements that re-focused attention to the widespread sexual abuse of children (Herman, 1997) including interpersonal abuse, arguably, a form of complex trauma.

2.2.1 A history of childhood.

According to Demause (1974) the history of childhood is a nightmare from which we have only recently begun to awaken, evidenced by the fact that the further one goes back in history, the lower the level of child care and the more likely children were to be killed, abandoned, beaten, terrorized, enslaved and sexually abused. Newman (2000) supports this view and proposes that the social history of childhood is "an upwards temporal incline from barbarity to humanity" (p. 323). The context of how our present day view of childhood evolved requires revisiting how our understanding of the meaning of child and childhood evolved throughout history including in it the concerns of religious groups such as the Salvation Army, and novels such as those of Charles Dickens. The concept of childhood gaining more recognition with the influence

of key historical events such as: The Industrial Revolution (1760 -1840); World War I (WWI) (1914 -1918); The Great Depression (1929-1941); and World War II (WWII) (1939 -1945). A major contributing factor within this range of historical events and timeframes was society's understanding of childhood and what it was or was not. Repertoires of themes were influential in the construction and re-construction of childhood (Hendrick, 1997; James & Prout, 1997a, 1997b). In the eighteenth and nineteenth centuries, there were a number of conceptualizations of childhood, making it impossible to identify a single definition. Hendrick (1997) summarized competing identities as coming from the influences of "Rousseau, Romantics, child-labour reformers, anti-slavers, penologists, educationalists, moralists, psycho-medics, and advocates of all aspects of child welfare, each adding to an ongoing conception of a proper childhood" (p.60). Conceptualizations were further refined by societal influences including a class society, cultural influences, religious influences, economics, education, child labor and philosophical influences (Heywood, 2008), plus the principles of medicine, psychology, and education, political goals, and the emerging value of the family (Hendrick, 1997). Together these influences support the concept of child and childhood, at least in part, as social constructions which have changed based on presiding views and values of the day but which also saw the evolution of the belief that children were different from adults, and in fact were the polar opposites of adults, and therefore required treatment different from adults (Addams, 1912; Freud, A., 1976; James & Prout, 1997b).

The Industrial Revolution (1760 - 1850) saw urban children working in factories and rural children working in agriculture. During that time children were assets to

families in that they brought in wages. It was a time when moral treatment (1790's - 1900's) was the predominant view of mental illness for all citizens, including children (Hendrick, 1997). However, society was then changing from an artisan system of labor to capitalism. This saw a weakening of the old paternalistic order, and brought challenges to religious beliefs of social positions and roles in life being divinely preordained. It was also a time when scientific reasoning promised to unravel mysteries of mental illness (Bransford & Bakken, 2002). Efforts to prevent children from earning a wage were being made whereby in many countries governments attempted factory legislation, child labor laws and compulsory education (Hendrick, 1997).

It is only relatively recently that Western society has treated children as individuals, and therefore distinct from their family. According to MacLeod et al. (2004) this shift began during the Industrial Revolution when children's living conditions became a concern and governments responded by limiting age and hours of work, and by mandating primary school attendance. At the same time, volunteer social reformers stepped forward to care for children who were neglected or abused (MacLeod et al. 2004). Today we have evidence that goes beyond social construction, supporting the contention that children's biopsychosocial development, including neurological structure and functioning, are not complete until the late teens or early 20's (Davies, 2011) thereby extending the conceptual frame and timeframe of childhood far beyond past beliefs.

At the turn of the 19th century the role of children in society was beginning to change, from views that they were non-people who were to be manipulated, conforming, and obedient (Heywood, 2008) to the view that they were citizens who albeit were property of their parents, were still entitled to the protection of the law as evidenced by

1889 anti-cruelty law by the National Society for the Prevention of Cruelty against Children (NSPCC) (Newman, 2000). At that time society did not seem to notice that children were people from birth, and how they were treated framed their behaviour into adulthood (Satir, 1987). However, the early work of social work pioneer Jane Addams (1905, 1912) was instrumental in bringing attention to concerns for the welfare of children. Child therapists such as Anna Freud and John Bowlby contributed greatly to this societal awakening through their direct therapeutic work with children and their influential writings. In 1951 Carl Rogers brought recognition to therapists in the field of children's mental health with his edited publication *Client-Centered Therapy*. As efforts towards recognizing the rights of children increased, the UK and USA saw a deflation of children's economic value and inflation in their emotional worth (Heywood, 2008; Newman, 2000).

Throughout history the construction and re-construction of childhood has been influenced by many factors. Changes and new understandings were instrumental in the recognition of children as individuals with their own unique needs and their own rights, separate from those of adults. Among the needs recognized through such changes was that of therapeutic services specific to children, contrary to the model of adapting adult services to children, or adjusting children to fit adult services, as discussed in the following section.

2.2.2 A History of therapy with children.

Before the 19th century, the idea that the state should intervene in relationships between parents and their children was almost unthinkable. Governments expected the

head of the household to be responsible for the orderliness of its members and in return children and women were seen as property of the heads of households (Heywood, 2008; Newman, 2000). However, before the turn of the century, the efforts of social reformers such as Jane Addams, and newly passed laws highlighting the special needs of youth over adults resulted in the establishment of the first juvenile court in Boston. This court combined the ideas of holding hearings for youth separate from those for adults, having a judge who was specialized in working with youth, and the idea of probation for youth, each being a new concept in the legal treatment of children and youth.

The children's court movement made significant contribution to social diagnosis by social workers (Richmond, 1917). Because of these changes, and the growing influence of Christianity and education, the 1870's to the 1930's saw an emergence in America of a more positive conception of childhood, and the growing need to change societal expectations of children and youth, so as to implement labor laws restricting child labor, and focusing attention on the educational needs of children (Heywood, 2008).

Consequentially, there was an ongoing reconceptualization of childhood and a discovery of adolescence, which was as much a social construct as was childhood. At the same time, science had put forth a germ theory of mental illness and those who refuted this looked for other explanations. Consideration was given to Sigmund Freud's views on mental illness, specifically hysteria (Freud, 1896), one of the most widely discussed diseases. It was here that psychoanalysis began to take root in Western society. This, the enlightenment period, also known as the age of reason, saw the view of childhood change to be that of a time of education, particularly for boys (Heywood, 2008). The treatment of mental illness also changed to what was known as the Mental Hygiene Movement,

beginning in the 1900s through WWII (Bransford & Bakken, 2002). Emerging from this movement was the development of child guidance clinics, at the request of the settlement house movement, overseen by sociologist and social worker Jane Addams, and supported by the work of pioneer social worker Charlotte Towle who taught at the Institute for Child Guidance in New York (NASW, 2014).

The earliest organized psychological work with children began in 1896 with Lightner Witmer's child guidance clinic at the University of Pennsylvania (Reisman & Ribordy, 1993) at a time when children were still seen as non-people, and thus the idea of therapy with them was a bold venture. This was the beginning of therapy with children. Here, learning principles were applied to autism, anxiety, and fears. Its success brought skepticism towards traditional and largely unsuccessful psychoanalytic methods, thus opening the way for a new generation of professionals to use conditioning and behaviour modification (Barnes, 1996). Social workers were involved considerably in this child guidance movement, including work within the University of Pennsylvania (Rogers, 1942).

In examining how and why child psychotherapy became possible, the period between the two world wars stands out as particularly significant. Post war reconstruction brought much needed attention to the treatment of children. A White House Conference on the problems of childhood resulted in clinics offering early intervention by 1922 to children exhibiting behavioural problems, and support and education to their parents, and by the late 1950's there were over 600 child guidance clinics providing fieldwork experiences in the training of social workers (Bransford & Bakken, 2002). However according to Rogers (1942) social workers had already been doing this work

independently.

There were new developments in medicine, and welfare provision. Concern was high over infant mortality rates, about children's health, and about the decline in the population as a result of considerable losses in WW1. Education had become compulsory. Attention was paid to children who did not fit into the education system in terms of possible treatments for them. Within this movement, providing supportive environments, which would foster emotional as well as intellectual growth, became a priority (Urwin & Hood-Williams, 1988). The end of WWII saw the beginning of 'The Community Mental Health Movement', which still continues today. Emphasis was shifted to prevention and early intervention, and laws were implemented to provide for the needs of special populations, including children (Heywood, 2008).

The child study movement flourished throughout Europe and the United States at the turn of the 20th century (Urwin & Hood-Williams, 1988). Psychiatrists worked in close collaboration with social workers in psychiatric clinics, child guidance clinics, and family service agencies, with the two professions greatly influencing each other (Hollis, 1969). The fields of play therapy and social work were part of this movement as evident in the writing of social worker Elaine Dorfman in her chapter on play therapy in *Client-Centered Therapy* (Rogers, 1951), thus interconnecting the two fields of practice.

2.2.3 Social work's historic roles with purposeful play.

Social work historically was concerned with social justice and personal and social care (Addams, 1905; Richmond 1917; Robinson, 1934). It focused on poverty and ill treatment, in parallel with social care, social support and social security. Clinical social

work focused on deviance (e.g., addictions) and personal and social problems such as impacts of health problems on family security, addictions and mental health (Richmond, 1971), but also had a supportive role as seen in its involvement with support groups, such as the Y (today known as YMCA). The Y which was founded on Christian principles, and incorporating the mind body and spirit, was instrumental in the development of sport and team activities, which were considered to be character builders (McCuaig, 1982). It was while teaching at the Y in 1891, that James Naismith invented basketball. Such a supportive role was also seen by the use of play within Jane Addams Hull House and Toynbee Hall in England. At Hull House, Ms. Addams fostered development of the play movement by developing programming for children, including music, art, childcare, kindergarten, and boy's and girl's clubs. The Boys and Girls club movement also attended to the needs of marginalized children and youth as it was within these clubs that play was used to build personal and collective strengths. Based on this it is apparent that Jane Addams recognized the power and value of play, and therefore her work can be seen as one of social work's earliest connection to play therapy (Rogers, 1951).

2.2.4 Professional acknowledgement of child abuse.

The first written work on child abuse was by a French forensic physician, Ambroise Tardieu, in 1857 when he was commissioned to examine children from a medico-legal viewpoint, about which there was no mention in previous medico-legal writings (Roche et al, 2005). However the issues, although unrecognized medically or legally up to that point in time, were identified through other means, such as the writings' of the *Christmas Carol* by Charles Dickens in 1843 based on his own accounts of

children working in appalling conditions, and later, *Les Miserables* in 1862, by Victor Hugo, depicting the abuse of a young girl named Cosette.

Tardieu studied thirty two child death cases, and presented his findings as three groupings of children; those who were mistreated (9), those who were subjected to severe physical abuse and torture (5), and autopsy cases where the cause of death was by physical abuse (18, inclusive of one case of sexual assault) (Roche et al, 2005). In reporting his findings he reported that the inflictions were made by parents/caregivers, who asserted their right to discipline their children. Tardieu's work did not awaken social consciousness or indignation or interest as he had expected nor was his work ever quoted in the psychoanalytic or psychiatric literature (Roche et al, 2005). However, he published his findings in his 1857 book*, A Medico-legal study of Assaults on Decency*, followed by six later editions. This was the first book written about the sexual assault of children, and the first of its kind in Europe. Tardieu's assistant and eventual successor, Paul Brouardel, further drew attention to the abuse of children by their parents through his medical work, and wrote his findings in a book in 1909 on the rape of children entitled, *Les Attentats aux moeurs*, in which he stated "Sexual assaults are crimes of the home" (p.8). However, this remained an issue that science and the public seemed to prefer not to notice. It was a time of low literacy, minimal development of communication technology, and the realities that social attitudes may typically change slowly. Even with advances such as radio, television and public literacy, social attitudes were very slow to change, taking over 100 years before substantial change was seen.

2.2.5 Historical efforts to expose child sexual abuse.

Paul Brouardel's acquaintance, Sigmund Freud, also a follower of Jean Charot and Pierre Janet, both of whom worked with women who suffered from hysteria, believed he had found the underlying cause of their neurosis. He presented his findings in his paper *The Etiology of Hysteria* (1896) at the Society for Psychiatry and Neurology in Vienna. He presented his revolutionary new theory that the origin of neurosis laid in childhood sexual traumas, which he had discovered in his work with adult female patients. However according to Masson (1984), Freud's idea was not well received, and despite the fact that he believed he had discovered an important truth, he was unprepared for the reactions of his colleagues. Freud was ostracized both professionally and personally until such time that he retracted his views (Brown, 1990: Masson, 1984). However, according to Newton (1995), Freud never really gave up on his trauma theory that seduction of children by their fathers could cause neurosis, but he did eventually question that molestation could be the cause in every instance of neurosis. Either way, society was not yet ready to hear about incest, seduction or resulting traumas, evident by its resistance to Tardieu, Browardel, and Freud, and their theories of abuse. The importance of their work was not addressed until more than a decade later and all the while the abuses and atrocities against children continued, yet remained unmentioned, though not likely a secret.

However, continued effort was made to bring the issue or child abuse into social consciousness. Therapeutic intervention with children was challenged by societal views of childhood. Societal blindness to the harms and traumas inflicted on children was ongoing, including that of sexual abuse, which was exposed by Jane Addams in her 1912

publication, *A New Conscience and an Ancient Evil*. The field of social work therefore was a forerunner in the field of children's trauma and incest. Social work was further influenced by Freud's follower, Otto Rank who wrote about these issues as early as early as 1912 and through his relationship with Jessie Taft and of the University of Pennsylvania School of Social Work, was able to impart his theories on subjects such as incest.

Efforts continued into the early sixties when Kempe et al. (1962) published The Battered Child Syndrome, in *The Journal of American Medical Association*, noting that, despite evidence of x-rays, there remained reluctance by professionals to conclude physical abuse as a cause of injury. Failures to protect children could be related, in part, to the reluctance of physicians to make a diagnosis that would withstand both college of physicians and legal examination at a time when many assumed that mothers, fathers, teachers, and clergy would not abuse children and that parents would hit a child to "correct" them, thus supposedly not abusing them (Kempe et al. 1962). However, social work efforts on this subject continued into the 1980's with the writing of *The Best Kept Secret. The Sexual Abuse of Children,* by Florence Rush (1980). Yet, today's viewpoint has not evolved much beyond past thinking. Resistance to acknowledgement of abuse is still seen at many levels including governments and their laws. In 2004, the Supreme Court of Canada upheld a controversial spanking law, (Section 43) allowing the use of spanking 'by way of correction'. This law remained virtually unchanged from its appearance in Canada's first Criminal Code in 1892.

Professional resistance continues today as well. As recently as 1997, Demause wrote of challenges to his own theory that abuse of children was more the norm than the

exception. Yet despite this resistance, once such beliefs are challenged, there is more openness to giving serious consideration to the risks and harm of child abuse. Social work has been challenging such beliefs since 1912, with Jane Addams writing of *A New Conscience and an Ancient Evil*. One of the early trauma theories and interventions undertaken by social workers was that of crisis and crisis intervention, which has remained a focus up to present day. However, more recently, social workers have focused attention to the victims and survivors of abuse through writing about the effects of traumatic stress, in publications such as: *Trauma and Its Wake* (Figley, 1986); *Crisis Intervention* (Parad & Parad, 1990), and a *Crisis Intervention Handbook* (Roberts, 2005).

2.2.6 Early study of the effects of trauma.

Clinical exploration of the effects of trauma was later prompted again by studies of war veterans and the concept of war stress. Stress at that time usually carried the same name of the provoking agent, such as lightning neurosis, railway spine, or shell shock which was also known as battle fatigue or combat exhaustion (Kardiner, & Spiegel, 1947). Until WWI (1914-1918), the issue of traumatic neurosis received little attention. However this Great War made the world neurosis-minded, and it was then studied with more care than at any time previously (Kardiner & Spiegel, 1947). A major concern in studying traumatic neurosis was whether to account for its symptoms on the basis of organic (having a causative agent) or functional (no obvious pathology or known cause) hypothesis.

Traumatized soldiers from WWI were diagnosed with war neuroses, including the phenomena of shell shock, as were soldiers of both WWII and The Vietnam War. These

ongoing diagnoses eventually resulted in the inclusion of posttraumatic stress disorder in the Diagnostic Statistical Manual III in 1980 (APA, 1980) thus recognizing the detrimental effects of this mental disorder. Clinical intervention with veterans propelled the field of social work into a recognized specialty prompting the development of a new training curriculum to prepare social workers to treat returning veterans (Bransford & Bakken, 2002). The expansion of Schools of social work in Canada was supported by the Government of Canada based on post WWII military needs (Kimberley, 2012-06-04).

2.2.7 Contributions of the women's movement.

The work with war trauma paved the way for the application of crisis trauma theory to crisis intervention by the 1970's, most clearly within the area of rape crisis and then by the 1980's to children in need of protection, especially when sex abuse by parents and by clergy became more public (Thomlison & Bagley, 1991). At the same time there was an increased societal awareness of violence against women and children, specifically highlighting child abuse and its effects, and women became champions of this cause. The women's movement became a powerful collective voice against the societal view that victims were responsible for the crime (Lake, 1994). Kitzinger (1997) likened the fate of women and children to be intertwined, as women take primary responsibility for all types of childcare. Women's consciousness-raising groups shared common characteristics with the Vietnam veterans' groups in that they were based on open sharing, validation, and support and "helped overcome barriers of denial, secrecy and shame" (Herman, 1992, p. 29). They broke through into social consciousness about the reality of abuses, including those against children, and the reality

of traumas and long term harm (Briere, 1989) inflicted on children as a result of those abuses. This anti-abuse and trauma intervention movement was successful in completing what other very influential individuals such as Charot, Janet, Tardieu, Brouardel and S. Freud had started more than a century earlier.

2.2.8 Children's rights within the context of play.

Throughout the construction and re-construction of the concept of childhood, the issue of children's rights accompanied questions of children's needs, to formulate the concept of 'the best interests of the child'. In 1989, many years after its original writing, The United Nations Convention on the Rights of the Child was implemented, and outlined the rights and needs that all children (should) have. It outlined a total of forty two articles highlighting children's rights including the following; children are defined as everyone under the age of eighteen (Article 1), and have: the right to treatment or special care when needed (Article 23), the right to be free from sexual abuse (Article 34), the right of protection from any type of exploitation (Article 36), the right to help if harmed or badly treated (Article 39), and noteworthy is Article 13, the right to find out things and share what you think with others by talking, drawing, writing, or in any other way. Article 13 alone identifies the special needs of children as a population in terms of their rights to communicate in their own language, that of play (Axline, 1947; Schaefer, 1976).

As of June, 2016, all countries around the world have ratified this international legislation with the USA being the only exception, basing its resistance on economic issues (not wanting to give universal free health care to children) and religious issues (the Christian conservative right wing agenda, led by arguments about parental rights).

However, the continued resistance to full support of the Convention has damaged efforts to concentrate global efforts to curb disturbing trends of continued atrocities to children inclusive of child exploitation, child pornography, and a worldwide increase in child trafficking, which continue to dominate as sources or trauma and failures to protect.

2.3 Study of the effects of trauma on children

Social awakening to the plights of children continued throughout the 70's and 80's with publications ensuring that child abuse, neglect, and trauma became serious topics of professional and academic endeavour. Lenora Terr, clinical psychologist, pioneered the reawakening of interest in childhood trauma with her classic 1990 study of Children of Chowchilla (Terr, 1990; Eth & Pynoos, 1985). She studied the psychological effects on a group of children who, while on a school bus, were kidnapped and taken to a secluded location where they were literally buried inside the bus. Terr's study highlighted the long-term effects of unresolved trauma. She also highlighted and differentiated the two very different types of trauma: Type I (which she refers to as god-made) includes hurricanes, tornadoes, and floods, and Type II (which she refers to as man-made), which includes war and abuse. With this study, Terr began to refine assessment of physical and psychological trauma of children, a process that had begun many years before with the work of Kempt (Kempt, 1978; Krugman & Korbin, 2013).

Children can become traumatized whenever they fear for their own lives or for the life of a loved one. Humans are biologically predisposed to protect themselves from harm and our basic internal protective mechanism is that of flight, fight, or freeze. This response is a protective device that only goes wrong if one is exposed to too much danger

with too little protection (Bloom, 1999). When children are exposed to danger repeatedly, their bodies become unusually sensitive so that even minor threats can set off a sequence of responses, either physical, cognitive, or emotional, or a combination of all three (Briere & Scott, 2015). Such reactions are biologically built-in for protection. If a child is subjected to a significant number of experiences whereby it is learned that nothing they can do will effect change, then they stop trying to effect change, and learn to accept what they cannot change. This learned helplessness could change their ability to recognize and escape from danger or to regulate their emotions, as their thinking is severely impaired. In such cases emotional memory is activated and trauma is engraved into their brain (van der Kolk, 2005). Trauma theory thus changes the clinical question from 'What is wrong with you?' to "What has happened to you?' (Bloom, 1999).

2.4 Literature on resiliency

Within the literature on trauma and complex trauma, reference is often made to the concept of resilience, meaning "the ability to bounce back, and recover" (Silva, 2004, p. 20). It "encompasses positive adaptation in the context of significant adversity" (Robson, 2010, p.249). Resiliency is of vital importance in identifying the positive and protective attributes and characteristics of traumatized children (Levine & Klein, 2007). It provides hope that children who have experienced trauma, specifically complex trauma, can recover and lead relatively normal lives.

Ungar (2013) identifies four specific sources of resiliency. These are; children's individual temperament and coping; children's social determinants of health; interventions by mental health professionals, and others who can impact their lives (i.e.

teachers, and other service providers), and; government policies that influences which resources are made available and accessible to children who have been maltreated. These factors incorporate individual, family, and community as sources of resiliency.

Individual characteristics can include qualities such as wishful thinking (as a coping mechanism), self-esteem, trust, optimism, and lack of guilt (Silva, 2004). However, early trauma can lead to biological dysregulation, whereby children who constantly live under the threat of victimization or re-victimization learn to expect the unexpected on a daily basis, which in turn affects their body alarm system and impairs their development (Pine, Costello, & Masten, 2005). Silva (2004) explains the body's immediate biological reaction to traumatic stressors is with catecholamine's, which are small organic molecules that act on the brain and throughout the body. These are one of the earliest and most crucial response substances. There are three types; dopamine, epinephrine, norepinephrine. Their secretion has a regulatory role, the release of which increases heart rate and blood pressure. Also, they stimulate the breakdown of fats, which produces energy. Insulin secretion is decreased resulting in an increase in glucose, which all together prepare the body for a flight or fight response.

This internal system works well for adults who have the option and ability to 'flight or fight'. However, with the lack of either of these responses available to children who unlike adults cannot 'flight' abusive situations, nor can they 'fight', fright becomes their only outlet (Silva, 2004), and if that traumatic energy is not released, it is remembered in the behaviour and the body of the victim (Norton et al, 2011). Unlike adults, traumatized children are more prone to not only feel helpless, but to actually be helpless. Their unresolved energy remains pent up, until it eventually finds expression in

a wide variety of behaviours and symptoms (Levine & Klein, 2009). Children's symptoms tell their traumatic story and are expressions of energy that is stuck in defensive mode, utilizing any of a number of universal symptoms of trauma; hyperarousal, constriction, dissociation, and feelings of numbness, shutdown or freezing (Briere & Scott, 2015; Levine & Klein, 2009; Crenshaw & Hardy, 2007). Any of these symptoms could potentially be misread as resiliency, as often is the case with children who present as unaffected by their trauma. Without knowledge of the impact of complex trauma or reliable indicators of resiliency, the need for therapy is often dismissed based on a child's asymptomatic presentation. However there is evidence of the need for knowledge of the many presentations of trauma, especially in identified populations such as out-of-home youth, who have been traumatized through various forms of maltreatment and for whom these experiences were found to have significant negative effect on individual, relational, and community resilience features (Collin-Vézina et al, 2011).

Each of the universal symptoms has unique presentations in childhood. When these remain unresolved over a period of time, they can remain unresolved or delayed for decades, or new symptoms can emerge. Within adult mental health and addictions services, clients often present with symptoms that developed as a result of their efforts to deal with unresolved childhood traumas (Farrugia et al, 2011). Often these clients believed they had dealt with their original trauma only to find that it remained pent up inside them and they must revisit it and gain mastery over it before they can begin to heal in an adaptive fashion. Mastery helps children adapt to memories of situations, including traumatic experiences, and to the stresses and sequelae resulting from their trauma (Soloman, 1954). In my practice with children, this process begins early, with a view to

discovering a child's resiliency, and utilizing it throughout the treatment process, within the confines of active therapies. Social workers have historically referenced this type of work as strength based counselling.

Traumatized children's support system, especially the caregiving system, is the strongest factor in a child's resiliency and long-term outcomes (Malchiodi, 2014). The quality of the attachment relationship between the caregiver and child can be the primary mediating factor between the development of traumatic symptoms and the child's resiliency. A child with secure attachments may adapt more easily to life events, have better coping skills, and have more interpersonal supportive resources than a child with insecure attachments (Chu & Lieberman, 2010). However, when a support system is unavailable or destroyed as a result of traumatic experience, children will often loose access to their internal adaptive coping mechanisms. However Ungar (2013) noted there is much more research on individual, family, and school factors associated with resilience than there is on the broader system tasked with the provision of formal services to ameliorate the impact of maltreatment and its resulting biological and behavioral sequelae. According to Devine and Kimberley (2012), minimal services to children "creates a risk for lives of chronic resilience" (p.66), identified as the "political code for taking care of themselves and their own needs"(p.66).

Within the professional community, there are numerous evidence-based interventions to address traumatic symptoms, most of which are based on talk therapy, emphasize resilience and include components of cognitive-behavioural approaches, specifically psychoeducation, building attachment, and emotion regulation (Blaustein & Kinniburgh, 2007). However, because children have limited ability following complex

trauma exposure, to express their feelings verbally, traditional talk therapy may not be beneficial for them (Levine & Klein, 2007). Their expression of traumatic stress is often witnessed through both disordered play and repetitive play which often contain a narrative theme of their trauma (Levine & Kline, 2007). To witness disordered and repetitive play as a means of accessing underlying trauma, social workers need to be aware of the therapeutic needs of children and be prepared to see and hear their traumas in ways that are unique to children. Such interventions go far beyond talk therapies.

Knowing how children process their trauma has far reaching impacts. Often a child may be viewed as resilient, when actually they are experiencing a delayed response to their trauma. Other times, therapeutic services to traumatized children can be delayed because of legal concerns that such interventions may 'contaminate evidence' if and when court appearances are required. Additionally, knowing that children most often cannot retrieve specific details through 'talking', places them in impossible situations, because the legal experts, the family, and the offender all expect a full verbal disclosure from victims, without which the outcome of the legal process is less than favourable for child victims.

2.5 Linking childhood trauma to adult disorders

A history of childhood trauma has been found to underlie many adult diagnoses used in today's mental health systems (Briere, 1989; Herman, 1997). In fact, many adults who seek mental health services, often becoming high end users of such services, do so for issues resulting from past childhood traumatization's, (Courtois, 2004; Levenson & Grady, 2016). For example, dissociation, also known as dissociative identity disorder, is

most often a trauma-based condition, which can be viewed as creative resilience (Spandler & Warner, 2007). It commonly develops as a coping strategy in the presence of severe and repeated abuse. After an episode of dissociating, grounding is often required, and a common technique used to do this is self-harm, often initiated by cutting oneself. Cutting behaviour is one of the primary diagnostic criteria of borderline personality disorder, primarily diagnosed in women. Some see such diagnoses as the latest example of the historic tendency to explain away the strategies used by some women to survive abuse (Spandler & Warner, 2007). It is all too common that neither therapist nor client recognizes the link between a presenting problem, such as self-harm, and a history of complex trauma (Herman, 1997; Briere & Lanktree, 2012).

Many psychiatric diagnoses such as multiple personality disorder and psychosis are growing exponentially based on histories of childhood trauma (Teicher & Samson, 2013; Bebbington et al, 2011). Such diagnosis are challenged by the belief that trauma can have a functional aspect in that behaviours which appear negative often enable a person to adapt in a world they see as being unsafe as it created the trauma in the first place (Burstow, 2003). It is these negative behaviours that have become the focus of much medical and pharmacological attention.

Expressions of trauma symptoms and behaviours in adults can often be traced back into their childhood where the trauma began. Some believe that traumas can serve to make a person stronger (Afuape, 2011) if they can find a positive outlet. Such strength can be seen in the histories of often highly successful people who succeeded not because of the trauma, but in spite of it, such as Edgar Allen Poe and Stephen King, who turned their childhood traumas into the socially acceptable outlet of writing (Terr, 1990).

However such strengths are often found to be exceptions to the norm as very few people have had such success. The risk of such a belief would be to diminish the attention to trauma and its effects, because some thinking is defined as being too medicalized versus expanding the definitions and understandings to respect the biomedical, the psychological, and the social, and their interactions (Kimberley & Parsons, 2012; 2017).

2.6 Modern day efforts in suppressing attention on child abuse and trauma

Recognition and interest in trauma and child abuse specifically have always fraught powerful social and psychological forces aimed at suppressing them (Herman, 1997). The first feminist writers of sexual abuse faced strong resistance by the media and within the professional community. An example of this resistance was evident following publication of Louise Armstrong's book, *Kiss Daddy Goodnight; A Speak-out on Incest* (1978), which was described as "pornography masquerading as science" (Lanius et al, 2010). It was not until the 1970's, through the efforts of the women's movement that the issue of child sexual abuse became more worthy of the reflective attention of the public (Cosentino & Collins, 1996). In the often forgotten words of Anna Freud, "Where the chances of harming a child's normal developmental growth are concerned, it (incest) ranks higher than abandonment, neglect, physical maltreatment or any other form of abuse. It would be a fatal mistake to underrate either the importance or the frequency of its actual occurrence" (Freud, A. 1991, p. 34). Social workers have been working with issues of sexual exploitation and incest when the word 'sex' was seldom used even in professional circles. This is evident by the work of social worker Florence Rush, in her 1980 publication of *The Best Kept Secret. Sexual Abuse of*

Children.

As recent as 1998, the Rind study reignited the issue of the consequences of child sexual abuse by publishing a study of college samples in which they concluded that lasting psychological harm through sexual abuse was uncommon. In July 1999, this study became the first scientific study to be formally denounced by the US Congress, however not before it was used by pedophile groups and attorneys in support of those groups, and the False Memory Syndrome Foundation in support of their cause.

Such efforts at discrediting children and their experiences are detrimental to child victims and recognition of their needs. Just because a child's memory is imperfect does not mean it therefore does not represent a true event with true traumatic consequences. In my experience a group of very young children provided their individual accounts of abuses upon them, all by the same offender. However, based on their variations of particular issues, such as the colour of curtains in the place where the abuses took place, their case never did proceed to court. This decision negatively impacted efforts to provide treatment to a number of these children. The requirements for conviction in this case negatively affected the needs of children. The fact the evidence may not be sufficient for criminal conviction does not mean that it is not sufficient for assessment, treatment and protection (Meyers, 2011). However, when the test of conviction outweighs the need for treatment, child victims become re-victimized all over again, as their experiences have determined a most likely negative trajectory without any professional intervention to redirect it. From a social work perspective, resilience and vulnerability can both be present. However, the presence of resilience and strengths does not mean that developmental vulnerabilities have vanished or are not clinically significant.

Many of society's most esteemed social institutions, specifically Christian Churches, have taken part in the denial and resistance or distortion in the recognition of abuse, but child sexual abuse in particular. As part of their work, they set up schools, orphanages, and 'Indian' residential schools, where some of the most endemic forms of child-youth abuse existed. The reality of the atrocities within these institutions was exposed in the 1990s (The Hughes Inquiry 1991, and the Winter Commission Report, 1990), through a surge of litigations against the Catholic Church in which it was harshly criticized for its negligence in dealing with reports of sexual abuse within the Mount Cashel Orphanage. This forced society to face and accept the reality of the atrocious harm inflicted on innocent children, without comprehending the developmental repercussions this type of abuse would have on its victims.

Such denial goes well beyond social institutions, to the highest power in our societies, that of governments. One of the greatest traumas recognized in society today, after decades in the making, was inflicted by governments on aboriginal peoples. Their traumatic experiences of colonization by European settlers, propelled by governments, have permeated throughout generations to present day, and remains one of the ongoing crises of our time. This is evidenced in present day Newfoundland and Labrador where aboriginal communities continue to fight past traumas in order to save present generations of children who self-harm at a much higher rate and at a much younger age than non-aboriginal youth. Residential school syndrome recognizes the interaction among the loss of parents and family, institutionalized abuse and maltreatment, trauma effects, and transgenerational impacts (Kimberley, 2015).

Despite their efforts however, such powerful forces have not been able to

maintain their efforts at suppression and denial. Key forces within society, specifically the ongoing efforts of the Women's Movement, and the many scholars and professionals attending to issues of trauma, attachment, dissociation, self-regulation, developmental sequelae, and transgenerational impacts of child abuse and exploitation, continue to highlight the abuse of children as a social problem. It is within the field of social work that the impacts of the abuses and the related risks and needs continue to be recognized, highlighted, and treated.

2.7 Continued progress in attending to childhood traumas

Today our knowledge of trauma, although in its infancy, is growing as we continue to build on its resilient foundation. One area where this work is breaking new ground is within truth and reconciliation work by and with Aboriginal peoples (Solantro, 2014). Efforts to apply traditional therapies to this population have been largely unsuccessful, thus demanding new,innovative, and culturally sensitive ways to intervene (Al-Krenawi & Kimberley, 2015; Brady, 2015). Working with an efficacious knowledge of trauma theory, including the progress of trauma to complex trauma, and incorporating the debilitating effects of intergenerational trauma (Bombay et al, 2009), plus understanding that all traumas have personal meaning to each individual which is in the individual's body, mind and soul, and in their very being, has formulated a template for trauma work. This aboriginal template (Solantro, 2014) has moved current trauma work towards models of active experiential healing, similar to the work of the functional school of social work. Experiential healing calls for treatment of all parts of the person, known as experiential therapy. Key components utilized in this therapy go beyond evidence

based practices to include modalities such as healing circles, inclusion of elders in workshops (which is known to provide empowering and culturally relevant support to the healing process), returning to the land, and telling stories of their own cultural history, heritage, and legacies. According to Solantro (2014), 80% of the present healing work in aboriginal communities is experiential, and is evidencing significant success.

Aboriginally defined and culturally relevant active healing practices go beyond the limits of evidence-based practice to serve a population that traditional therapies do not serve well. The lessons of failed attempts to apply traditional therapies to individuals with specialized needs can be generalized to clinical work with children, who by their very nature and developmental stages are experiential learners. Experiential healing is also the very foundation of play therapy, which utilizes the modalities of art, drama, sand tray, puppetry, dollhouse play, storytelling, and play to create experiential therapeutic moments within a play therapy setting. Combining this with children's natural language of play (Landreth, 2012) brings play therapy into focus as a logical modality of intervention, especially for complex trauma. Experiential therapies are increasingly being recognized in literature as effective modes of intervention with complex trauma and its sequela, specifically with children. However, it is recognized that many therapists may not be aware of experiential or action therapies, many of which have been supported by significant findings in neurology and developmental pathway research.

Still, it is important to recognize that children experience crises, complex traumas, and compromised support, which impact their developmental paths and give them a burden of post trauma effects, and related lifetime risks such as mental health and addictions. These risks may be addressed by age-stage appropriate active therapies, such

as play therapy, which can integrate related opportunities to build strength and resilience, and to actualize potential, but only if we are able to recognize and move past social constructions of children and their healing. Complex trauma is often hidden in the most obvious places: an asymptomatic child, a resilient child, an eternally obedient child, a child who ages out of 'in-care' to independent living, a child who is chronologically mature but developmentally immature, and a child who matures into adulthood and 'forgets' their traumatic experiences. It is also hidden behind the symptomologies utilized by these children to effectively tolerate perpetually high internal stress, which are inevitably presented as behavioural problems.

The biopsychosocial realities associated with complex trauma require interventions that not only meet the requirement of early intervention, but respect the need to go beyond traditional talk therapies to meet the challenges of the predictable symptomologies and negative trajectories of the lives of children exposed to complex trauma. Continued growth and development of experiential therapies, such as play therapy, are proving to meet the needs of children, most especially those affected by interpersonal abuse and breach of attachment, both key features of complex trauma.

2.8 Social work practice within children's mental health

The field of children's mental health has remained in the shadows of the mental health field for most of the 20th century. It was not initially believed that children suffered from mental health concerns, and any reference to those who did was met with the contention that 'they will get over it'. However, children's mental health was not destined to remain in the shadows, and has forced itself into the open, often through violence

rooted in child maltreatment and childhood trauma. This exposition has opened the field of children's mental health to an ongoing search for effective interventions (Liberman et al, 2011). According to Marmor (1987), clinical intervention approaches with children has challenged some of the foremost experts since the beginnings of the helping professions. One of the important challenges faced both historically and presently is to decide with some degree of assurance which specific form of psychotherapy is best suited for any particular client knowing there is no single best way of treating all clients and all conditions (Marmor, 1987). We also have to be astute enough to know when an intervention is not effective, and confidant enough to change our approach when needed (Axline, 1947). Thus social workers require a range of effective interventions for all issues presented by children, inclusive of the common, the unique, and especially the diverse. Play therapy is one approach that offers an alternate therapeutic approach for those children presenting with diverse issues such as complex trauma, for which traditional approaches, many of which were designed for adults, are not likely to be effective.

Like most disorders affecting child and adolescent health the etiology of children's mental health disorders are complex and multifactorial. However there seems to be a barrier to the acceptance of the existence of child and adolescent mental health issues as legitimate medical conditions that are worthy of the care of professionals and the attention of health care funding bodies (Leckman & Leventhal, 2008). Yet, disorders related to trauma and complex trauma can have profound effects on children, from inception and far into their future, and then into their following generations.

It is a sad reality that mental health interventions are necessary with children at all, however given that they are, it is critical that we approach children's therapy from positions of knowledge, experience (Robson, 2010), confidence, competence, and expertise. Children and adolescents specifically require professionals to be prepared with adequate interventions to fulfill their demands, since psychopathological patterns, comorbidities and response to treatment are different from what is seen in the adult population (Graeff-Martins, Flament, et al, 2008). However, there has been an almost total failure of all countries in providing adequate policy, training and services for child and adolescent mental health (Graeff-Martins, Flament, et al, 2008).

Even though children's therapy has progressed, as is evidenced by the over 550 treatments in use for children and adolescents, for over 200 disorders of mental health (Fonagy et al, 2002, 2015) the vast majority of which have not been subjected to controlled or uncontrolled investigation (Kazdin & Nock, 2003), there still remains a significant lack of appropriate services for this disenfranchised population (Kutcher, Hampton, et al, 2010). In Canada specifically, a country with the highest suicide rate among children and youth (Kirby & Keyon, 2006), children's mental health is the most neglected piece of the Canadian health care system (Kutcher, Hampton, et al, 2010). In fact, it has been referred to as the "orphan's orphan" (Kirby & Keon, 2004) of the health care system, based on the frequent reference to mental health as the orphan of the Canadian health care system. Within this system, polices and programming has focused primarily on the adult population, leaving children's services as an adjunct to adult services (Kirby & Keon, 2004). Within this system the majority of children with mental disorders do not receive services at all (Robson, 2010), most notably those with the most

serious issues (Jensen et al, 2011). Often times services are sought/offered when mental health deteriorates and the risks and needs may be reduced to problem behaviours (Robson, 2010); simplistic behavioural approaches may re-victimize children by expecting them to change in the best interest of the family, the school and the community. In my experience within mental health programming, children/youth are often interviewed and based on identified supportive factors in their lives such as family and friends, it is determined they may not be deemed in immediate need of services, and therefore they are either waitlisted or not offered services at all. These same children often return later, in deteriorated conditions, with added issues of self-harm, harm to others, anger issues, legal issues, and/or thoughts of suicidality, and the clinically significant links between their initial quest for services and their eventual 'scream' for services are often never validated.

The lack of sufficient and adequate services to children, arguably the most vulnerable of our population, highlights children's mental health as an urgent Canadian need, one that requires an important distinction that children are not small adults and even though child and adult trauma are similar on many dimensions, children and youth require intervention approaches that reflect their developmental and contextual risks and needs (Tishelman & Geffner, 2011). We owe children who have contact with our services the best therapeutic interventions that we can develop, and we need to develop these with respect, efficacy and compassion (Robson, 2010). To do this we need to be child-centred, child-friendly, and respectful of childhood and its social contexts, including therapy from a child's perspective.

Professionals who work with children are invariably seeking specialized skills and techniques to work with traumatized children in ways that are sensitive to both the unique needs of the issue and the diverse developmental, and individualistic needs of children (Drewes, 2009). One field that has focused mostly exclusively on children's mental health needs is that of play therapy, which places intense focus on developmentally sensitive methods. This field has much to offer in terms of therapeutic intervention with such children and their presenting issues. Play therapists are trained to use the therapeutic powers of play to help children work through psychosocial difficulties (Schaefer, 1976; 2011) including traumatization, to address the diverse challenges for children. It is within their therapeutic experiences that I will seek an understanding of practices and conceptualizations used in treating complex trauma. To do so, I will begin with an exploration of the field of play therapy from its inception to contemporary practice.

2.9 Social work practice with trauma and complex trauma

Relatively little attention has been paid to the effects of traumatic experiences in children, especially interpersonal trauma (Cohen, 2005; Schwean & Rodger, 2013). Even less attention has been given to the effects of multiple traumatization's or complex traumas, either in professional literature or in treatment approaches. Yet, particularly complex patterns of symptoms in children who have experienced chronic abuse have been identified, which go well beyond the PTSD conceptualization (Robson, 2010), inclusive of dissociation and affective symptoms, personality changes, vulnerability to repeated harm, hypervigilance, sleep difficulties, and a sense of foreshortened future. In

addition to this symptomatology, research indicates that children manifest symptoms in ways that are different from adults, for example through nightmares rather than the dissociative flashbacks that adult's experience (Robin, 2010). Such symptomatology and its presentation has been known as complex PTSD, or complex trauma, which children's practitioners believe requires specialized modes of therapeutic intervention (Cunningham & Booth, 2008; Kezelman & Stavropoulos, 2012).

Evidence is compelling that the effects of trauma inflicted early in life can result in serious cognitive and learning problems, as well as social and emotional difficulties (Cloitre et al, 2009, 2011; Davies, 2011; Herman, 1997, 2007; Putnam, 2006; van der Kolk 2005). This is seen in clinical practice on a regular basis whereby children are often referred for issues without recognition of any connection to an early trauma in their life. Their treatments then focus too often, on the presenting issue, not on the underlying trauma. The immediate positive outcomes of such treatments therefore are often not sustained, and children will return for counselling with different presenting issues, yet most likely from the same underlying trauma. Not all children who experience trauma will require intervention, as protective factors can serve to ameliorate its effects. However, when the impacts of traumatization go beyond the support and protection that a caregiver can provide, professional intervention and treatment are imperative to help children before more serious problems arise. Many children who enter into the foster care system specifically have experienced complex trauma. They are identified early as high-risk children, who often will tax the system based on their behaviours, which often has resulted from their traumatization. Recognizing the needs of such high-risk children and understanding that effective intervention and 'customized treatment' (Briere & Langtree,

2012) can make a difference leads to more effective practice. The field of social work with its knowledge, experience and expertise in working with high-risk children, and with its use of foster care as a therapeutic tool (Crosson-Tower, 2014) is strategically positioned to lead the way in continued development of effective child-centred interventions. However, a dearth of research in this area (Schwean & Rodger, 2013) leaves social workers facing an immediate crisis of how to intervene effectively with this diverse population.

Therapy with traumatized children requires specific features. Foremost, trauma and its sequelae should be assessed in terms of developmental contexts. Pynoos et al (1999) suggest that these contexts generate new sources of traumatic distress, situation-specific, secondary stresses, and new efforts at adjustment, which carry additional implications at each occurrence for acquisition of developmental competencies and prolongation or new onset of psychopathology. To be age appropriate and effective, Terr (2010) outlines the following features as requirements for working with this vulnerable population: safety established to a child's standards; proceeding in therapy at a child's pace; therapy to take place in a calm, soothing and supportive environment; therapy delivered by a skilled therapist who is capable of entering a child's world and containing their pain; individualized modes of treatment; a complete armamentarium of techniques; interventions that are age-appropriate and allow adequate time for processing; and mental health check-ups or sequential treatments that coincide with developmental changes as a child grows, allowing for processing of their trauma from each new developmental stage of life, as it occurs. Additionally, the therapist has to be constantly cognizant of the effects of the trauma(s) a child has experienced, especially unbearable betrayal,

immobilizing powerlessness, outrageous intrusion, intolerable anxiety, and impossible comprehension (McMahon, 2009). These therapeutic patterns can be implemented skillfully and safely by play therapists within the symbolisms of play (Boyd Webb, 1999; Gil, 2006, 2010, 2011). The task of therapy is to help children process their trauma with a goal of surfacing and ascribing child and situation-relevant meaning. Progress often requires revisiting the trauma in ways that are safe and child-centred with reduced risks of re-traumatizing. Often this means children need to forget the trauma in order to be able to remember it under conditions of increased security, which is the paradox of trauma work.

Too often, interventions provided to young children for early trauma are followed up only after they later become involved in the youth justice system, following a criminal offence**.** I have had the experience of providing therapeutic intervention to a four-year-old sexual assault victim, (offender was deemed not guilty) who did very well with his initial child appropriate therapy. He returned for treatment at predictable stages, and continued to benefit from age appropriate interventions. However, his presentations became less urgent as he aged, and his need for follow-up was determined unnecessary by a clinical intake process that was designed for a system that prioritized based on clients' presentations. In this youth's mid-teen years, he committed a violent assault on another teen, which opened the doors of the correctional system to him, doors he has since not been able to exit. Now as a man in his mid-twenties, he is seeking services to help him deal with his anger (at his abuser and at the system that did not convict) and his violence. Examples such as this are abundant in the field of children's mental health services, and likely will continue without a comprehensive model of intervention, which

recognizes the need for children and youth to have the option to enter and exit services throughout their development, and thus avail of sequential treatment(s) as required.

Trauma is understood as a sensory experience, not an event and therefore it is the sensory system that needs to benefit from treatments (Bloom, 1999). Trauma may assault children physically, cognitively, emotionally, and spiritually, and therefore treatment strategies must deal with post-trauma effects and long-term risks along each of these dimensions, as clinical intervention in just one area is not sufficient for achieving mastery and healing (James, 1996). Because of the anticipated complexity and interaction of symptoms as well as short and long-term developmental impacts, most mental health programs are too limited for traumatized children as many of these programs were developed using primarily a cognitive behavioural approach targeting behaviour and thinking, but most often neglecting the dynamics of underlying trauma. Trauma experiences may contribute to treatment impediments for children such as impaired empathy, reluctance to trust, and disbelief in the value of treatment (Greenwald, 2009).

It is impossible to develop a common profile of traumatized children, as expressions of their experiences are individual, multidimensional, and complex, while representing some diverse groupings (e.g., 'Indian' residential school survivors). Children's lives can take many different trajectories following experiences of complex trauma, including paths to recovery. Some are adversely impacted but show remarkable resilience (Afuape, 2011; Ungar, 2013). Some evidence transitions between periods of resiliency (e.g., good school performance; strengthening of safe social supports) and periods of recurring maladaptation (e.g., dissociation; attraction to unsafe social supports). Some never seem to recover, and instead develop chronic problems that persist

and even become compounded throughout their lifetimes. Yet others seem almost impervious to these experiences, and appear to become stronger in the face of trauma (Brom et al, 2009). Compounding risks and harms is the fact that many adults do not detect that children are traumatized and if they do suspect trauma, the attending adults try to minimize the issue. I have seen such adult patterns in my work on many occasions, from issues of sexual abuse ("they won't remember it"), to a family pet being burned in a house fire ("we replaced it with a new one and she did not know the difference"). I have seen the resulting negative impact of systemic denials, minimizations, rationalizations, and unjustified dismissals on children as well.

Because of the many diverse expressions of the effects of trauma, interventions need to be highly specialized and individualized for each child presenting with symptoms of traumatization. Because of this diversity, social workers need to look beyond the one-dimensional approaches that are based on verbalization and intellectualization. Also, we need to recognize that children's many maladaptive symptoms and presentations are the result of attempts to manage overwhelming emotions, which can be functional in the short-run, but detrimental in the long-term. If we fail to protect children from such overwhelming stress, then we can count on contributing to life-long adjustment problems that take a toll on them, their families, and society as a whole (Bloom, 1999). Adjustment problems can progress to be expressed as sets of behaviours that require short and/ or long-term involvement in the mental health system, and without successful outcomes, can then resurface within the youth justice system. More common however, is the surfacing within mental health and youth justice systems concurrently. This is not a new development as both the mental health and justice systems historically have been the stop

points for victims of early traumatization. Recognizing this alone highlights questions as to why early interventions, with age appropriate counselling services for children have not been given more attention, especially since research has shown that early intervention is fundamental to ameliorate the progression of trauma sequelae (Kirby & Keon, 2004). The awareness through research of the sequelae of trauma and complex trauma during each developmental stage, without appropriate interventions could in fact signal that traumatized children are an oppressed group, who are in need of specialized and context-relevant services. The 1989 *Convention on the Rights of the Child* (www.phn.gc.ca) (ratified in 1991) (Cohen & Naimark, 1991) brings awareness of the need to protect children from such oppressions. Yet mental health services to children continue to proceed with interventions that are less than child appropriate, despite research that indicates the need for age and stage appropriate services (Fonagy et al, 2002, 2015).

In 2013, the newly released DSM-5 made significant progress in the identification of trauma and traumatic stressors, especially with children. It specifically identified the experiencing of sexual violation as a traumatic stressor, which is much clearer than the stressors identified by its predecessor DSM-IV. In addition, PTSD symptom criteria are elaborated somewhat and expanded from three to four groups (re-experiencing, avoidance, persistent negative alterations in mood and cognition, and arousal), plus reduced diagnostic thresholds are now provided for children under 6 years old (Wakefield, 2013). Within this long-awaited systemic recognition, social workers need to move forward in the development of improved and context-relevant interventions, and challenge some of the preferred programs that have been deemed to have met the tests of effectiveness by program developers and managed care systems. We have to look beyond

their selling features and promotions, to find developmentally congruent trauma interventions for children. Gains are being made in the field through the work of individuals such as Dr. William Steele, social worker and founder of The National Institute of Trauma and Loss in Children (TLC). Through dedicated program development this institute has repeatedly trained professionals to relate to childhood trauma.

The danger of not treating complex trauma effectively lies not only in its immediate effects, but also in its effects throughout the lifecycle, which are then carried forward to the next generation of children via clinically significant compromises in parenting styles (Kimberley, 2015). Traumatic stressors can lead to difficulties in emotional regulation, behaviour, consciousness, cognition, and identity formation (Cook et al, 2003, 2005; Schore & Schore, 2008) and chronic interpersonal relational difficulties (DSM 5, 2013; Davies 2011). In fact, in its white paper on *Complex Trauma in Children and Adolescents*, the National Child Trauma Stress Network in United States (Cook et al, 2003) has identified seven primary domains of impairment of children expose to trauma; (1) biology, (2) attachment, (3) dissociation, (4) affect regulation, (5) behaviour regulation, (6) cognition, and (7) self-concept. Each of these has been researched as separate entities by various clinicians and researchers. The following is a synthesis of material on each.

(1) Biology: The study of neurobiology has supported the belief that the structure and function of the mind and brain are shaped by experiences (Perry, 2009; Pynoos et al. 1999). According to Applegate and Shapiro (2005), in their seminal work for the social work profession, *Neurobiology for Clinical Social Work Practice,* social workers need to

be educated on the new brain research to understand its implications for conceptualization of risk and resiliency in clinical social work practice. The brain develops largely sequentially, from the bottom up, from the least complex to the most complex, and each part will become more fully functional at different times during a child's development (Perry, 2009; Taylor, 2013). The clinical implication of neurobiological findings is the knowledge of the differential impact of traumatic experiences at varied stages of development. Trauma interferes with the integration of left and right hemisphere brain functioning, such that a child cannot optimally access relational thought in the face of overwhelming emotion (Cook et al, 2007). The neurological impacts also contribute to the observations that some children may present as asymptomatic following a traumatic experience, which may be mistakenly assessed as resilience alone, while not surfacing clinically significant vulnerabilities. At the opposite end of the spectrum where negative behaviours present as over anxious, impulsive, and dysregulated, children will have a difficult time participating in and benefiting from services targeting more focused social skills, self-esteem and reading (Perry, 2009). Knowledge of the impacts of traumatic experiences changes both the discourse and understandings of children's presentations for professional and paraprofessional helpers. For such children, conventional mental health services, which are reactive rather than proactive, are relatively ineffective, and may even be associated with verifiable behaviour changes that paradoxically may do little to ameliorate the risks and needs of the ostensibly compliant child. Active therapies (e.g., play therapy) assume that the process of therapeutically oriented activities will help restructure some neurological processes (e.g., hypervigilance) in support of more normative development.

(2) Attachment: John Bowlby's theory of attachment suggests a universal human need to form close attachment bonds (Bowlby, 1969; Davis, 2011; Sinason, 2011). The biological function of the attachment bond between a parent and a child is protection; the security in turn supports normative range development (Davies, 2011). Of the different types of attachment (secure, avoidant, ambivalent, and disorganized), the attachment-disorganized child has either experienced a traumatic loss or physical or sexual abuse (Davies, 2011; Riggs, 2010). The experience of overwhelming and uncontrollable fear with no safe place to go activates the attachment system and proximity seeking but without reaching supportive and security-providing resolution. In cases whereby trauma is extra-familial, timely and child-centred reunification with a caregiver is vital for a child's well-being. The complexity and uncertainty of trauma under conditions where primary attachments are not readily available for support was evident to me when responding to the September 11 (9/11) redirection of air traffic to Gander, Newfoundland and Labrador, following terrorist attacks on the United States of America. I transported displaced, terrified children to designated safe homes with the primary goal of safety which included helping them make immediate telephone contact with a loved one, thus enabling them to reestablish their own safety within their attachment system, thereby helping them to process their traumatic experience in ways that increased security and decreased uncertainty within a crisis context. For some children post trauma effects appeared to be moderated.

When those whose responsibility it is to protect a child perpetuate trauma, the impact on attachment is very clinically significant (Sinason, 2011) in that it may promote the development of a trauma bond. New research on adult attachment is suggesting that a

child's whole attachment experience is internalized and carried forward into new relationships, thus continues to influence individual functioning into adulthood (Riggs, 2010). Relational impacts of trauma and developmental sequelae have implications for clinically significant compromised parenting and parenting development programs and activities as well. Active therapies may be used to help reduce negative and maladaptive attachment patterns and to increase positive and adaptive attachment patterns for children, in parallel with support for parents or alternative care providers (VanFleet, 2014). Current understandings of the interface between attachment and trauma also have implications for parenting and parenting capacity programs as well.

(3) Dissociation: One aspect of this experience is a set of disparate personalities, each of which, at any particular point, may regard themselves as the self (Sinasen, 2011). Each self serves a unique function, as I witnessed in a youth who presented with many selves, all of differing genders, ages, and experiences, but helping her survive unbearable and unspeakable abuse, hurt and fear. It is estimated that dissociative disorder resulting from complex trauma approaches ninety percent (Sinason, 2011). Dissociative defense routines may function as a key protective factor of complex trauma in children (Silberg, 2013a). While dissociative responses and patterns begin as protective mechanisms in the face of overwhelming trauma (Cook et al, 2003), these patterns often develop into a problematic disorder as they continue to be expressed even when they no longer are needed to protect. Chronic trauma exposure can lead to an over reliance on dissociation as a coping mechanism (Cook et al, 2007). I have often had referrals on children for psychogenic fainting, amnesia, and emotional numbing. Stein (2007) categorizes these types of dissociations as built in safety valves. The therapeutic challenge is to erode these

coping patterns under conditions where imminent threat and risk are significantly reduced or absent; active therapies may help children learn to better judge social situational contexts and to select healthy and adaptive attachment objects and patterns and to "let go" past functional patterns of dissociation which became maladaptive within contexts of relatively safe social bonds under conditions of removal or control of imminent threats.

(4) Affect regulation: Complexly traumatized children show impairment in their ability to express emotions and their ability to adjust or regulate internal experience. When children are provided with inconsistent models of affect and behaviour or with inconsistent responses to display of affect, no coherent framework is provided through which to interpret experience (Cook et al, 2007). For example, children who are told they are a disappointment to the adults in their lives will become confused when their actions are suddenly supported and encouraged by the same adults. Patterns such as "you are strong - stand up and fight the bully"… to "why are you always getting into fights; you have an anger problem", become even more problematic when the same behaviours become socially unacceptable, as in the case of a five-year-old child taught by her mother to shoplift. In my experience of working with such children, their ability to regulate emotions in an environment that is consistently inconsistent and chaotic is next to impossible. Alternative care may be needed even when a child does not appear to have experienced any contact abuse. In some contexts active therapies may be used with high risk children in care, thus helping foster families work in the best interests of children, including children's mental health, while not becoming chronically overwhelmed. Affect regulation interventions may be helpful as part of a treatment plan (Schore & Schore, 2008). Play therapy and other activity-oriented therapies may help with affect regulation.

(5) Behavioural Regulation: This is imperative if children are to succeed in the many dimensions of, and contexts for, areas of development that require control, compliance, and conformity. To be competent in this area a child must be able to link choices to outcomes; to build a sense of self; and meet developmental tasks (Blaustein & Kinniburgh, 2007). Complex trauma is associated with both under and over controlled behaviour patterns, including compulsive compliance with adult requests, resistance to changes in routine, inflexible bathroom rituals, and rigid control over food intake (Cook et al, 2003). Without an understanding of these behaviour variants, a traumatized child may be labeled with any number of diagnoses that are based on negative identities alone, without any significant and child-centred knowledge of the underlying trauma and associated complexities, including efforts to adjust. For example, in my clinical experiences, girls become quiet and hyper vigilant in the aftermath of trauma, whereas boys become more ostensibly dysregulated. Application of complex trauma knowledge allows child-centred comprehension of such behaviours and thus can prevent often inaccurate diagnoses of depression in girls and misapplied attention deficit hyperactivity diagnoses in boys (Cook et al, 2003), a pattern seen all too often by social workers in the field of children's mental health services. Active therapies use children's action patterns under conditions of physical-behavioural expression to help arrive at more accurate and child-centred assessments, and to ameliorate maladaptive patterns of self-expression through developmentally-relevant actives ranging from play, to art, to music, to dance, to "sport", to simple *in vivo* activities which provide an opportunity for children to be active and expressive in a non-clinical setting. For example, one child who experienced high and complex trauma which included exposure to familial and community violence, was

given opportunities to express her anger (affect) and aggression (actions) with a punching bag at the age of 5; by the age of 11 she informed her social worker that she no longer needed the punching bag and that her anger was no longer troublesome.

(6) Cognition: Studies of maltreated children have shown the following patterns: impairment in cognitive functioning, including memories; delays in expressive and receptive language; deficits in overall intelligence scores (IQ); less flexibility in creativity and in problem solving tasks; deficits in attention, abstract reasoning, and problem solving; and lower grades and poorer scores on standardized tests (Cook et al, 2003; Putnam, 2006). These repeated findings have been demonstrated across a variety of traumatic exposures (i.e. physical abuse, sexual abuse, neglect, and exposure to domestic violence) and cannot be accounted for by the effects of psychosocial stressors such as poverty (Cook et al, 2003, 2005). Thus low functional IQ scores can often be challenged when children do not perform well academically or in terms of their expressions of comprehension of social situations. Such a challenge was successful for me in the case of a traumatized child who initially scored in the developmentally delayed range, and later showed higher than average IQ. The application of active therapies gives the therapist an opportunity to refine biopsychosocial assessments of children (e.g., insight and functional intelligence), to help overcome presumed deficits (e.g., attention and comprehension) and to enhance strengths and optimize capacity (e.g., improve reasoning and problem solving under conditions of risky peer pressure). Such a child does not react to their environment as it is but as they see it, with a host of internal factors influencing his perception (Hollis, 1969).

(7) Self-concept: Among the dimensions to consider initially are opportunities for individuals to develop a sense of power, uniqueness, and connectedness (Bell, 2006). Repetitive experiences of harm and/or rejection by significant others, and the associated failure to develop age-appropriate competencies are likely to lead to a sense of self as ineffective, helpless, deficient, and unlovable (Cook et al, 2007). Such children have problems estimating their own competence. Often, they are likely to blame themselves for negative experiences and are likely to avoid sharing negative self-talk and beliefs about self. I believe this calls into question referrals to mental health services for self-esteem issues, which has escalated in recent years. Clinicians need to be able to look beyond presenting issues to develop an alliance with children and youth such that underlying factors and dynamics may be discovered and acknowledged representing more clinically significant truths associated with the referral such: as "adults have let me down and have treated me as if I am hopeless … I feel like I am hopeless … a loser". Active therapies may successfully surface suicide risk in ostensibly resilient children at one end of the spectrum and help children and youth reconstruct their identity, self-concept, self-worth, self-esteem and self-confidence on the other end of the spectrum, as they develop beyond the trauma experiences and their sequelae.

The types of therapy commonly provided to support children and young people who have been abused fall into two broad categories: talk therapies (which includes cognitive behavioural therapy, psychodynamic therapy, and psychotherapy) and creative therapies (including play therapy, art therapy or drama therapy). In child-centred therapies, a child is considered an active subject with the ability to act and speak on his/her own (Allnock & Hynes, 2011). Within each type of therapy, clinicians are

continuously seeking specialized skills and techniques to work with traumatized children in ways that are sensitive to both the unique needs of the issue and the diverse developmental needs of children (Drewes, 2009). The field of play therapy, which places significant focus on developmentally sensitive methods, has much to offer to clinical social work intervention with traumatized children. Play therapists are trained to use the therapeutic powers of play in an informed fashion, to help children actively work through psychosocial difficulties. For the play therapist, becoming attuned to children's beliefs, attitudes, values, and expectations, about self, as well as feelings about self and identity, is important in terms of understanding the impact of trauma on a sense of self-identity. According to Boyd Webb (2011) social workers are increasingly utilizing specialized methods such as play therapy (including the use of art, sand play, music, and storytelling) in their work with young children. It is notable that the American Board of Examiners in Clinical Social Work (ABE) now has a specialty in child and adolescent therapy as a practice specialty of advanced clinical social work. This action recognizes the body of specialized knowledge in this field as a justification for the formal recognition of child and adolescent clinical social work (Boyd Webb, 2011).

One of social works early casework theorists, Florence Hollis (1969), described the difficult work of dealing with underlying issues, by comparing it to weeds in a garden. She explained that if you have a garden and weeds were choking out the good plants, you could cut off the tops of the weeds and the garden would look good, but the roots would still be there. She asked if it would not be better to pull out the roots, knowing it would be harder, but the results would be better. She then likened this to human emotions, saying that many of us try to hide our difficulties and stamp them

down, but this takes energy that could be used for better things. She stated the only way she knew to deal with these emotions is to uproot them and deal with the underlying things that are painful and intolerable (Hollis, 1969). Ms. Hollis was describing the treatment of trauma, from a casework perspective. Such a philosophy applies to trauma work with children today.

Meeting the therapeutic needs of children has been and continues to be the focus of many practitioners. However, it is the specialty area of play therapists that are trained specifically to work with children and youth utilizing the power of play. Therefore, it was within their therapeutic experiences this researcher sought understandings of practices and conceptualizations in treating complex trauma. As any research of this complexity and depth has to be bounded, this researcher depended on the play therapy experts as the case example of therapists dealing with complex trauma in children. Any parallel interviewing and observing children themselves or observing children in play therapy would constitute another study. Such studies are justified in terms of further research.

2.10 Introduction to play therapy

The field of play therapy has a long history of specialized work with children, dating back to the late 1800's, when it was known as psychoanalytic play therapy (Bhatti, 2006). This type of therapy used interpretation to understand a child's words and their activity with toys, as both of these are children's ways of expression, compared to an adult way of expression, which is through their use of words (Klein, 1976). Today's play therapy continues to be based on the recognition that play is the natural language of

children (Gil, 2010; Schaefer, 1976), as it is through play, that children learn to make sense of their world and most things in it (Riedel Bowers et al, 2016). Using this age/stage appropriate approach to communicating, clinicians are able to observe behaviours directly and intervene appropriately (Crisci et al, 2009). Play therapy provides an important venue for therapists to understand a child's struggles and what they may be experiencing internally. Play and activity provides insight into the effectiveness of interventions with children's felt concerns, including traumatization (Boyd Webb, 1999; Gil, 2010; Goodyear-Brown, 2010). Within these interventions lie processes that can inform therapeutic work by all clinicians working with children, including social workers. There is a large body of evidence in play therapy literature that looks at multiple childhood issues from viewpoints of establishing safety and relationship building, and at specific therapeutic interventions used in treatment. There is however, less information on the processes that occur during therapeutic interventions (Kenney-Noziska, 2012) specifically during the middle phase of treatment, where play therapists implement therapeutic factors, as discussed above, skillfully and safely within the symbolisms of play (Gil, 2006, 2010, 2011). Knowledge of these processes can enhance effective clinical interventions with children exposed to complex trauma. These processes, which are to be found in the interface between complex trauma and play therapy, form my area of research. Therefore it is within the therapeutic experiences of skilled play therapists that I will seek an understanding of practices and conceptualizations in treating complex trauma in children. To do so, I will begin with an exploration of the field of play therapy from its inception to contemporary practice. This exploration is preceded with a

discussion of the parallel development of the fields of play therapy and social work, inclusive of challenges internal and external to their respective progress.

2.10.1 Cognate development of play therapy and social work.

The history and development of play therapy, parallels that of social work as can be seen through tracing the developments of both professions. The social work profession has its roots in a time period when the societal roles of women and men differed greatly. Efforts for social reform included activist movements, research to combat misogynist views, and focusing attention on justice issues (Tyson, 1995). Many of the leading pioneers in both social work and play therapy were deeply influenced by the women's movements and worked for women's suffrage. Amid this context, the fields of psychoanalytic therapy with children (later known as play therapy) and social work each began with their own unique directions to address identified needs; psychoanalytic therapy with children aimed to address the unique and specialized needs of children, (Freud, 1976; Klein, 1976) while social work aimed to address the many diverse needs of the poor (Addams, 1905, 1912; Richmond, 1917). Both fields started with key figures: Anna Freud with the application and incorporation of play within psychoanalytic therapy with children (Freud, 1976,1991), and Jane Addams in the application of social work principles working with those marginalized and at risk, through Hull House (Addams, 1905). With the entry of other key figures specifically Melanie Klein in psychoanalytic therapy with children and Mary Richmond in social work, both fields became divided in their overall visions. In therapy with children, Anna Freud emphasized theory, while Melanie Klein emphasized technique and process (Donaldson, 1996) (the theory-practice

divide). In social work Jane Addams emphasized the common good, while Mary Richmond emphasized individual treatment (Franklin, 1986) (the theory- practice divide). Social work added the framework of the functional school (Robinson, 1934) that emphasized process, and personal and social development, including that of child development.

Within social work, Mary Richmond's early focus on diagnosis, evident in *Social Diagnosis* (1917), was challenged by a functional school of thought that was introduced by Otto Rank through the Pennsylvania School of Social Work, after Rank reduced ties with his mentor Sigmund Freud. This division between the diagnostic school and the functional schools of thought changed the direction of social work teachings and practice, and divided the profession (Doyle, 2011). While the diagnostic school focus was identifying the client problem by focusing on the underlying meaning of client behaviours, the functional school saw the client as being responsible for change in the here and now, and emphasized the power of the therapeutic relationship in aiding the change process. It was not until 1957 that the two became more synthesized through the work of Helen Harris Perlman, who identified the common elements of client strengths and client-worker relationships as the mediums of client growth (Perlman, 1957).

In play therapy, the divisions between directive and non-directive play therapy saw the similar separations within its field. Traditional therapists saw non-directive as the preferred mode of intervention based on the early models utilizing psychoanalysis. In psychoanalysis models, the therapist did not engage directly with children, but observed and assessed, with the belief that children have within themselves what is needed to heal, and the role of the therapist was to be present, support, encourage, and help analyze

(Schaefer, 1976). This was challenged by directive play therapists who believed it was of more value to engage in play, only after being invited in by children to do so, and to use the play therapy process within their developing and supportive therapeutic relationship to help children work through their problems (O'Conner & Braverman, 2009). This division has only recently been challenged with the view that the divide needs to be mended, so that the field can focus on more important issues such as the processes within play therapy (Kenney-Noziska et al, 2012).

Divisions within social work and play therapy saw each of these fields separate within, which significantly impacted the directions both fields would eventually take. By separating within, both fields have historically been challenged on their professionalism. The most infamous challenge to play therapy was to prove its effectiveness, with a well-known article by Phillips (1985), published in *Psychotherapy*, called 'Whistling in the Dark'. Social work's most infamous challenge to prove itself was with the now infamous question 'Is Social Work a Profession' asked by Flexner (1915), in his publication in *Proceedings of the National Conference of Charities and Corrections* in. The questioning of a profession from within has the potential to cause significant harm, or it can provide opportunity to display strength. Both the fields of social work and play therapy responded to their respective challenges through research which supported not only their effectiveness, but also their potential and their significance to society. Such research continues today with increasingly more publication of studies in peer-reviewed journals, supporting practice and recommending future directions for research and professional scholarship in both fields. The area of complex trauma has been the recent focus of both social work and play therapy research efforts, as evidenced by publications in respective

professional journals, but also through publications by leaders in both professions; social workers (William Steele, Beverley James), play therapists (Eliana Gil, Cathy Malchiodi, Sue Bratton, Athena Drews), and those who have trained in both social work and play therapy (Nancy Riedel Bowers, Nancy Boyd Webb, Paris Goodyear-Brown).

A review of the development of both fields shows that their early divisions were also their beginning points. Anna Freud eventually acknowledged and supported Melanie Klein's work in the practice of psychoanalysis using play (Freud, 1976). In social work, Jane Addams acknowledged the importance of Mary Richmond's focus on individual work. She also stressed the importance of play for children and proceeded to foster the development of the play movement through her work at Hull-House with the development of programming for children including music, art, child care, kindergarten, and boys and girls clubs (Heywood, 2008). In doing so the fields of social work and what is now play therapy interconnected. This connection was further strengthened when Sigmund Freud acknowledged to the world that children were sexual beings (Freud, 1953), a concept totally new to the philosophers of the day (Heywood, 2008). This opened the field of studies and interventions with children beyond that of psychoanalysis, which historically had an exclusive hold on the field. The fields of social work and psychoanalysis, using play, were both positioned to become significant contributors in the field of therapeutic intervention with children.

The child study movement flourished throughout Europe and United States at the turn of the 20th century (Urwin & Hood-Williams, 1988). The interconnected fields of play therapy and social work were part of this movement. Social work historically had been concerned with social justice, focusing on poverty and ill treatment, yet it gradually

moved into social support and social security. With the development of clinical social work as a specialty within the social work profession (Lieberman, 1982), its practitioners borrowed from psychodynamic, cognitive-behavioural, and systemic approaches in order to address the wide range of issues presented by clients in various settings (Applegate & Shapiro, 2005). Clinical social work focused on deviance and social problems, such as addictions and mental health, but also had a supportive role as seen in its involvement with support groups, the YMCA, and play within Jane Addams Hull House. Social workers who worked with children recognized the need for specialization in working with this population, which the developing field of play therapy was able to offer. It is apparent that Jane Addams recognized the power and value of play, and therefore her work can be seen as social work's earliest connection to play therapy, cementing the interconnection between the fields. Many social workers have since trained as play therapists and have become leaders in the field, as will be seen in the following exploration of the development of the field of play therapy. While there is no clear evidence that the functional school's focus on the helping process was ever translated into play, there is evidence through the work of Jessie Taft that she was seen as a therapist who worked with problem children, and who proposed therapeutic adoptions; she was also greatly influenced by Otto Rank who had an interest in the effects of incest (oral discussion with Dr. Dennis Kimberley, 2016-01-15).

2.10.2 Play therapy development.

As stated previously, theories of play and its development are rooted as far back as Plato whereby it was determined that play produced more information than

conversation in interacting with children (Plato c.427BC –c.347BC). This belief was supported in the mid 1900's by Eric Erikson who believed that a few hours play can tell us things that children could never verbalize (Erikson, 1976). Today's many definitions of the word "play", although similar, vary depending on the source. Oxford English dictionary (2005) describes play as an exercise, brisk or free movement or action; Merriam-Webster.com (2012) defines play as a state of being active, operative and relative; free and unimpending motion; and Miriam-Webster's New Collegiate Dictionary (1989) defines play as the spontaneous activity of children. The definition of "play therapy" varies as well. Oxford dictionaries.com (2014) defines play therapy as therapy in which emotionally disturbed children are encouraged to act out their fantasies and express their feelings through play, aided by a therapist's interpretations. The merriamwebster.com (2014) defines play therapy as psychotherapy in which a child is encouraged to reveal feelings and conflicts in play rather than by verbalization. Dictionary.com (2014) defines play therapy as a form of psychotherapy used chiefly with children, in which patients act out situations in play that are expressive of their emotional problems, conflicts, etc. Today's official definition, as coined and promoted within the field of play therapy by The Association for Play Therapy (APT) (2013), defines play therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (www.a4pt.org). Within each of these explanations of play and play therapy lie the basic premises that the use of play within a therapeutic process is based on freedom, activity, spontaneity, expression, revelation, and acting out, making play the "natural medium of

self-expression" for children (Axline, 1947, p. 9) in present day play therapy as it did historically. The current global perspective is that play as a concept and as a healing agent continues to undergo modifications, especially with the advancement of technology based play (Riedel Bowers et al 2016).

According to Lebo (1952), the first person to advocate studying the play of children was Jean-Jacques Rousseau, who in 1758 recognized the value of play and stressed the importance of play in understanding children. Rousseau identified a natural connection between play and work stating that "Work or play are all one to him (the growing child), his games are his work; he knows no difference. He brings to everything the cheerfulness of interest, the charm of freedom" (Lebo, 1952, p.126). Play, as an avenue for freedom of expression has since become a basic premise for further theoretical developments of play (Riedel Bowers, 2013).

It was not until 1901, with publications by Karl Groos that play began to receive scholarly examination. Groos stressed the importance of games in the play process to strengthen the socialization process. His work was followed shortly after by the writings of Sigmund Freud, who in 1909 wrote *Analysis of a phobia of a five-year-old boy* (Little Hans) which Lebo (1952) suggests was the first documented child analysis. Freud's use of psychoanalysis, an adult model of therapy, in working indirectly with Little Hans through his father, was contrary to that proposed by Rousseau in which the therapist plays at a child's level. Such an approach led to considerable difficulties, as it was known that children, unlike adults, were unable to put their anxieties into words, nor were they interested in exploring their past life (Lebo, 1952). It is important to recognize though

that classical psychoanalysis devoted much attention to observing the minute details of human expression from body movements to non-verbal oral expressions such as sighs.

Therefore, it soon became clear that the techniques and processes being utilized with children needed modification in order to be used effectively (Lebo, 1952). Theorists agreed that children used play for self-teaching; Piaget believed play was a way of accommodating and assimilating reality (Piaget et al, 1962) while Erikson (1963) saw play as a safe place to work out conflicts, by exploring and manipulating ideas in social relationships. It was recognized that as children's cognitive processes expand, play became more complex with rules, moral judgment, and language development (Erikson, 1976). It was also recognized that a child plays through situations similar to how adults think through situations and therefore it is through play that children learn the rules and expectations of the adult world (Erikson, 1976; Schaefer, 1976).

One of the earliest pioneers to use play directly in therapy with children was Dr. Hermine Hug-Hellmuth, the world's first practicing psychoanalyst (Hug-Hellmuth, 1920; MacLean, 1986). She began using play as a tool to diagnose and treat childhood emotional problems. She emphasized the educative aspects of working with children, and insisted that play was essential in child analysis (Lebo, 1952). Dr. Hug-Hellmuth believed that the analysis of children leads to the knowledge that within children there exists another layer in the unconscious, another distribution of the systems conscious and pre-conscious, that is not present in adults (Hug-Hellmuth, 1920). Dr. Hug-Hellmuth's belief is the basis of present day therapeutic interventions by play therapists that believe children require interventions designed to meet their needs, not those which are reflective of adult models of intervention, as seen in too many of today's interventions.

Freud's case study of Little Hans in 1909 was the first case study to support his theory of infantile sexuality. It was also a forerunner to the work of his daughter, Anna Freud, and his student Melanie Klein, both child analysts who both dominated child analysis from the1920's onwards. These two pioneers of play therapy, although both followers of Freud, took very different paths in their work with children. Anna emphasized psychoanalytic theory (Freud, A., 1976) and applied analytical concepts and developmental education and therapy efforts with children who had experienced war trauma. Klein emphasized psychoanalytic practice methods (Klein, 1976). This division between scientific theory and practice, which had continuously troubled experts for centuries, was also a divisive feature between these two pioneers. Anna Freud (1976) continued to followed her father's model of child development emphasizing theory, leading to her own development of child analysis. In contrast, Melanie Klein (1976), having applied Freud's model of adult analysis to children in practice, disputed his theory of early development. She developed her own innovation, that of the analysis of play (Klein, 1976). Klein did not believe that children could free associate as adults do in therapy. According to Donaldson (1996), this difference in position caused a division between these two pioneers of child analysis, resulting in Vienna and Berlin, the two most powerful psychoanalytic centres on the continent, siding with Anna Freud over Melanie Klein on this issue.

However, Klein continued on to present her work in Britain, showing how she had overcome the adult concept of free association by using play activity as equivalent to free association (Donaldson, 1996). The British were very accepting of this concept, and the British Psych-Analytical Society lent its support to Klein. Any criticism of Klein

became a criticism of the whole British Society as the view of inherited characteristics appealed to this country, which was then dominated by class divisions. Alternately, Anna's view of child neurosis, as being external to children, and located in the strictures of parents and society, appealed to Vienna's principles. These alternate and conflicting views initiated a lengthy rift in the two camps of child analysis, with Anna eventually conceded, and admitted value in Klein's analysis of play (Donaldson, 1996).

Support for Klein's work helped propel the field forward. It was soon followed with the work of John Bowlby who trained with Klein. His theories on attachment formed the basis of Developmental Play Therapy (Bowlby, 1969; Donaldson, 1996). Another less known but very influential pioneer in play therapy was Margaret Lowenfeld, a pediatrician and psychotherapist. Her outstanding contributions sprang from her recognition that play is an important activity in children's development and that language is often an unsatisfactory medium for children to express emotions (Urwin & Hood-Williams, 1988). She was one of the first to make links between emotional and physical processes as they emerge in the psychosomatic disorders of childhood. Her form of psychotherapy differed in that she used play, not only as a medium for children to master emotional conflicts and confusion, but also as being reflective cognitive processes, and thus giving the observer access to the patterns of expression indicative of children's thoughts (Lowenfeld, 1991, originally published 1935).

Other influential therapists began contributing to the field. Carl Whitaker, one of the founding fathers of family therapy, spent 1940 to 1945 using play in working with delinquents. He spent a year from 1941 to 1942 on a playroom floor with five or six little children, concluding, "If there is any one thing that will get you over making believe

words say something its doing play therapy and nothing else" (Zeig, 1985. p. 360). Carl Rogers contributed to the field with his counseling theories based on person centred therapy, "from which two of his associates, Virginia Axline and Elaine Dorfman, pioneered and designed person-centred play therapy for children" (Kottman & Schaefer, 1993, p.6). Social worker Elaine Dorfman authored a chapter called 'Play Therapy' (Rogers, 1951) in which her focus was on child-centred play therapy, which like all forms of play therapy was based on the belief that children "have the capacity for growth and self-direction" (p. 138). Dorfman produced "a very important work … on client-centered play therapy … with further developments in theory, and the beginnings of systematic research in play therapy" (Barrett-Lennard, 2007. p.65). Other early play therapists included; David Levy, Frederick Allen, and Clark Moustakas, each emphasizing the power of the therapeutic relationship in conjunction with children's natural growth processes as key to helping children individuate and develop self-esteem (Boyd Webb, 1999; Levy, 1976; Schaefer, 1976).

Support for Klein's work was not only the beginnings of psychoanalytic therapy with children, but of the entire field of play therapy, as it is known today. From her work there evolved three major traditional models of play therapy; psychoanalytic play therapy (and its derivative, Jungian play therapy); Child Centered Play Therapy (derivatives, filial play therapy, and relationship therapy); and Cognitive Behavioural Play Therapy. These models were the cornerstones of the field of play therapy. Early play therapists adhered to only one of these models, whereas modern play therapists are more eclectic in their approach and therefore incorporate features of various models to develop their own style of therapy.

2.10.3 Early play therapy approaches.

As stated above, the three major traditional models of play therapy are psychoanalytic play therapy, child-centred play therapy, and cognitive behavioural play therapy. The following is a discussion of each of these models, inclusive of models that branched out from each.

According to Lee (2009) psychoanalytic play technique evolved as a way to enter a child's psychic world. Play was used as a tool of child analysis that allowed the analysis of children to help them recognize their own internal pressures. This was seen as a way to help resolve conflicts, and move children forward in their development. Psychoanalytic play therapy is focused on personality development in which all behaviour is motivated by instinctual drives and their energies, with the need to fulfill the pleasure principle while attempting to negotiate the demands of reality (Lee, 2009). As a technique, psychoanalytic play aims to restructure the personality, by reconstructing repressed memories, fantasies, wishes, and experiences (Klein, 1976).

Jungian Play Therapy was an offshoot of psychoanalytic play therapy. Carl Jung, a colleague of Freud, developed its foundations. It was Jung's positive thoughts and reasoning that influenced John Allen's later work in the development of Jungian Play Therapy (Allan, 1997). Jung's view of personality was more positive and less deterministic than Freud's. Jung placed focus on individuation, or the innate capacity of humans to move towards wholeness and self-realization, by tapping into inner wisdom (Jung, 1961). Jungian play therapy is a creative approach that emphasizes symbolic meaning. Jung believed that children's personalities strived for personality integration. The clinician uses relationship to facilitate a child's psychic healing by recognizing a

balance between the ego and the self. By recognizing polarities (good/bad; shame/pride) children facilitate inner healing by resolving dichotomous feelings (Green, 2009). Jungian Self is explained as the central organizing principal of the collective unconscious. Ego emerges out of Self to form "I," the centre of consciousness, helping children deal with the outer world. Children's' psyche's know where to go and it is the job of the therapist to follow. Interpretations, questions and reflections are some of the tools used during Jungian play therapy to help children increase their self-awareness and move toward potentiating health and healing.

Critics of psychoanalytical and Jungian play therapy view them as condoning oppression, evident in the differentiation of the sexes, especially in the area of sex and sexuality, as well as the claim that females were passive, inferior beings (Lee, 2009). They have also been criticized for lack of relevance to culturally diverse populations. This, however, may lie in the fact that these therapies were set in a time when both women and children were seen as lesser beings, largely unnoticed and therefore not understood. From another perspective, both Freud and Jung were scholars, whereby Freud integrated Greek cultural metaphors and Jung integrated Eastern cultural thinking to European-based scholarship.

Child-centred play therapy, with its derivative filial therapy, is the second major model of play therapy. Carl Rogers, one of the world's most eminent and influential psychologists and the father of client-centred therapy, developed non-directive therapy in stark contrast to directive psychoanalysis and in protest of its diagnostics. Client-centred therapy was aimed at releasing the integrative capacities of the individual. In his book, *Client Centered Therapy*, published in 1951, he discussed his client-centred therapy

technique as being effective not only with adults and adolescents, but also with children through the use of play. Rogers dedicated an entire chapter of his book to the topic of play, by included the work of his colleague and associate Elaine Dorfman. In doing so, he highlighted the therapeutic relationship with children as being the most important aspect of counselling. The social work profession shares recognition for promoting the importance of relationship and process in enabling the actualization of inherent healing and growth potential. Since its inception, social work has emphasized the clinical-client relational matrix as the most important element in promoting change in people and their environments (Applegate & Shapiro, 2005). Rogers' work was further refined by Virginia Axline, an early pioneer and author of both ' *PLAY Therapy'* (1947) and '*Dibs In Search of Self'* (1969), each a seminal work in the field. Axline described play therapy as an opportunity that is given to children to play out feelings and problems just as, in adult therapy, talk is utilized to work through difficulties (Axline, 1947; Axline, 1976). She further explained that play therapy may be either directive – that is, the therapist assumes responsibility and direction for guidance and interpretation, or it may be non-directive whereby the therapist allows children to lead their sessions. Axline developed eight basic principles of play therapy, all of which remain as cornerstones today. These are: establishing rapport; accepting children completely; establishing a feeling of permissiveness; recognition and reflection of feelings; maintaining respect for children; allowing children to lead the way; that therapy cannot be hurried; and knowing the value of limitations (Axline, 1947).

At the same time Rogers was writing on non-directive therapy, Otto Rank**,** a follower of Freud, was developing his own approach, that of relationship therapy (Lebo,

1952). This approach had the therapeutic relationship as its essential feature, which was seen as being curative in its own right (Dorfman, 1951). These approaches led to significant changes in the aims and methods of psychotherapeutic work with children (Rogers, 1951). Jessie Taft, Frederick Allen, and Clark Moustakas all maintained strong ties to psychoanalysis yet all adopted Rank's line of thinking to work with children in play therapy by highlighting the importance of the client (child)-therapist relationship and de-emphasizing the importance of past (Barnes, 1996). This work has continued to evolve today in the work of contemporary pioneer Gary Landreth (Landreth, 2012; Landreth & Sweeney, 2009).

In the late 1950's, Doctor's Bernard and Louise Guerney developed filial play therapy, a derivative of child-centred play therapy**,** the roots of which began with Freud's very first child client, Little Hans (Freud, 1909). From the very beginning of child therapy, the essential role of children's attachment figure(s), their parents, was emphasized as can be seen in Freud's work with Little Han's who was not treated directly by Freud, but through his father. Filial therapy was developed as a brief intervention, grounded in psychoeducation, and delivered by combining play therapy and family therapy Crenshaw, D., & Hardy, K. (2007). In filial therapy, the therapist trains and supervises parents to play in non-directive ways with their own children, as a means to help with communication (Guerney & Guerney, 1976). Sessions can then be conducted at home without the therapist's direct supervision. Because traumatized and attachment disrupted children often show social and emotional delays, as much as one third behind their chronological ages, filial therapy has been used in its traditional form with traumatized adolescents as old as 16, often in conjunction with foster and adoptive

families (Van Fleet, 2009). The expectation is that if parents can change the way they react to their children, it can have a significant impact on their children's behaviours and reactions. However, filial therapy's concept of the therapist 'just listening' without questioning, interpreting, diagnosing, or partaking has proven to be a fertile ground for criticism of the effectiveness of child-centred play therapy. It is seen as a lengthy and costly therapy as it requires many sessions. Its value has been questioned with specific populations especially those that often are nonverbal in therapy. Filial therapy was initially criticized as being contrary to the medical model in that it was grounded in psychoeducation with themes similar to the work of Anna Freud. Today filial therapy achieves continual empirical validation (Bratton et al, 2005), in many areas of intervention including child abuse and neglect (Ginsberg, 2002).

Cognitive Behavioural Play Therapy (CBPT) is the third major model of play therapy. It developed in the late fifties when CBT gained acceptance (Barnes, 1996). CBPT uses play to teach skills and alternative behaviours. The therapist offers interpretations in order to bring conflict into verbal expression. There is no personality theory that underlies cognitive behavioural play therapy. The focus is on psychopathology and its contributing factors. It is based on cognitive behavioural principles, and integrates them in a developmentally sensitive way (Knell, 2009). This approach emphasized changing of cognitive views as well as behavioural symptoms through the interplay between cognition, emotion and behaviour. CBPT is based on the belief that a person's perception of events, not the events themselves, determines how a person understands them. It places strong emphasis on children's involvement in treatment, focusing on mastery, control, and responsibility for one's own behaviour

change, through personal understanding and empowerment (Knell, 2009). Psychoeducation, praise and interpretations are used to teach new skills. Critics of CBPT question its effectiveness with complex issues. Research has proven its effectiveness with many childhood issues; however issues such as complex trauma most often require more in-depth consideration and treatment. With childhood trauma comes the inability of children to attend or focus, thus they are unable to engage in a meaningful way.

Play therapy has continued to develop over time. Modern approaches became more eclectic than its pioneer models. Therapists developed their own models by borrowing from various approaches. Modern approaches include: Adlerian; gestalt; theraplay; ecosystemic; prescriptive play therapy; and narrative play therapy. The following is a brief review of each.

2.10.4 Modern approaches to play therapy.

Adlerian play therapy developed from the psychoanalytic model. It is an integration of the concepts and strategies of individual psychology as developed by Alfred Adler with the rationale, material and techniques of play therapy (Kottman, 2009). Its main tenant is that people are social beings and have a primary need to belong, thus all behaviour has a purpose. People, including children, are able to make decisions about their own subjective interpretation of events and relationships, rather than on actual facts. Maladjustment is seen by Adlerian's as discouragement. Through Adlerian play a child can work towards decreasing discouragement, through courage, connect, capable, and count (Kottman, 2009).

Gestalt play therapy is an experiential therapy concerned with all aspects of children's senses, body, emotions, and intellect. It requires an understanding of child development, child psychopathology and psychotherapy. Violet Oaklander (1978), author of the classic *Windows to our Children*, initially developed the Gestalt approach, in which the theory of personality is based on functioning within environmental conditions. A child organizes his behaviour to physically and emotionally survive, and as this need is met, an unfinished situation is met. A child learns to distinguish between me-not me, in developing a sense of self, which needs to be supported. If a child is not supported in this self-process of acceptance and rejection, he becomes constricted, leading to many of the symptoms seen in therapy, such as dissociation, depression, hyperactivity, phobias, and other adjustment difficulties (Carroll, 2000). The goal of treatment is not to gain insight but to have new experiences of self within the therapeutic relationship.

Theraplay, developed by Ann Jernberg in 1979 (Booth & Jernberg, 2010) uses a repertoire of playful, structuring, nurturing, engaging, and challenging activities that characterize the healthy parent-infant relationship. It was developed from the challenge to provide treatment for several hundred preschool children in the Chicago Head Start Program, established to address systemic poverty in the United States. It targeted children prior to their entry into the formal school system (Bundy-Myrow & Booth, 2009). Theraplay is playful: uses no toys and few props; asks no questions; focuses on health; is structured by the adult; encourages physical contact with the therapist; is designed to meet children's underlying unmet needs; and is geared towards enhancing parent-child attachment. It combines structure, engagement, nurture, and challenge in the therapeutic setting. It assumes that change is possible and that the essential ingredients of change lie

in the creation of a more positive relationship between children and their parents (Bundy-Myrow & Booth, 2009).

Ecosystemic play therapy, first described by O'Connor & Schaefer has two distinguishing features: the commitment to an ecosystemic perspective at all times, and the adoption of a clear and consistent personal theory (O'Conner, 2009). The structural elements of this model are: the concepts of personality and psychopathology, the notion of treatment goals, a description of the role of play in treatment, and the technique itself. An ecosystem is seen as a complex community and environment forming a functional whole in nature. It is multiple interacting systems that change over time, with the basic unit being the individual and his functioning in the ecosystem. The ecosystemic play therapist takes all systems into account when conceptualizing the presenting problem and formulating a treatment plan (O'Conner & Braverman, 2009).

Charles Schaefer, a prolific writer on the subject of play therapy, developed prescriptive play therapy (Schaefer, 1976). This is a child-led, practitioner informed approach with the underlying premise that all play therapy approaches have the potential to be useful for some children, but no single approach is the best for all children. This approach is challenging to the clinician as training is required in a variety of approaches, to weave together interventions into one comprehensive, tailor-made treatment program for a particular client (O'Connor & Braverman, 2009). Prescriptive play therapy is an integrated approach in that therapists incorporate what they know about children and play therapy into the process of treatment selection. It is eclectic in the sense that the model is not an intervention, but rather a road map for selecting among a variety of approaches, regardless of the therapist's preferred discipline or orientation (Gil & Shaw, 2009).

Narrative play therapy is a form of storytelling whereby through play children tell and retell their own stories, including the unique, the contradictory and the aberrant events of their lives (Cattanach, 2009; White, 2007). It is through the telling and retelling of the dominant stories of their lives that themes expand, meanings shift and change, alternative stories are explored, and new stories emerge. This is achieved in both the telling of their story, and in the identification of how they respond to their trauma and the skills involved in their response and the values that underlie those responses (White, 2006). In narrative play therapy the therapist and child co-construct their new story. It is not uncommon that children exposed to trauma and complex trauma identify helplessness as their dominant story, erasing their sense of agency. Narrative play therapy seeks to identify where children feel they can be influential in their own lives and where they can be an agent in their own story (Yuen, 2007).

Together, these diverse but often overlapping theoretical perspectives are evidence of the increased variability with which play therapy is being delivered. Despite their differences, all approaches have, as a basis, the same underlying factors, which are the therapeutic relationship and the attention to action processes and activities involving the therapist, which are main tenants of all play therapy approaches. All approaches take into account developmental ages and stages of each child, respecting both. Whether the treatment philosophy is directive or non-directive, the theoretical approach utilized by individual play therapists is used together with selected modalities of play in which a variety of materials and techniques may be utilized. Some of the main modalities utilized are; sand/water play; art; storytelling; doll house play; puppet play; music; creative arts; crafts; and board games; all limited only by the therapist's imagination. Play therapists

are trained in each modality, with some specializing in a single modality only. Play therapy varies in terms of the extent to which parents are brought in; the extent to which the play environment is altered; the frequency of treatment; how play is conceived as a function of treatment; and whether and to what extent verbal explanations or interpretations are given to children (Millar, 1972). Each variation remains child-centred with the intent to meet children on their own level, so that the therapist has to do the work of entering a child's world, contrary to adults models of therapy that require children to enter the adults world.

2.10.5 Continued growth of play therapy.

According to Charles Schaefer (2011), play therapy grew exponentially in the helping professions until the 1970s, when cognitive behavioural therapy (CBT) began its rise to present day status as the most utilized form of therapeutic intervention. As CBT gained more and more usage, interest in play therapy waned. By 1982, Schaefer and his colleagues attempted to regain some of the lost interest by establishing the American Play Therapy Association (APT). Their goal was to promote the advancement of play therapy and growth within the field. By 2006 there were 5000 members and 102 training programs in colleges and universities throughout the United States, as indicated on APT website (http://www.a4pt.org/).

In 1985 the Canadian Association of Child and Play Therapy (CACPT) was formed with the same goals. According to CACPT website, this association was the first professional body in the world to offer a national program of certification in child psychotherapy and play therapy which involved rigorous and credible standards

(http://www.cacpt.com/site/). Programs were offered primarily in Ontario, with requests for attendance coming from all over North America. This saw the beginning of the Canadian Play Therapy Institute (CPTI), which developed training programs that continue to be offered today by CACPT. A world conference on play therapy was held in at Chichester, England in 2004. This was the largest international event of its type held anywhere in the world, with over 70 workshops, and over 400 delegates from 29 countries, confirming that play therapy clearly had made a comeback. In Canada, a second adjunct training program, The Rocky Mountain Play Therapy Institute (RMPTI) has developed in recent years, approved by CACPT and APT. Its program has been developed around the concept of the traditional medicine wheel.

Despite growth in the USA and abroad, there are few play therapy training programs in Canada, and those that are available, are not accessible to the majority of social workers. Certification programs are offered in central and western Canada, however cost, travel, and time requirements disadvantage many of those interested in pursuing training. In addition, there are only two Canadian Universities that offer individual courses in play therapy, as part of other programs. This has resulted in a very limited presence of play therapists in Canada.

Play therapy has been called into question based on its lack of research to support its claims as EBP. Phillips highlighted this issue with his controversial article in the journal *Psychotherapy,* titled 'Whistling in The Dark.' in which he called for proof of efficacy (Phillips, 1985). Some of the challenges identified by Phillips have since been addressed. One of these has been the lack of a uniform and accepted definition of a play therapy. APT answered this call in 2008 with a clear definition of a play therapy as "the

systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (www. a4pt.org). Another criticism has been that of small number sample sizes in research produced within the field of play therapy. This problem has been addressed by the use of a meta-analysis of studies from 1942 – 2000 (Bratton et al, 2005), demonstrating the efficacy of play therapy. In addition, the International Journal of Play Therapy, a peer-reviewed journal, continues quarterly publication of ongoing research. From 1990 to 2006, 36 research studies (27 published) on the impact of play therapy have been conducted, demonstrating the positive impact of play therapy on general behavioural problems (Ray, 2006). A review by this researcher of publications from 2007 to 2016 identified a further 21 research studies, (plus 15 publications on trauma and complex trauma), providing abundant evidence of the effectiveness of play therapy with children and youth.

2.10.6 Play therapy research.

A review of literature in the field of play therapy reveals a large body of publications, especially over the last forty years. Many of these have been descriptive and theoretical with a majority of research publications based on case studies. Using research engines ASSIA, Social Work Abstracts, Social Service Abstracts, and PsyINFO, a total of one hundred and twenty four publication were found using the search terms; play therapy, traumatized children, and complex trauma. The majority of these are book reviews, individual chapter reviews and discussions. A smaller number are qualitative

studies with only a very small number of quantitative studies. In the past decade two meta-analyses' have attempted to validate play therapy's efficacy. LeBlanc and Richie (2001) completed a meta-analysis aimed at determining the overall effectiveness of play therapy outcomes. They included twenty-three journal articles, sixteen dissertations, and three unpublished documents. From these, 166 effect sizes were calculated. The overall finding was that play therapy appeared to be as effective as non-play therapies with children, and verbal therapies with adults (LeBlanc & Richie, 2001). This study highlighted the need for further studies to differentiate therapy characteristics that led to effective treatment. As indicated above, Bratton, Ray, and Rhine released the results of the largest meta-analysis ever completed in the field in 2005. They included ninety-three studies spanning five decades of research in their analysis. Their findings revealed a large treatment effect for play therapy interventions with children, plus an identified need for more utilization of filial therapy, which has met the criteria as evidence based practice. They also highlighted the need for continued research on a multitude of treatment factors and their impacts on treatment outcomes (Bratton et al, 2005). However, their meta-analysis has been criticized for lack of homogeneity in the inclusion/exclusion criteria of cases studied.

In 2011, PTUK and PTI released results of a ten-year study into the effectiveness of play therapy and creative arts (Thomas, 2011). It was based on the analysis of 8026 cases. This was undertaken in response to call's (both internal and external) to prove efficacy, but also to overcome problems identified with past research using small sample sizes, meta-analysis, and random controlled trials. The findings were that between 74% and 83% of children receiving play therapy, delivered to PTUK/PTI standards, showed a

positive change. Baggerley & Bratton (2010) responded to the call for still more evidence of play therapy's effectiveness, with an article that listed twenty-five filial therapy studies from 1991-2009, all of which were randomized clinical trials (Baggerley & Bratton, 2010). In 2012, the call was again answered with a publication of an international compilation of articles, which concluded with the finding that play therapy with children is a well-established specialty, which is continuing to evolve across clinical themes, cultures, and treatment settings (Baker & Brandell, 2012).

Although publications on play therapy have been found in many professional journals the majority of research and literature is published in *The International Journal of Play Therapy.* A review of this journal's publications shows play therapy applied in many diverse contexts with a plethora of children's issues, including childhood trauma. In my review I found one study that sought the perceptions of clinicians regarding the effectiveness of interventions for traumatized children. This research by Fitzgerald et al. (2012), provided insight into participant's perceptions of evidence based interventions, and their preference for practice based evidence, in which they utilized play interventions unique to each child. This study was seen as a beginning of exploration of the perceptions and experiences of counselors who work with traumatized children. It was a qualitative study, as are the majority of studies published, with a marked increase in quantitative studies in 2012. A review of literature on play therapy with abused children was published in 1994, exploring the approaches by play therapists intervening with abuse (White & Allers, 1994). Ogawa (2004) explored play therapy interventions specifically for traumatized children. Findling et al. (2006) explored the development of a trauma play scale to measure the effects of trauma. Norton et al. (2011) explored children's

somatic expressions of trauma through experimental play therapy. In Vicario et al. (2013) the issue of a cultural approach to childhood trauma was studied with a view to developing a new model of treatment. Such publications have brought attention to the issue of complex trauma and to the interventions play therapists are using to address it. In addition to journal publications, many therapists have authored works specifically related to childhood trauma. Lenora Terr (1990) was the first researcher to bring attention to the field of childhood trauma in *Too Scared to Cry,* a study of children of Chowchilla, and in doing so revealed the limitations of applying adult treatment models to children. James (1996) wrote *Treating Traumatized Children*, which brought attention to the effects of trauma on children. In her earlier work she highlighted the complexities of childhood trauma and the many issues of concern in treatment, which she felt above all else required a robust and playful way of being. Herman (1997) brought attention to disordered play resulting from trauma, in her publication of *Trauma and Recovery*. She highlighted the reenactment, the forbidden games of traumatized children, the grim and monotonous play, the unchanging repetitiveness, and their recreation of their own terror. She also highlighted that knowledge of disordered play is vital to understanding play itself. Boyd Webb (1999) brought together play therapy and trauma in her book *Play Therapy with Children in Crisis* where she partnered with leading social workers in the play therapy field to highlight the work of play therapy practitioners with high-risk children. Goodyear-Brown (2010) wrote *Play Therapy with Traumatized Children* in which she also outlined the need for many and varied approaches to work with traumatized children. Her work disputed the one-size fits all approach as is used in other forms of interventions. She contends that based on play therapy's growth and evolution,

approaches can be chosen based specifically on the needs of the individual child. Eliana Gil (2006) wrote *Helping Abused and Traumatized Children,* in which she highlighted both the need for both empirical research and clinical experience, plus the need to take into account a child's individual symptoms, needs, vulnerabilities, and personality, in the application of play therapy to childhood trauma. Gil recently made a major contribution to the field with her publication of *Trauma-Focused Integrated Play Therapy* – A 12-session play based treatment and research protocol (Gil, 2011). Her manualized approach to treatment of childhood trauma is unique to the field. It responds to critiques that saw the lack of manualized approaches as problematic within the field. This work uses EBP's such as trauma focused CBT, and a treatment model using an array of play therapy approaches and modalities. Having used this program, I believe it does much more than fill a gap in research. Its specialized clinical focus on trauma has provided a much-needed direction for front-line clinicians. Many other authors have added to the literature in this field. Norton, Ferriegel, and Norton (2011) found that by identifying the instinctively universal language of trauma on the body and by utilizing somatic attunement and reflections, as in play therapy, children who are abused can access their implicit memories of traumatic events in order to heal. Malchiodi (2014) found that witnessing and validating a child's memories through play modalities is an important first step for childhood trauma survivors. Drewes (2009) wrote *Blending Play Therapy with Cognitive Behavioural Therapy,* in which she identifies the merger of the two as a strengthening of the whole of science and practice through its parts. McMahon (2009) focused on the use of play in working with traumatized children and their families in *The Handbook of Play*

Therapy and Therapeutic Play. Each of these publications adds to the growing body of knowledge on the benefits of play and play therapy.

Although play therapy practice has been widely accepted, and its publications especially in the area of trauma work is impressive, its research has lagged behind causing a continual challenge to establish itself as a viable option within the helping professions (Ogawa, 2004). In today's culture of EBP, this has increased efforts within the field to prioritize research efforts to validate its efficacy. Many in both the fields of play therapy and trauma work echo this concern (Cohen et al, 2010; Edgar-Bailey & Kress, 2010; Gil, 2010; O'Conner & Braverman, 2009; White & Allers, 1994). However, a concern with the prioritization of research is that by focusing efforts primarily on efficacy-based results, the development of richer descriptions of the therapeutic process has been simultaneously neglected (Riedel Bowers, 2001). Considering that the issue of complex trauma has only recently been given attention in DSM 5, and the field of play therapy has identified and is meeting its own challenges, it is expected that future publications will include many outcome studies in the area of play therapy and complex trauma. However, there is a concurrent need for study of process as well, which seeks to identify the specific therapeutic factors that produce desired changes (Drewes, 2009). A clearer knowledge and understanding of therapeutic factors will allow clinicians to tailor their treatments to children's unique needs. In identifying the precise processes and operations of change, education and training can be enhanced for clinicians who provide direct treatment to traumatized children. It could also provide an understanding of the therapeutic process and its key features that lend towards positive outcomes. As a front line practitioner and researcher, this is my main area of interest. In

my research, I went beyond EBP to PBE, to seek understanding of the conceptualizations and practices of play therapists with diverse case presentations of childhood trauma. I sought a comprehensive understanding of how play therapists reinforce strengths and resilience, as well as ameliorating risk and harm, as shown in play therapy literature.

2.11 Introduction to research approach

Play therapy uses relationships and creativity to intervene in ways that conventional approaches cannot. In the field of children's mental health services, especially in the area of complex trauma, play therapy has been shown to effect positive change (Boyd Webb, 1999; Gil, 2006, 2010; Goodyear-Brown, 2010; McMahon, 2009; Malchiodi, 2014). Meeting the therapeutic needs of children is the specialty of play therapists and it is within their conceptualizations, practices and experiences that I sought an understanding of the change processes in therapy with children, specifically those who present with complex trauma. To find such understanding, qualitative research, which is suited to exploration, understanding, and discovery, (Sandelowski & Barroso, 2012) became the natural paradigm of choice.

Within qualitative research, I sought to study practice-based evidence, using the qualitative method of the naturalistic inquiry to explore the causal mechanisms of therapeutic influence. Naturalistic qualitative methods are compatible with social work's client-centred traditions (Germain & Gitterman, 1996). It is a method that requires the researcher to be in personal contact and in doing so to utilize all our senses to obtain detailed and rich descriptions (Germain & Gitterman, 1996). In the naturalistic inquiry the investigator is the major instrument of study. Social workers are skilled at exploring,

observing, and following cues and therefore are natural investigators into people and their environments. Being an instrument of study places me in a natural position to describe processes of change as social work practitioners especially "can capture subtle nuances of meaning and behaviour" (Germain & Gitterman, 1996, p.449). This methodology is embedded firmly within the constructivist paradigm (Lincoln & Guba, 1985) and is seen as the ideal approach, because it allowed for a detailed exploration of play therapists perceptions and experiences.

2.11.1 Insights gained from previous studies.

Within the naturalistic inquiry, a researcher should consider insights gained from previous studies (Erlandson et al, 1993) such that a theoretical perspective from a previous study may be utilized if that perspective was grounded in prior naturalistic research. Thus, this researcher sought insights from previous studies on the topic of 'processes of therapeutic change'. Such changes are often referred to by various other headings such as change mechanisms, moments of change, and therapeutic change, all of which have been studied previously, exemplified by authors such as Rogers (1957), Blatt et al, (2003), Robson (2010), Lipoitz & Markowity (2013), von Greiff & Skogens (2013), and Mander et al, (2013). Specific to therapeutic change in children who have experienced trauma is the work of psychiatrist Lenore Terr, who wrote *Magical Moments of Change (2008)*, and *Too Scared To Cry (1990)*. She studied the moments of change in therapy, and encouraged others in the various mental health disciplines to embark on continued study of how psychotherapy works, concluding that the processes of change remain somewhat elusive. Jan Hindman who wrote *Just Before Dawn* (1989), in which

she looked at how therapy with children works in the nonmedical therapeutic field, encouraged continued work within the study of the therapeutic process. Psychologist Allan Kazdin has written extensively on the concept of mechanisms of change in psychotherapy research, noting that even after decades of research we do not know how or why even the most studied interventions produce change (Kazdin, 2003, 2008; Kazdin & Nock, 2003). In 2014, a Canadian study by Tasca et al, respondents inclusive of clinicians, researchers, educators and representatives of professional organizations inclusive of social work, rated 'understanding the mechanisms of change in therapy' as the most important issue (out of 38 issues) of immediate relevance for practice-based research. Based on such findings, my research build upon the solid foundations of previous authors, and continued the search for understanding the processes of therapeutic change through study of the subjective experiences of practitioners immersed in the field of children's therapy.

2.12 Summary of chapter

This literature review has explored, summarized, and synthesized available literature on the issues of trauma and complex trauma, and play therapy as a developmentally appropriate intervention in the treatment of children challenged by such traumas. It has established the foundation to support my study, which sought to identify and understand the change processes within the play therapy process of treating children who have experienced complex trauma. As stated at the beginning of this chapter, the identification of these change processes holds promise for informing the practice of clinical social work with children who have experienced complex trauma. It is within

these contexts that the design and implementation of the naturalistic inquiry into the identification of play therapy change processes, as outlined and described in chapter three, takes on significant meaning.

Chapter 3: Methodology and Methods

3.0 Choice of research design – The Naturalistic Inquiry

The naturalistic inquiry (NI) is particularly relevant to social work as its goal is that of interpretive understanding, which is an essential component of social work and is achieved through the assessment process (Rodwell, 1987). This type of inquiry relies mainly on the participant's views of the situation being studied. In this case, an understanding of change processes was sought through the tacit knowledge of play therapists. Tacit knowledge is that which is understood, implied, unspoken and explicit. It includes "inexpressible associations which in combination give rise to new meanings and ideas" (p.196). This knowledge can then be converted to propositional knowledge (Lincoln and Guba, 1985) to communicate to others. Propositional knowledge is composed of all interpersonally shared statements (Lincoln & Guba, 1985) of what is known, or is a truth. According to Mathinsen (2011) "writing about tacit knowledge seems to produce understanding based on things not being left unsaid but outspoken - putting words to the notions" (p.22). The combination of qualitative research and tacit knowledge representing social work has provided understanding into many complex phenomena in social work practice and has therefore enhanced knowledge of how we conceptualize the world (Mathinsen, 2011). Participants' subjective views of their experiences are varied and multiple, leading researchers to look for a complexity of views rather than narrowing meaning into a few categories or ideas (Creswell, 2009). Researchers using this model seek to accumulate sufficient knowledge to lead to understanding.

My area of interest is that of therapeutic change processes within the middle phase of treatment in isolation of the first and last phases of treatment, with children who experienced complex trauma. The middle phase of treatment, also known as the working through process, is that part of treatment whereby therapeutic change occurs. In the naturalistic inquiry, it is anticipated that the inquirers initial focus would change as interviews progressed, which did occur. It became apparent early in the interview process that the phases of therapy are so interconnected that they can rarely, if ever, be spoken about in isolation. I incorporated this change into the interview process, respectful of the knowledge of participants of this interconnectedness. For a conventionalist, such changes would be seen as unacceptable. However, in the naturalistic inquiry changes are expected. Change is seen as constructive, as it signals movement to a more complex and perceptive level of inquiry (Riedel-Bowers, 2001; Lincoln & Guba, 1985). Changes within my inquiry were tracked and recorded, with explanations in my writing as to why they occurred. Also, member checks made with participants as part of the naturalistic inquiry method, both during and at the end of inquiry, were utilized to allow for change. The naturalistic inquiry enabled me as a researcher to explore and examine changes as they were found in the interview data, which then signalled directions regarding what I might best explore in subsequent interviews, to refine and clarify answers.

3.1 Relevance of the naturalistic inquiry to social work

Social workers have historically emphasized the importance of finding alternative ways to study and evaluate practice that makes use of practitioner's informed judgments, and which are compatible with social work's traditional values (Shulman, 2015a).

According to Gilgun (1994), remarkable similarities persist between qualitative research and social work practice including the detailed processes of assessment (for the social worker) and the research interview (undertaken by a researcher); both require engagement and empathy with clients and participants. Within qualitative research, the naturalistic approach to practice research promises to be a fertile ground for generating new findings to this continuing search (Tyson, 1995). "Naturalistic clinical research is ideally suited to advance knowledge in social work because it encourages social workers to engage in the best practice of what they are capable and to generate rigorous and valuable research" (Piper & Tyson, 1999, p.279). According to Rodwell (1987), the naturalistic inquiry can be seen by social workers as a method suited to investigating and understanding the complexity and variability of sociobehavioural phenomena, which a normative scientific position is unable to attain.

The naturalistic inquiry requires specific skills that are natural to social work practitioners such as assessment, analysis, and co-construction of meaning, and thus is especially compatible with clinical social workers that wish to conduct research. It is the type of inquiry in which experienced practitioners can more thoroughly study clinical practice in its full complexity, to enhance the possibilities of new discovery (Pieper, 1994). According to May (1996), the congruence of counsellors as practitioners and as naturalistic inquirers can be illustrated by similarities between the two. First of all, both have epistemological similarities whereby the practitioner as researcher interacts with the object of inquiry (in this case play therapists) so that each one has influences on the other. Secondly, both practitioners and researchers have similar emphasis on person-in-environment. Thirdly, parallel characteristics and skills are required of both practitioners

and inquirers. Epistemological similarities, person-in-environment emphasis, and the parallel skills of practitioners and inquirers make the naturalistic inquiry and social work relevant to each other (May, 1996).

3.2 Restating the research question(s)

This study sought the perceptions of a select sample of certified play therapists that have expertise in trauma work associated with their active play interventions with children who had experienced complex trauma. Specifically I sought their understanding of the therapeutic change processes within play therapy interventions provided to these children. This included their judgment about efficacy of play therapy in meeting the needs of children related to assessment, amelioration of impact, and reduction of compromised development. The following research questions were developed to guide the study:

1. What practices have play therapists found to be effective in assessment and treatment of children exposed to complex trauma?

2. What practices have play therapists found to be effective in reducing the long- term impacts of complex trauma?

3. What are play therapists' understandings of therapeutic change processes in which they have confidence?

In relation to these questions, I described and analyzed theoretical frameworks, key concepts, and key practice activities identified by certified play therapists addressing the needs of children exposed to complex trauma. The knowledge derived will be used to

inform social work and play therapy practice with children and youth who have experienced complex trauma.

3.3 Application of the mandatory requirements of the naturalistic inquiry

Lincoln and Guba (1985) describe the naturalistic inquiry as a function of what the inquirer does, or the set of activities the inquirer actually engages in while conducting research. Either has to follow the three mandatory requirements of the naturalistic inquiry. The first of these requirements is that the inquiry process be consistent with the proposed axioms of the naturalistic inquiry. The second is that the inquirer is committed to the development of skills to operate as an effective instrument. The third requirement is that the inquirer has developed an initial design statement (Lincoln & Guba, 1985). The following is an application of each of these requirements to my study.

3.3.1 Study's consistency with the five axioms of the naturalistic inquiry.

The naturalistic inquiry is based on five axioms and acceptance of these has major implications for the systematic inquiry process. The inquiry process changes throughout and the changes are dependent on these axioms, as outlined by Lincoln & Guba (1985, p. 37) and replicated by Riedel Bowers (2009; 2016). These axioms are as follows:

(1) Axion 1: the nature of reality (ontology),

(2) Axion 2: the relationship of knower to known (epistemology),

(3) Axion 3: describing an individual case that is time and context bound (generalization)

(4) Axion 4: the effect of the researcher and participant on each other (causal linkages) and,

(5) Axiom 5: inquiry that is value-bound, not value-free (axiology)

The applicability of each of these axioms to my area of research can be seen in the following discussion.

(1) The axiom 'ontology' supports the "assumption of multiple realities" in a world that is very complex in that there are no simple explanations but that of multiple factors coming together and interacting in complex ways, and therefore any attempt to understand experiences must respect the complexity as well (Corbin & Strauss, 2008). According to Lincoln & Guba (1985), reality can exist at one of four levels; objective reality (which asserts that there is a tangible reality and experience with it can result in knowing it fully), perceived reality (which asserts there is a reality but one cannot fully know it), constructed reality (which asserts that reality is a construction of the minds of individuals, including in social interaction with other individuals), and created reality (in which the assertion is that there is no reality, but presumptions of reality are created). The naturalistic inquiry takes the position that there are multiple constructed realities, which can only be studied holistically (Riedel Bowers, 2016; Lincoln & Guba, 1985). Inquiry into these multiple realities will each raise increasingly more questions leading to new levels of complex understandings (Corbin & Strauss, 2008). In this researchers study the acceptance of multiple constructed realities in the inquiry process, in the concept of complex trauma, in the model(s) of play therapy, in the naturalistic inquiry, and in analysis of the data set, enabled understanding, which then led this researcher to the development of applied and theoretical knowledge.

Such construction of reality accounts for naturalistic inquiry having become known as constructivism (Lincoln & Guba, 1985), and "constructivism has been making its way quietly along the path into social work theory for some time" (Carpenter, 2011, p.119). My research sought the multiple realities as experienced and interpreted by certified play therapists; these complex understandings were constructed based on respecting unique, diverse, and common presentations of traumatized children with whom these therapists have worked.

(2) Epistemology questions the relationship of the knower to the known and the effect the investigator has on the behaviour of the participants. In the naturalistic inquiry, the knower (researcher) and the object of inquiry (subject) interact to influence each other. In fact, they are inseparable, which is essential, as the researcher interacts with participants and their data over time so that the results, inclusive of history and present context, are fully understood. The inquirer must know their topic thoroughly to do this. They also must know their topic well enough to identify both appropriate sampling, and aspects of samples' information that will require further probing so as to form sound judgments. An uninformed researcher cannot do this. The naturalistic inquiry requires that the inquirer use their subjective experiences, their education, and their own informed positions within the research process. Lincoln and Guba (1985) refers to this as being "objectively - subjective" (p.103), which enables the inquirer to be creative and deliberate in the research process, while searching out details within the participants responses. However, the researcher has to remain neutral and objective. This is achieved by removing any emphasis on the investigator and placing it on the data, to look for reliable, factual, confirmable or confirmed "evidence". Therefore, focus is maintained on the

features of the data. Such active involvement with the data requires experience with the topic at a tacit level. It also requires the researcher to join with participants in a cooperative and interactive relationship to uncover "truths".

The skills needed to achieve these requirements of the naturalistic inquiry are very similar to the skills required in clinical social work, and therefore are suited to my experience as a social worker with many years of clinical experience in settings where services have been provided to children. I have multiple social work experiences in working with traumatized children that informed my approach to this research. I have formal training in play therapy, and have used play extensively in the provision of therapeutic services to children. I have also taught practitioners about the use of play in therapy. This combination of experience and training positions me as a researcher to be able to move beyond objectivity to the preferred level of being objectively- subjective. Achieving this level of judgment comes from the development of tacit knowledge, which is the grand total of one's professional experience. It includes a multitude of inexpressible associations, which give rise to new meanings, new ideas, and new applications (Lincoln & Guba, 1985). The experiences of children in therapy have complex meanings to them; the meanings expressed and emergent from therapist participation in the naturalistic inquiry would be expected to respect the structure, process and content of the play therapy, as lived by both the therapist and the client.

(3) Generalization within the naturalistic approach is inherent in the understanding that the results are applicable to this particular study and similar situations. This is the extreme opposite of traditional positivist and some post-positivist positions, which view generalizations as being universal. In accepting multiple perspectives of

reality, the naturalistic inquiry asserts that no one perspective can tell the full story, nor do all perspectives aggregated necessarily tell the whole story. The naturalistic inquiry seeks to produce a unique body of knowledge that describes an individual case. It does not seek an 'either/or' position but recognizes the broad continuum of knowledge between the general and the specific. It then deals with the continuum between these, as neither of the two ends contains all the possibilities that exist (Lincoln & Guba, 1985). According to Lincoln & Guba (1985), the only generalization in the naturalistic inquiry is that there is no generalization, yet "what is good for one is good for all – at least all in that class" (p.111). Therefore, conclusions of the naturalistic research may be transferable to similar situations and environments. Transferability is consistent with process-oriented case studies in social work that inform potential understanding and approaches, largely within the context enriching practices and generalizing to similar cases. In this study, theory and conclusions that emerge from the thematic analysis of data obtained from play therapists on their understandings and experiences of processes of therapeutic change can be transferred to the work of others, specifically social workers and other therapists who use play and who provide therapeutic interventions to children exposed to complex trauma. In my case report, (dissertation) I have provided sufficient information, known as thick description, about the context of the inquiry so that anyone interested in transferability has a synthesis of information to follow.

(4) Causal Linkages are factors that can interact and mutually shape ways that lead to judgments, thus shaping the inquiry. They include both the participant and inquirers history, training, professional and personal lives. In the naturalistic inquiry, all entities are in a state of mutual simultaneous shaping, so it is important to distinguish

cause from effects. Research is an interactive process shaped by one's personal history, biography, gender, social class, race, ethnicity, and by the same qualities of the people in the research (Denzin & Lincoln, 2000). My style of research and the research study itself has been shaped by my own history as a white, middle class female, in a 'have-not" province. My narrative includes my lived and life experiences, historically and presently. It also includes my life-long academic pursuits inclusive of continued professional development, and varied work experiences in the fields of youth corrections, children's mental health, youth residential treatment, and in private clinical and consulting practice. The qualities that have shaped my own history have also been influenced by, and have influenced the corresponding biography of the research participants.

(5) Axiology addresses the role of values in research and their influence on shaping outcomes, recognizing that the inquiry of the research project is value bound. Inquiries are shaped by a researcher's personal values that are expressed by their choice of a problem and focus on that problem. They are also shaped by the research paradigm chosen by the researcher to guide the research, by the theories used to guide the collection, analysis and interpretation of the data, and by the values inherent in the process. Congruence within the choices made by the researcher and their values enables the inquiry to be meaningful and produce findings from diverse perspectives (Lincoln & Guba, 1985). Biases are recognized as well, and were safeguarded against in this study through methodological safeguards as discussed in section 3.3.3.1 of this chapter.

A naturalistic inquirer acknowledges both the values and the biases they bring, as well as the values and biases of participants, knowing that the research will be influenced by both. The inquirer also recognizes the influence of the values of the underlying

theory(s), the values of the paradigm that guides the research, and the general cultural values that characterize the environment within which the inquiry is being conducted. In the naturalistic inquiry, the researcher chooses the topic of discovery as well as the method to accomplish this. The participants answer questions with some influence from their past and present professional and life experiences. The choice of the naturalistic inquiry as a research design allowed this researcher to enter into the world of the participants, valuing their voice, their experiences, and their realities. The emergent design of the naturalistic study allowed value differences to be kept in context. By then immersing oneself into analysis of the data, this researcher enabled and allowed the emergence of themes, theory, and knowledge.

3.3.2 Researcher's commitment to skill development.

In the naturalistic inquiry the researcher has to operate as an effective instrument that requires appropriate skill development, "high enough to ward off criticism on the grounds of instrumental inadequacy" (Lincoln & Guba, 1985, p. 252). The naturalistic inquiry presumes that a researcher who commits themself to this type of research will have acquired and will continue to fine-tune the skills needed to operate as a highly effective instrument. I have met these requirements both in my academic achievements and my many clinical experiences with children who have experienced trauma and complex trauma, in both public and private practice. My academic achievements include formal study in play therapy through CACPT at three summer institutes in London, Ontario, resulting in a certificate of completion of the academic work required towards full certification as a play therapist. Success in academics, practice experience and continued commitment to skill building are verifiable via my current curriculum vitae.

3.3.3 Initial design statement.

As the naturalistic inquiry is emergent, its design cannot be established before the study begins. It emerges, develops and unfolds as data are collected, preliminary analysis is conducted, and context becomes increasingly more fully articulated. The naturalistic inquiry utilizes an original design statement, to list agents, set schedules, budget, establish boards, plan for peer debriefing and plan for an external audit which is an important step in providing evidence of dependability and confirmability (Lincoln & Guba, 1985). Contingencies are unpredictable thus the researcher anticipates the design will change.

An initial design statement, which serves to present a researcher's intent, process and context, was developed and submitted to Memorial University's Interdisciplinary Committee on Ethics in Human Research Committee (ICEHR) (see Appendix A), and obtained approval on May 4, 2015 (with extension granted to May 31, 2017). This design statement was developed using recommendations from Lincoln & Guba (1985). All components of this design statement are identified in Figure 1 – The Flow of the Naturalistic Inquiry, which is followed by a discussion of each of the components and their characteristic flow within the naturalistic inquiry. These components of the naturalistic inquiry were applied to my inquiry as identified in the following discussion.

1. Natural Setting: This researcher travelled to Toronto, Ontario to conduct interviews, so as to be able to interview participants where they practice. Geographically all nine participants resided in eight different cities throughout Ontario, Canada. The goal was to meet with them in-person, preferably in their work places, but with the understanding that locations would be of their choosing. Four participants chose to be

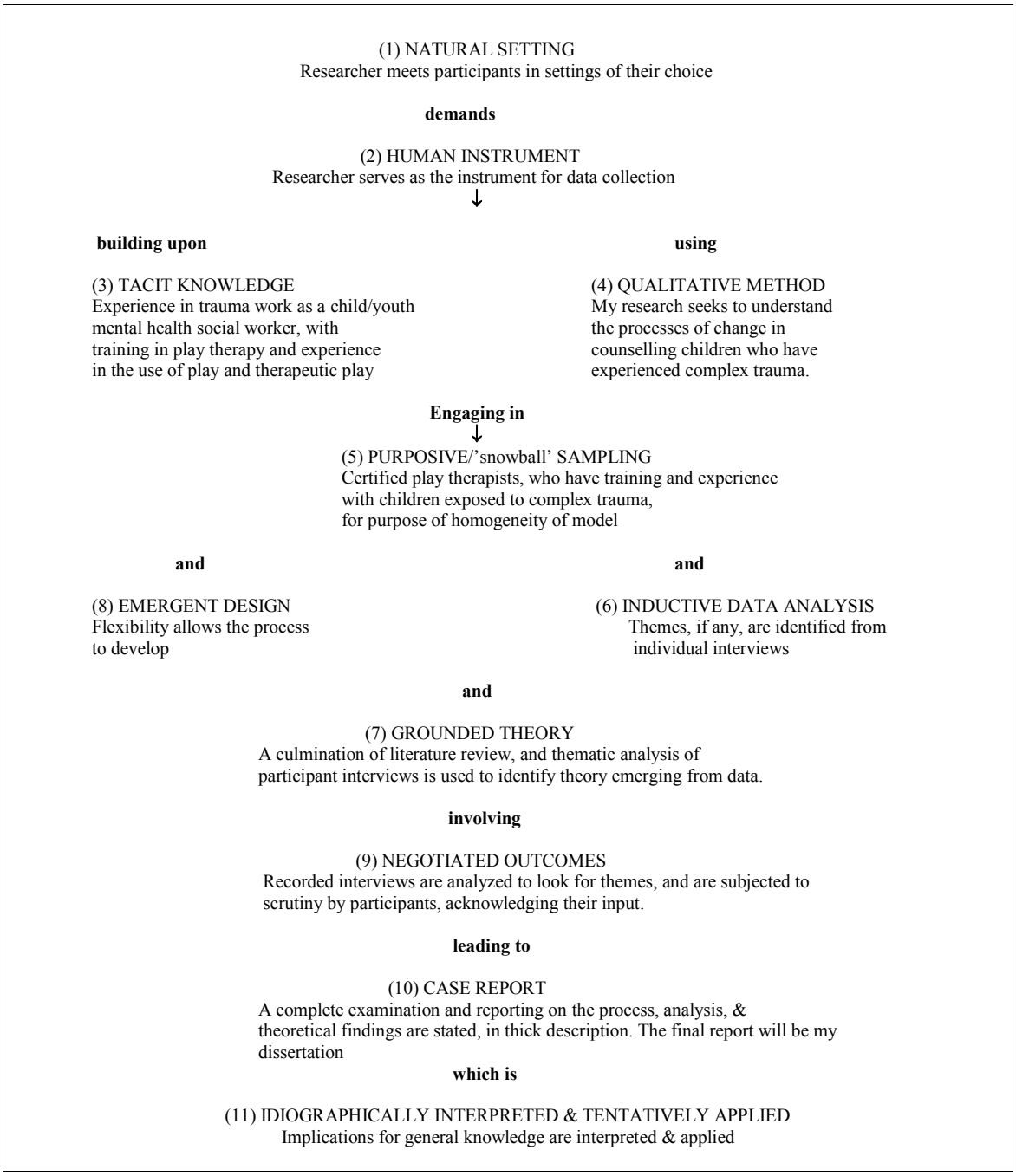


Figure 1 The Flow of The Naturalistic Inquiry (adapted from Lincoln & Guba, 1985, p.188)

interviewed in their homes: one chose to be interviewed in a coworker's office, one participant chose to be interviewed at her hotel room during a training event in Newfoundland, two participants chose to be interviewed via Skype (both were in their home offices at time of interviews) and one participant chose to be interviewed via

telephone (while she was in her office at her worksite). Lincoln & Guba (1985) suggest, "research interaction should take place with the entity-in-context for fullest understanding" (p.39), however they also recognized that in the study of a phenomenal group "one identifies members of the group in whatever ways they can" (p.233). In this context the participants put forth their preferred setting and mode of interaction. Glaser (2004) supports the relevance of being able to move beyond a single definition of 'natural setting' so as to be able to accommodate the focus of the study. Therefore an expanded concept of context encompasses that which participants put forth as their preferred setting and mode of interaction. Although this researcher recognized the merits of interviewing in play therapy settings, all participants identified their office space as being "too busy" for this purpose, thus it was determined that the choice of setting was respectfully and fully that of participants to identify and offer.

Requests from participants to meet in various locations, in person, via skype, and by telephone required me as researcher to be flexible to accommodate those choices. Flexibility is a key requirement of a naturalistic researcher. The requests to be interviewed by skype and by telephone fell outside of this worker's expectations, but they did fall within the parameters of the naturalistic inquiry, as identified Glazer (2004) and by Bowen (2008), both of whom clarified that wherever participants choose to be interviewed is seen as their 'natural' setting. The Encyclopedia of Qualitative Research Methods (Given, 2008) confirms that a 'natural setting' is one this is natural to the participant as compared to a laboratory setting. The use of technology such as skype and telephone allowed for interaction that paralleled face-to-face interactions, and thus honored the concept of natural setting. The two participants who requested skype

interviews initially agreed to in-person interviews however due to unforeseen circumstances at the last minute, both participants were unable to follow through, and both requested alternate modes of interview, at later dates. One participant who identified in-person availability as problematic and who did not have access to skype, requested a telephone interview which provided her with a level of control over her time and availability. As per the flexibility required in the naturalistic inquiry, these modifications were agreeable. However, one of the skype interviews could not proceed as planned, as the participant had been involved in a motor vehicle accident immediately prior to the interview. Despite the participant's willingness to proceed, this researcher made a judgment call to reschedule based on concern for her well being, which is well within the parameters of flexibility within the naturalistic inquiry.

The focus of my study took meaning from the various settings chosen for interviews, from the modes of interaction chosen, as well as from the participants themselves. As researcher I became part of each of the settings and contexts chosen by participants, which was natural to them and where they determined they were most comfortable to be interviewed. As well, my knowledge about the importance of comfortable settings and contexts, of play therapy and play therapy settings, and of language relevant to play therapists, were each instrumental in adding to the naturalness of the 'setting' chose by each of the participants.

2. Human Instrument: I utilized my skill set as a clinical social worker, as a PhD student and as a past student of play therapy, and as a researcher, to act in capacity as a human instrument, to gather data. I capitalized upon my privileged access to the field of play therapy and to experienced play therapists to conduct all interviews, utilizing my

knowledge base to focus the inquiry, while remaining fully committed to my role as a researcher.

3. Tacit Knowledge: Tacit knowledge is a culmination of all that is remembered, experienced and associated with. This is contrary to propositional knowledge, which is all that is learned (Lincoln & Guba, 1985). As a researcher my tacit knowledge has developed from a culmination of many years as a children's mental health social worker both in public and private practice, as a past student of play therapy, and as a clinician who has used play and therapeutic play with high clinical significance.

4. Qualitative Method: Qualitative social research seeks to explore in depth the beliefs, attitudes, and understandings of participants. The qualitative method was chosen following focus on the 'research problem' which was fully identified through the literature review which allowed me as researcher to have a clear understanding of the question and the inquiry needed to address the problem.

5. Purposive Sampling: Certified play therapists from Ontario, Canada, who have experience and/or training in trauma work, and who provide counselling services to children who have experienced complex trauma (a homogenous sample) were chosen to represent a purposive sampling through a combination of 'snowball sampling' (whereby participants provide the researcher with other potential participants), and self-identification (by responding to the study's e-blast seeking interested participants (see Appendix G). An e-blast is an email designed to explain the study and solicit interest, which was sent out to individual email addresses of those in the interest group. The following is a discussion of the selection process, and entry into the field.

In Ontario, Canada, there are a total of thirty seven (37) certified play therapists registered with CACPT, all listed on its website, with individual email addresses. Contact was initiated with all participants listed (minus Dr. Nancy Riedel Bowers, a member of my dissertation committee) via an e-blast (see Appendix G), in which an email was sent out seeking expressions of interest. Eight play therapists self-identified by responding to this e-blast. Nine were later identified through snowball sampling, (3 who had also self-identified). Of the total of fourteen potential participants, nine were interviewed, before the saturation point was reached. As stated by Lincoln & Guba (1985), "the criterion invoked to determine when to stop sampling is informational redundancy" (p.202), also known as the saturation point which in the naturalistic inquiry signals the end of the interview process. Data saturation is reached when there is enough information to replicate the study and when the ability to integrate additional new information has been reached. This is indicated by the end of any new themes, signalling the saturation point for the data (Fusch, 2015). Saturation serves the important purpose of ensuring replication, verifies, and ensures both comprehension and completion (Bowen, 2008).

The initial participant was identified by the study's gatekeeper, followed by snowball sample when available, and self-referrals in the alternative, in keeping with the study's design. Of the nine participants, 5 were self-referrals, and 4 were identified through snowball sample. All nine participants met the inclusion criteria: being a resident of Ontario, being a certified play therapist, having training/experience in complex trauma, and provided services to children exposed to complex trauma (Appendix H). All interviews took place between July 21, 2015 and September 25, 2015. Interviews were

approximately one to one and a half hours each. All interviews were audio recorded, with the written permission of participants (see Appendix C) utilizing both a primary and a back-up recorder. Upon identification of a potential participant, contact was initiated in one of two ways. For participants identified through snowball sampling, the referring play therapist made initial contact to determine interest. Following confirmation of interest,, this worker followed the contact format outlined in Appendix F.. For participants who self-identified, contact was made directly, also following the contact format outlined in Appendix F.

A contact format was followed. First, this researcher, utilizing Appendix F (The oral telephone recruitment script), made telephone contact. Upon confirmation of interest in proceeding, a copy of Appendix B, Letter of Introduction and Explanation, was forwarded via email. Participants were given the opportunity to review same, and again confirm interest in continuing. Upon confirmation of same either by telephone or email depending on preference, a letter of informed consent (Appendix C) was forwarded for review prior to meeting. Date, time and place of interview were then scheduled.

6. Inductive Analysis: Inductive data analysis is a process of "uncovering embedded information and making it explicit" (Lincoln & Guba, 1985, p.203). This type of analysis serves to identify themes emerging from the data. Inductive analysis was carried out utilizing thematic analysis, which provides a flexible approach to analyzing qualitative data (Braun & Clarke, 2006). The analysis process is discussed in detail in chapter five.

7. Grounded Theory: This is a systematic methodology in the social sciences involving the construction of theory through analysis, thus it emerges from the data rather

than precede the data (Corbin & Strauss, 2008; Lincoln & Guba, 1985). Naturalistic inquiry's emergent design acknowledges that perceptions of reality are multiple and constructed (that is, reality is a construction of the minds of individuals), and therefore constructivist grounded theory was drawn upon for this research. According to Glaser (2002) the constructivist belief is that interviews yield the social construction of data through the interacting and mutual interpretations of the interviewer and the participants as the interview process unfolds. Thus constructivism assumes the relativism of multiple social realities, recognizes the mutual creation of knowledge by the viewer (researcher) and the viewed (participants), and aims toward interpretive understanding of subjects' ascribed meanings, and thereby offers accessible methods for taking qualitative research into the 21st century (Charmaz, 2000). Constructivist grounded theory is discovered both empirically and interpretively, by means of observation or experience and the meanings assigned to both empirical and interpretive knowledge. Models of explanation and interpretation occur by connecting themes, which were generated from the data, which enabled me as researcher to add to the theory bases already in existence. In my study, grounded theory was identified following the analysis of the first interview, and then was expanded upon following the analysis of each subsequent interview, so as to incorporate any and most new findings. The final theory which emerged at the end of the data analysis was a synthesis of these findings, which can be found at the end of chapter four.

8. Emergent Design: Allowing the design of the research to emerge enabled me as researcher to engage in a free-flowing dialogue with participants so that the process of the interview was flexible and able to move to where the information led. It also allowed for continuous data analysis, so as to continuously incorporate much of what had been

learned from preceding interviews into subsequent interviews. This process became a reality in the focus of interviews as they progressed. I was able to attend to issues of interest identified in previous interviews, and to fine tune questions related to emergent themes. These results may be found in chapter four, where an overview of interviews is provided.

9. Negotiated Outcomes: The analysis of all recorded interviews by this researcher, and subjecting those analyses to interviewees for their scrutiny and feedback through member checking processes following individual interviews, and then again following the process of analysis, was a major component of this naturalistic study. In doing so, the outcomes of the research study became influenced in discussions that reflected negotiation processes. Following each interview, I completed a summary and returned it to the participant seeking their feedback. Each participant responded to this request, some providing more detail on specific parts of the summary, while others simply confirmed their agreement with the summary. For the final member check, a single narrative summary was sent to all participants seeking their feedback. All participants provided feedback as requested, which was incorporated into the final analysis. A copy of the final member-checking document can be found in Appendix L.

10. Case Report: This dissertation represents the case report inclusive of the statement of the problem, the literature review, the methodology to address the question, the data analysis, emergent grounded theory, ending with conclusions and recommendations as outlined in chapter six.

11. Idiographic Interpretation and Tentative Application: Individual and summative findings from the data are interpreted as they relate to the study site. ‘Thick

description' of the findings of this study was applied making this study transferable to other sites.

Design in the naturalistic sense means planning for certain broad contingencies, without indicating exactly what will be done in relation to each (Lincoln & Guba, 1985). A naturalistic inquirer does not make the same a priori, or pre-plans as would be made for conventional research, as its design is an emergent one. However, there are considerations to be made. A researcher should consider insights gained from previous studies (Erlandson et al, 1993) such that a theoretical perspective from a previous study may be utilized if that perspective was grounded in prior naturalistic research. A thorough review of such insights can be found in section 2.11.1 (Insights gained from previous studies) of the literature review.

Although the naturalistic inquiry is emergent, and its design cannot be established before the study begins, there are ten design elements that can be pre-specified (see Appendix A). There is no assumption of linear use of these elements, but their interconnectedness and their influence on each other is recognized. Within these design elements are some of the most important aspects of the naturalistic inquiry. The following is a discussion of each of the design elements, adopted from Lincoln & Guba (1985), and applied to my research.

3.3.3.1 Determining the focus of inquiry.

Determining a focus area serves to establish boundaries for the study as well as the inclusion – exclusion criteria for new information that comes to light. Even with

inquiry boundaries that are based on contextual knowledge, a researcher is exposed to excessive information that, while interesting, is not relevant. Reflexive focusing helped at arriving at a decision to retain or discard specific information. For purposes of clarity these elements will be discussed in terms of; Phase 1 – Design – how the element was designed for in this study; Phase 2 – Modifications made to the design based on findings in the field; and Phase 3 - Implementation of the design elements.

Phase 1 – Design: My area of focus was the conceptualizations and practices of play therapists in the middle phase treatment of children who were exposed to complex trauma. The goal of my research was to identify the processes of therapeutic change within the treatment process that affected positive outcomes with children exposed to complex trauma.

Phase 2 – Modifications to this focus: In the naturalistic inquiry, changes in focus are expected and seen as constructive because they signal movement to a more sophisticated and insightful level of inquiry (Lincoln & Guba, 1985). It became clear very early in the interview process that processes of therapeutic change could not be discussed in isolation, or separately from other phases of therapy. All participants incorporated discussions of the beginning phase of treatment as a means of leading into the discussion of middle phase treatment. Participants unanimously highlighted the aspects of relationship building and safety as foundations to all trauma work with children, and therefore determined that these components required significant discussion in order to lead into the topic of change processes. Therefore, modifications were made to expand the boundaries of the study to incorporate discussion of the phases of treatment, and the importance of both therapeutic relationship building and therapeutic safety, while

maintaining focus on the research questions. The naturalistic inquiry enabled me to follow these modifications, which then led me to where I needed to go throughout the interviews to find answers. Also incorporated into these modifications was the inclusion and analysis of resources that were recommended (and at times provided) by participants. By including these resources as a form of data, this researcher was able to incorporate new information into subsequent interviews, to seek a deeper understanding of the research questions. These recommended resources, as described later, became part of this researcher's audit trail. Changes in focus were recorded in my field journal, which became part of the study's audit trail.

Phase 3 – Implementation: As researcher, I began my interviews with a focus on identifying processes within middle phase treatment that led to therapeutic change. My working hypothesis, which developed with the first collection of data, was that there were change processes that could be identified, however they could not be studied independently of other aspects of treatment, and therefore had to be found within the discussion of the whole treatment process. A working hypothesis is tentative and is always different in context from one situation to the next. Beginning with the first interview, it became evident that my focus would have to change to accommodate the preliminary discovery that change processes were interconnected with all phases of treatment, not only the middle phase. Finding and understanding these processes would require expanding my study's boundaries to include discussions of all phases of treatment. From these discussions the processes of therapeutic change would be then be extricated for further study.

All changes in the focus of inquiry were recorded. Record keeping began with my entry into the field, starting with travel to the site. My record keeping consisted of field journals and a logbook, which were kept throughout my study. Field journals included notes of day-to-day activities, communications, records of contact with peer advisor including peer debriefings, interviews, changes - including changes in focus with explanations of same, budgetary documentation, and any other information relevant to recording for an audit trail. The logbook included individual daily reflections throughout the interview period. These also became part of my audit trail. As recommended in the naturalistic inquiry, the audit trail included all recordings, raw data, data reduction and analysis notes, data reconstruction and synthesis notes, process notes, instrument development notes, and any notes on my intentions as researcher.

The audit trail also consisted of records related to methodological safeguards within the naturalistic research process intended to prevent both bias and being presumptive (i.e. making presumptions about the data, before the data are in). The use of the same grand tour question for each and every interview is one such safeguard that was utilized. Another is the use of triangulation whereby all new information is validated against at least one other source before given serious consideration. Additionally, a crucial technique called member checking, both formal and informal, was utilized repeatedly throughout the research process, to ensure credibility. Each of these safeguards is discussed throughout this study's design.

3.3.3.2 Fit of paradigm to focus area.

A paradigm is defined as "a philosophical and theoretical framework of a scientific school or discipline within which theories, laws, and generalizations and the experiments performed in support of them are formulated" (Merriam-Webster on-line dictionary, www.merriam-webster.com). The Oxford English Dictionary (2005) (online version) defines a paradigm as "a conceptual or methodological model underlying the theories and practices of a science or discipline at a particular time; hence, a generally accepted world view". The Cambridge Dictionary (online version) defines a paradigm as "a very clear or typical example used as a model". Thus qualitative paradigms are based on sets of beliefs or axioms whereby the research problem is examined in terms of its relation to the naturalistic axioms**.**

My research adhered to all five axioms of the naturalistic inquiry, as indicated earlier. First, there was an assumption of multiple realities (ontology) of the individual play therapy participants and of the inquirer. Participants used case examples to identify their vastly different experiences in working with children who had been exposed to complex trauma. These experiences, their years of experience in this field, their training and their specializations, and their interventions with severely traumatized children, created their own unique and individual set of realities. Second, the influence of the knower to the known (epistemology) had an impact on the inquiry. The play therapy participants in this context were the experts, selected for their unique knowledge and experience in using play therapy and trauma-informed practices to intervene with complex trauma. However, as researcher, I guided that knowledge through meaningful interaction. This required me to be very familiar with my topic from a 'known'

perspective, to be able to direct the inquiry to where it needed to go and to have the skills to keep it focused there. Third, this research was context dependent, and therefore cannot be generalized. In the naturalistic inquiry, local conditions make it impossible to generalize. However, by providing sufficient information about the context of the inquiry, anyone interested in transferability has a base of information to work from. Fourth, causal linkages, also referred to as mutual shaping, took into account the many influences of all participants as well as any influences of the inquirer. These four factors influenced the direction as well as the outcome of the inquiry. And fifth, participant's values (axiology), both individually and as a group, were recognized to be of great importance to this research and were taken into account in the context of the inquiry.

Other considerations for 'fit of paradigm to focus area' are the degree of cooperation expected from participants (which as expected was high), and the constraints that might be placed on the researcher by participants (which were expected to be few). These expectations were met. Participants as a group welcomed this research into what they considered to be a significantly under-researched topic. They also appreciated being selected as a professional group for participation in this study, which recognized and acknowledged their expertise with children, inclusive of children exposed to complex trauma.

3.3.3.3 Fit of paradigm to the substantive theory.

This is a key step in studies whereby a theory is given upfront. However, in my study, theory was not given a priori, as it emerged from the site data. The goal was to inductively analyze from within participants' experiences to find new data that gives new

form to the inquiry itself, through the identification of theory, which became the end-point of the inquiry. From analysis of all data within this study, theory emerged to bring meaning and synthesis to the findings. This emergent theory is discussed in explicit detail in Chapter 5 (findings).

3.3.3.4 Where and from whom the data was collected.

In the naturalistic inquiry, maximum variation sampling (MVS) is preferred within a homogenous sample. Appendix K (Participant Demographics), highlights the practice experience and training of each participant. The purpose of MVS is to document unique variations that emerge in adapting to different conditions. The sample was selected in ways that provided the broadest range of information possible and expanded until informational redundancy was reached (at nine interviews), at which point sampling was terminated.

Selection of site was critical. It had to be a natural setting, be assessable, have a high probability of a rich mix of the participants, be one whereby the researcher is viewed as having knowledge and thus is accepted, and one whereby data quality and credibility of the study are reasonably assured. As stated earlier, my study's site selection was the province of Ontario, Canada. Since the development of CACPT in 1985, this is where the majority of yearly summer institutes in play therapy training have taken place. It is a central location for practicing play therapists, and it is one of the few areas in Canada where employers recruit play therapists specifically. It is also the location of one of only two university-based play therapy training courses in Canada.

As indicated above, the participants selected for inclusion in this study were certified play therapists who had training and/or experience in trauma work. This criterion served to identify and select a homogeneous group. Participants selected with these criteria also had a rich variety of education, training, and work experience. Participants, all of who were certified play therapists, identified with the following disciplines; 4 social workers (at levels of diploma, degree, PhD(c) and PhD); 1 psychotherapist; 1 mental health counsellor; and 3 psychologists.

As specified by Lincoln & Guba (1985), planning for data collection requires a number of specific elements. These include providing for identification of initial elements, planning for purposive sample selection, providing for the orderly emergence of the sample, providing for continuous refinement or focusing, providing for termination, and plans for subject protection. Each of these elements is discussed individually in the following section, beginning with the critical issue of subject protection.

3.3.3.4.1 Subject protection.

Research primarily seeks "to understand something not yet revealed", thus, often "entails risks to participants and others" (CIHR, NSERC, SSHRCC, 2010, p. x).
I am aware that in the naturalistic inquiry, some ethical considerations may be addressed in planning, but others emerge as the study unfolds. My research was guided by the core value of human dignity. According to Tri-Council Policy (2014), respect for human dignity requires that research involving humans be conducted in a manner that is sensitive to the inherent worth of all human beings and the respect and consideration that

they are due. This is expressed through three core principles, which guide researchers in conducting inquiry. These are; respect for persons; concern for welfare; and concern for justice (CIHR, NSERC, SSHRCC, 2014).

Respect for persons entails the protection of an individual's right and freedom to partake as much or as little as they choose. Therefore researchers are bound to seek participant's free, informed and ongoing consent. Participants in this study were made aware through a 'Letter of Informed Consent' (Appendix C) that they were free to withdraw from the study at any point. However, given the nature of the naturalistic inquiry whereby analysis of one interview is used as the basis for the next interview, participants could not be assured that their information could be withdrawn beyond a certain point in the study. Given that this would diminish participants' ability to exercise their autonomy, it was important that they be advised of this at the outset. This was explained in the letter, which was provided to all participants for review prior to interviews, with opportunity for discussion prior to endorsing the consent form.

Concern for welfare is intended to ensure that a person's life, livelihood, belongings, or any other part of their lives are not compromised as a result of taking part in this research study. This entails safety as a priority. Tri-council policy (2014) states that participants are to be provided with enough information so as to be able to adequately assess risks and potential benefits associated with their participation in the research. Given that participants are certified play therapists, participation in this study had to ensure protection of their professional reputations. Therefore participants were advised upfront as to potential risks and benefits involved in partaking in this study (see Appendix C).

Concern for justice is a principle that guides researchers to treat participants fairly and equitably. All participants were treated equally and respectfully as experts in their field, whose expertise would be used for the advancement of knowledge. Fair treatment was reflected in the collective understandings of play therapists as a group, and of conceptualizations of processes of therapeutic change, inclusive of diverse views as well.

Inherent in these three core components, which are imperative to research utilizing human subjects, there were a number of ethical considerations and guidelines, as outlined by Creswell (2009), which guided my research as follows:

1. Ethics approval, which takes into consideration the *Guiding Ethical Principles* of the Research Ethics Board at Memorial University and *Tri-Council Policy Statement of Ethical Conduct for Research Involving Humans* (Retrieved on-line January 2015) was obtained before proceeding with my research. My proposal was submitted to Memorial University of Newfoundland's Interdisciplinary Committee for Ethics in Human Research at icehr@mun.ca, and received approval (ICEHR#20152102-SW) on May 31, 2015, for a period of one year (see Appendix J), and later extended for a one year period. Participants were advised of this approval in both my "Letter of Introduction and Explanation" (Appendix B) and "Letter of Informed Consent" (Appendix C), and a copy was made available for their review upon request.
2. All research participants were informed about my study in a "Letter of Introduction and Explanation" (see Appendix B).
3. As researcher, I was respectful, honest, and trustworthy with research participants, recognizing them as equals rather than as objects of my study.

4. I ensured that participants were not exposed to unnecessary risks by attempting to balance benefits and risks in this study. Participants made the final judgment on the acceptability of this balance.
5. I carefully considered the implications of undertaking research with play therapists as a group in terms of benefits or negative effects on their professional reputations. Participants made the final judgment on the acceptability of this balance.
6. I ensured privacy, confidentiality and anonymity, especially regarding personal and other sensitive information gained from participants or elsewhere, within the limits of my ability to do so.
7. Participants took part voluntarily, verified by their signatures on the Letter of Informed Consent (Appendix C).
8. Participants were free to withdraw at any time.
9. I ensured, by my own signature, that participants read and understood my letter of consent.
10. I sought approval for audio recording, verified by signatures of participant and inquirer (Appendix C).
11. I informed participants of storage procedures to safeguard their data.
12. Significant information was made available to support 'informed' consent about participating (see Appendix C).
13. The peer advisor chosen for this inquiry entered into a peer advisor agreement (see Appendix D).

14. As a gesture of appreciation to participants, a monetary donation of $200.00 was made on behalf of participants as an anonymous group, to Vanier Children's Services, a children's organization, chosen by a draw from those identified by participants. (It is noteworthy that this organization replied with a thank-you letter noting that children's mental health is often an overlooked area of service).

3.3.3.4.2 Identification of initial elements.

Sampling in the naturalistic inquiry is contingent and serial. The selection of each participant is dependent on the preceding participant(s), and their understanding of the focus of the inquiry determined their consideration of the next participant, or if they were able to identify a participant at all. To ensure rich discussion and context, I sought selection of experienced knowledgeable play therapists that had training and experience in trauma work. Training in trauma work is often made available to members of CACPT from The Trauma Institute, located in the United States of America, but brought to Ontario on an ongoing basis. Although other forms of training are available, this training is availed of by many practising play therapists in Ontario as a specialty area. Given my topic, knowledge of trauma training having been availed of by many certified play therapists served to seek selection of those most knowledgeable in the field, although it was not exclusionary. The absence of formal training in trauma did not exclude recommended participants from this study.

Plans for identification of the initial participant were made beginning with the selection of a gatekeeper. A gatekeeper is a knowledgeable informant who supported this

researcher in gaining entry into the field and accessing potential participants. Ms. Theresa Fraser, President of The Canadian Association of Child and Play Therapy (CACPT), served in this role. She is very well respected and connected within the professional play therapy community, and thus was familiar with those practising in the field of play therapy, specifically with trauma. Her role was to ensure homogeneity of participants, so as to maintain integrity in my research methodology. She used her expertise to identify the characteristics likely to be important in the selection of an initial participant, and then identified a participant who met those criteria, and made initial contact to determine interest in taking part in this study.

3.3.3.4.3 Purposive sample selection.

A combination of snowball sampling and self-identification was utilized to access participants for my research. Snowball sampling was the preferred choice due to the specialization sought in participants. However, it was determined that in the event a participant could not be identified by snowball sample, an alternate method of identification was required. Therefore an e-blast technique was utilized to have potential participants self-identify, as discussed above. In combination these methods served to identify a rich array of participants, from which a purposeful sample of nine participants was selected in an orderly fashion. They also served to ensure elimination of any possible sample bias.

Respondents to the e-blast were directed to reply to the study's gatekeeper, Ms. Theresa Fraser, who was familiar to all play therapists based on her role as President of CACPT. Ms. Fraser screened all self-identified participants who responded to the e-blast,

to confirm they were certified play therapists, and to validate their suitability as a participant in that they were known to have training and/or experience in working with complex trauma. She then referred the participants to me by providing them my email address. Following my screening process, as discussed above, participants were advised that if selected for an interview they would be contacted during the data collection time frame identified.

In total, through snowball sampling (nine) and self-identification (eight), seventeen (17) potential participants were identified, with three participants identified through both self-identification and snowball sampling, changing the total number of potential to fourteen (14). Of these, nine took part in the study. After nine interviews, no new information was identified, which, according to the naturalistic inquiry, signalled the end of the interview process. At the completion of the data collection process, a thank you letter was sent to participants who had self-identified through e-blast but who were not interviewed.

3.3.3.4.4 Orderly emergence of the sample.

Of the nine participants, 5 (five) were identified through snowball sample and 4 (four) were self- identified. Orderly emergence required selection of participants one at a time. Therefore no new participants were selected until those previous had been 'fully tapped', that is to say their interview was completed, their data was paraphrased and returned to them, and their initial member checking process was completed. It was only then that the next participant was contacted, and the process started anew, as per the flow of the naturalistic inquiry (see Figure 1).

It was found that even though during the e-blast recruitment process, potential participants had indicated they would be available during the allotted time frame for this researcher to be in Ontario, circumstances changed and some participants were not available upon time of contact. Therefore in 3 (three) cases whereby participants had self-identified, upon contact they indicated that they wished to proceed with participation but were unavailable, and requested alternate forms of interview at later dates (two requested skype, and one requested telephone as web based resources were not available due to location). Balancing the requirement for orderly emergence and flexibility, these requests were accommodated.

Participants identified through snowball sample were provided an extra measure of protection. It was determined that no participant identified through this means would be cold-contacted by this researcher. Thus, selected participants were asked to contact the potential participant they identified through snowball sample, to assess their interest in participating in this research study. Following this initial contact, and upon confirmation of interest, I followed up via email, to assess for inclusion criteria (Appendix I) and upon confirmation of same, requested telephone contact, which was initiated by utilizing an Oral Telephone Recruitment Script (Appendix F). For participants who had self-identified, contact was made as required when there was no participant identified through snowball sample. In such cases selection was made based on location and availability. Contact with these participants was made via email, and followed up by telephone call.

The study's gatekeeper identified the initial participant for this study. Snowball sampling was the initial form utilized to identify further potential participants. In cases where identification was not possible via snowball sampling, self-identified respondents

were contacted. Participant #2 was snowball; #3 was self-referral; #4 was self-referral; #5 was snowball; #6 was self-referral; #7 was snowball; #8 was self-referral; and #9 was snowball.

Contact was made with the initial participant (and all participants recruited by snowball sample) utilizing an Oral Telephone Recruitment Script (Appendix F), after the participant expressed interest in proceeding. This script served to introduce myself as sole researcher, identify how I obtained their name, and to inquire about and confirm their interest in participation. If the potential participant was still agreeable to participating (they all were), they were sent (via email) a letter of introduction and explanation (Appendix B), and a Letter of Informed Consent (Appendix C) for review prior to the interview. The introductory letter informed participants of the focus of my research, who I am as a researcher, my employment and experience with trauma work both in public and private practice, and my contact information. Following this and with participants' agreement, a meeting time and place was established. Participants who self-identified were contacted via email with a request for a telephone meeting time, in which Appendix F was utilized as well, as was the above procedure which was followed.

Upon meeting with individual participants, the introductory letter was reviewed with the participant, with opportunity given for any questions about the study. The 'Letter of Informed Consent' (Appendix C) was also reviewed with opportunity provided for questions. This form required signatures of both the participant and the researcher. For the two skype and one telephone participant, signatures were obtained via fax before proceeding. This letter indicated that my study's proposal had been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance

with Memorial University's ethics policy. A copy of this approval was made available to participants upon request. It outlined the focus of the study, the timeframe for interviews, and the safeguards for subject protection and the protection of their information. This included specific information regarding consent and participation, intent to maintain confidentiality and anonymity (yet noting that this could not be guaranteed after information was utilized, as the method of inquiry is one that builds on previous participants' information), identification of measures to prevent raw data from being linked with any specific participant, measures taken to limit access to the data by others, the right of withdrawal and steps to be taken to exercise this right, notice that participation is voluntary, identification of the study's gatekeeper and peer advisor, information about this researcher's gesture of appreciation to a children's charity, a sign-off space for participants to verify agreeing to stipulations, and space for both my own signature as researcher, and participants' signatures, with appropriate date. Following endorsement of the Letter of Informed Consent, a copy of this form was provided to all participants, and a copy kept by me as researcher, for my records.

Involvement with each participant was fully completed before contact was made with the next. This included scheduling a time and place to meet, conducting the interview, review of any material and documentation provided, completion of a written member checking narrative within 24-48 hours, submission of this narrative to participant, and awaiting member checking feedback. This sequential process is in keeping with the naturalistic inquiry, in which successive interviews build upon data from previous interviews. Intensive work was required throughout and following the interview process, to remain immersed in the material, complete the member checking

process, and finalize involvement with the participant, before beginning the next contact, all within the time frame allotted for interviewing. Although this proved to be a timely and intensive process, all participants were cognizant of this researcher's time frame for interviewing, and were very prompt in providing feedback.

3.3.3.4.5 Continuous refinement and focusing.

Each interview followed the same format, guided by a 'Checklist for Study's Participants (Appendix N), which was developed to ensure all components of the format were included. Receipt of both the 'Letter of Introduction and Explanation' and the 'Letter of Informed Consent', by email, (for review prior to the interview) was confirmed on the checklist. For the in-person interviews, this letter of informed consent was reviewed and endorsed by participants and researcher, following opportunity for questions/clarifications (with copies then provided to participants for their records). For the skype and telephone interviews, these letters were scanned and emailed to participants for review prior to their interview, with opportunity for questioning (via email or telephone), then endorsed by the participant and returned by fax to me, prior to interviewing. At the beginning of the interview, it was then endorsed by this researcher, and later scanned and emailed back to participants following the interview process, as a copy for their records. This outcome was noted on the checklist. Date, time of interview, location, and file code, were all noted on the checklist

Prior to proceeding with interviews, each participant was requested to identify a person of support they could contact any time following the interview, if they felt the content of the interview triggered them in any way, given the subject matter, and the

potential to bring up memories of difficult cases from their work experiences, past and present. Participants unanimously expressed an appreciation of this consideration, and individually identified names of supports they could contact if required. The discussion of a support person was noted on the checklist.

A 'Demographics and Practice Information' form (Appendix E) was completed and completion was noted on the checklist. Each interview then progressed with the same grand tour question, which was 'What do you consider to be the therapeutic change processes within your treatment of children who have experienced complex trauma'? The application of this question was also noted on the checklist. The member checking processes was discussed, and also noted on the checklist. The length of time for the interview was noted on the checklist, as were any resources discussed and/or recommended or provided by participants. At the end of the interview, participants were asked to identify a children's charity of their choice to enter into a draw for donation by this researcher, and their selection was noted on the checklist. The final item discussed with participants was identification of the next participant via snowball sample. The outcome was also documented. In cases where the next participant was not identified by this means, participants were put at ease with the knowledge that a second method of recruitment was in place that enabled this researcher to proceed uninterrupted. This option and flexibility proved to provide ease to participants who for various reasons did not identify the next potential participant.

As the interviews progressed the focus became increasingly more refined. This researcher was able to utilize information from previous interviews to draw participants' attention to discussions and patterns being identified. Questions became increasingly

more specific to processes of therapeutic change, which were being identified by participants both individually and as a group.

3.3.3.4.6 Termination.

As the inquiry obtained focus, information considered important in the beginning become less relevant. This is an anticipated outcome of the naturalistic inquiry, which seeks to begin with a broad overview of a subject and increasingly narrow the discussion to the specifics of the inquiry. Lincoln & Guba (1985) indicates that most available information will be exhausted after approximately twelve interviews. However, termination is not determined based on the number of participants but on exhaustion of information such that no new information is being identified. As expected, and as the inquiry moved forward, the data collected became increasingly more focused, and therefore redundancy signalled the point of termination. Redundancy became clear and obvious after nine interviews.

3.3.3.5 Successive phases of the inquiry.

There were three successive phases to my interviews; orientation and overview, focused exploration, and member checks and closure. Orientation and overview was the beginning phase in which the concept of 'I don't know what is known' about the topic of 'change processes within the treatment of children who experienced complex trauma', was the focus. The unstructured interview format allowed for initial discussions of this topic to become more focused and refined not only in individual interviews, but also in subsequent interviews as the process evolved. This process led to the next phase, that of

focused exploration, which enabled me to focus on some of the more salient aspects of the interviews to seek deeper understandings resulting from the move in thinking of 'I know what I don't know'. The third and final phase was the member checking process which sought verification of the findings, and therefore credibility of the findings individually and overall. This process required continued and prolonged involvement by participants who were asked for review and feedback of the member-checking document prior to closure of the process. According to Lincoln and Guba (1985), these three phases can slightly overlap, and can allow the researcher opportunity to reiterate, reflect and recycle data from the interview(s). The net result set the stage for increased confidence in this study's findings.

3.3.3.6 Using human instrumentation.

The researcher is the instrument of choice in the naturalistic inquiry. The benefit of this selection, according to Lincoln and Guba (1985) is in the understanding that only the human instrument has qualifications and characteristics that make them capable of grasping and evaluating the meaning of different interactions. Humans are responsive and adaptable. We have a holistic emphasis, and are able to grasp and incorporate data in its own context. We also have a knowledge base that enables us to competently function in the domains of propositional and tacit knowledge simultaneously and continuously. Additionally, we are able to process data as soon as it becomes available. We are able to seek clarification and summarize on the spot, and are able to explore common and distinctive responses to achieve a higher level of understanding than might not be otherwise possible.

As sole researcher, I conducted all interviews for this study using an unstructured interview format for data collection. This is seen in the naturalistic inquiry as a clinical, in-depth, specialized, exploratory interview (Lincoln & Guba, 1985). It is a format that I have significant experience with based on many years of experience in the role of clinical social worker. Each interview began with the same grand tour question, which was, "What do you consider to be the therapeutic change processes within your treatment of children who have experienced complex trauma?" This measure was utilized to ascertain the elimination of any possible bias in the interview process. Also utilized for this purpose was initial and final member checking processes, whereby information by the interviewer was subjected to the scrutiny of the participants, at two separate phases of the data collection process. This collective examination served to reduce, if not eliminate any possible bias as well.

As expected, respondents reacted with interest to the broad issue raised by the inquirer. This encouraged interviewees to express conceptualizations of their interventions with trauma, structure their accounts of how and why they use these interventions, and allow them to introduce their notions of what they regard as relevant to the issue. As outlined by Lincoln & Guba (1985) the goal of the type of interview utilized was to obtain unique and wholly individual viewpoints. To achieve this, both the questions and answers were in the hands of the respondents. During the later interviews, a more structured format of questioning was utilized to build upon conceptualizations identified in earlier interviews.

I utilized my gatekeeper in the initial phases of inquiry, as indicated above. I also utilized my peer advisor in the initial phase and throughout my analysis phase as a means

of debriefing, as is also recommended in this type of inquiry. The role of peer advisor was undertaken by social worker, Ms. Angela Seaward, a past co-worker, who is familiar with my work and who expressed an interest in my research. Ms. Seaward endorsed the study's letter of informed consent. Also, members of my PhD supervisory committee were consulted at times throughout the research process when specific information required clarification or discussion.

3.3.3.7 Collecting and recording data.

The primary source of data collection was interviews. Times and places of each interview were predetermined in consultation with participants. All 9 (nine) interviews were completed at locations chosen by participants as discussed above. Interviews ran for approximately one to one and a half hours each. All interviews were audio recorded, with the written permission of participants (Appendix C) utilizing a primary recorder and a second or back-up recorder, so as to ensure interviews were not interrupted due to technical problems. Both recorders were small thus nonintrusive. Storage and protection of all data adhered to the guidelines outlined in the study's Letter of Informed Consent (Appendix C).

A secondary source of data was that of resources identified and in some cases provided by participants. One participant provided a power point presentation that she uses in her work with professionals on the topic of complex trauma. Another introduced a toy resource she uses; a plastic scull with an interlocking plastic brain used to inform children and parents about the brain and the effects of trauma on different parts of the brain. Another provided informational articles used in her work with complex trauma.

Another participant provided copies of a book on childhood trauma and attachment, which she herself authored. Still another participant made reference to, and recommended a children's storybook about the effects of trauma, which she uses in therapy. Reference was made to parent resources used in treatment, and a children's colouring book written and developed by a participant was provided. This book focused on the effects of trauma using children's language and age-appropriate examples. These resources were all reviewed in detail.

A third source was information obtained through the member checking process. Five participants availed of this opportunity to provide feedback through the first member checking process, clarifying points that were extracted from their interviews, adding new information, and in one case choosing to change the wording used in the member-checking document to more summative wording. Participant's feedback was incorporated into their interview data. The remaining participants provided positive feedback on the member check document, and accepted the information as presented. Participant feedback was imperative to the process, and no further interviewing was undertaken until this process was completed as this served to inform the next interview, a process that was repeated throughout the research so as to cumulatively shape subsequent interviews.

A fourth source of information was field journals and a logbook that I kept throughout the interview process. Field journals were kept by me and by my peer advisor as requested. My journaling included notes of day-to-day activities, communications, records of contact with peer advisor including peer debriefings, interviews, changes with explanations of same, budgetary documentation, and any other information relevant to recording for an audit trail. My peer advisor kept a record of all contacts made with her

throughout the study. The logbook included individual daily reflections, observations, and impressions throughout the interview period.

3.3.3.7.1 Demographics.

Information was collected from each participant using a 10-question demographics form (see Appendix E), which was developed to determine homogeneity of participants. Homogeneity was confirmed in that all participants are certified play therapists, and all are registered with their professional association of CACPT. Participant's year of certification as a play therapist ranged from 1995 to 2012. All participants were female, and all participants practiced play therapy using a combination of directive and non-directive approaches. All participants were experienced play therapists, having practiced between 4 and 20+ years. Additionally, 8 participants identified having formal training in trauma, and one received training through her employment. Three participants practiced play therapy publically, four practiced privately, and two practiced both publically and privately. Practice within the public domain included counselling centers, community services, children's services, and hospitals and/or hospices. Participants identified with the following disciplines: 4 social workers (at levels of diploma, degree, PhD(c), and PhD), 1 psychotherapist, 1 mental health counsellor, and 3 psychologists.

3.3.3.7.2 Data protection.

All collected data had been secured, inclusive of tape recorders, transcriptions, copies, documents, and individual paper files, in a locked cabinet in my personal home

office, accessible by me only. Keys to this cabinet are kept on my person, with back-up keys stored in my locked desk at my place of employment. All transcribed dictations are kept in files on my personal and private computer, which is password protected, and accessible to me only. As a backup measure, an electronic copy was uploaded to a flash drive and stored at my work office, in a locked cabinet accessible by me only.

Each transcription was copied three times. One copy was filed to serve as backup to guard against damage or loss; another copy was used as a working copy for coding and analysis, while the third copy was used for a recoding and reanalysis process. Paper files are identifiable by code only. A listing of participants names and their coded files names are kept in my private computer, password protected, accessible by this researcher only.

All electronic data analysis information, which had no identifying information but was identified by code names, was also stored on my personal computer, and backed up using a dedicated jump drive. It was stored at my office in a locked cabinet accessible only by me. Full data access was limited to me as principal researcher. However, exceptions existed and were afforded to my peer advisor Ms. Angela Seaward and my external auditor Dr. Dennis Kimberley who is also the chair of my dissertation committee, both of whom had access to coded files only.

Both the original recordings and the backup recordings are to be erased at the end of the dissertation process. However, all other data will be maintained for a period of five years in accordance with Memorial University's Policy on *Integrity in Scholarly Research.* Beyond this five-year period, data may be retained for future retrospective study.

3.3.3.8 Data analysis.

Interconnected with data collection is data analysis, together forming an interactive refining process (Erlandson et al, 1993), which continued until the dissertation was completed. These are inseparable, as in the naturalistic inquiry data analysis begins immediately following the first data collection (Lincoln & Guba, 1985). Continued analysis shaped the ongoing data collection, including changes to interview questions.

Data analysis involved taking information gathered from the interviews and their context, and reconstructing them into meaningful wholes. Methodological tools used in data analysis included triangulation (to established that the data gathered was generally supported or disconfirmed), and feedback received through the member checking process, which supported or disconfirmed the researchers findings (Lincoln & Guba, 1985).

3.3.3.8.1 Thematic analysis.

Thematic analysis is best suited to explain the specific nature of a given group's conceptualization (Joffe, 2012), in this case the understandings and conceptualizations of play therapists as to the change processes within the treatment of complex trauma. This type of analysis is also suited to data obtained through open-ended responses, within semi-structured interviews which imposes bounded topic areas to focus participant's thinking, in areas where it may be preferable to gain a more naturalistic inroad into people's meaning systems concerning the phenomenon under study (Joffe, 2012).

Thematic analysis was utilized to analyze and interpret the data set in this study.

This form of analysis simultaneously looks at evident themes as a route to understanding underlying themes and tacit content; its uses existing theoretical constructs to look at data while also allowing emerging themes to 'speak' by becoming the categories for analysis (Joffe 2012). Braun and Clarke (2006) provide a six-phase guide to performing this type of analysis (p.93) that was followed. Data analysis will be discussed in full detail in Chapter 5; however the following is an overview of the steps in thematic analysis:

1. Familiarization with the data; this step recommends immersion in the data to become familiar with the depth and breadth of the content. I completed transcription of all interviews, using 'audio to text' in which voice is translated into text. This served the dual purpose of transcribing and immersion in the data, which entailed proofreading, and repetitious rereading of the data. It also ensured confidentiality of participant's information.

2. Generating initial codes; this step required scrutiny of the data, listing ideas about what was in the data to produce initial codes in a systematic fashion across the data set. Each transcribed interview was studied individually, and then all were studied together as a set, generating a list of ideas of what was found, and then translating the findings into codes. This again required scrutiny techniques (Ryan & Bernard, 2003) such as; reading and re-reading all transcriptions several times; identifying reoccurring patterns across the data set, throughout this process and highlighting same; commenting in the margins of each document; use of a colour coding system; and use of a tracking system. In carrying out this process, I developed a codebook, which has become part of the documentation of the study's audit trail.

3. Searching for and developing themes; this step entailed collating codes into potential themes, such that the cumulated codes are sorted into different categories or themes, also known as theming the data. Several overarching themes emerged from the data set as a whole. The themes discovered were used to organize findings, and create a 'thematic map'. This thematic map took the form of listing all themes and sub-themes, within each interview. These were then colour-coded and placed into a colour-coded framework of the phases of the therapeutic process: relationship building, trauma processing, and termination.

4. Reviewing themes; this is a two-step process of analyzing content: (1) reviewing all the collated themes to find coherent patterns, and (2) applying this process to the entire data set for cross-case comparison (developing a conceptual/thematic 'map' of the analysis) ensuring there were clear and identifiable distinctions between themes. This required further reviewing and refining of the coding process, as coding and recoding is an expected and ongoing process. At the end of this phase, there was a synthesis of what the themes were and how they fit together.

Noteworthy here is that following the completion of steps 1- 4, I began a recoding process as is recommended for new researchers (Saldana, 2009). This entailed beginning at step 1 again, and repeating the entire process of coding anew. This enabled me to look at the data a second time with more experienced eyes, enhancing my ability to search within the data for deeper meanings. Additional techniques recommended (Saldana, 2009) and utilized for the process of recoding included: keeping the research question(s) in open view at all times, use of colour coding processes, use of matrix

systems to organize the large amount of data, and creative documentation to reflect findings. All these techniques were followed.

5. Defining and naming themes; required defining the substance reflected in each theme, and then identifying what was significant about them and why. This step tells the story of the data. For each theme, a detailed analysis was completed, identifying sub-themes. Within the themes that specifically identified the trauma-processing phase of treatment, three separate sub-themes were identified, and it is within these sub-themes that therapeutic change processes were identified.

6. Producing the dissertation; this begins when themes have been identified and becomes the story of the data. This information was documented in a report (Appendix L - member checking #2), which was forwarded to all participants for their review and feedback.

Since the form of data that was ultimately produced was unknown in advance, the form that the data might take could not be specified at the beginning of the inquiry (Lincoln & Guba, 1985). What was specified was the best means to analyze the data, as outlined above, which lead to an optimal understanding of play therapists work with complex trauma based on data saturation.

The product in the naturalistic inquiry is one that is negotiated, as evident by two separate member checking processes; the first followed the individual interviews; the second followed the collated analysis of all interviews. All respondent views are represented in the findings reported in chapter five of this dissertation The findings are written in thick description, a narration form that tells the whole story to achieve

understanding (Rodwell, 1987). It contains the depth and breadth the reader needs to understand the findings.

3.3.3.9 Planning logistics.

Logistics were planned with some accuracy prior to entering the field. These were grouped into four separate categories as follows:

A. Logistical considerations for the project as a whole.

1. Scheduling: Schedules were established for interviews, exploration and paraphrasing interviews, and member-checks. Schedules for interviews and member checks were established in consultation with participants, to coordinate with my time frame for conducting the interviews. All interviews were completed between July 21 and September 25, 2015.

2. Establishing a budget: Costs for data collection, inclusive of air travel, meals, accommodations, and travel to all interview sites in Ontario, and one in Newfoundland, were incurred totally by this researcher.

3. Make provisions for gatekeeper and academic support: These roles were undertaken by Ms. Theresa Fraser, and by my dissertation committee.

4. Arrange for peer debriefing: A long time co- worker and social worker, Ms. Angela Seaward, who is knowledgeable, informed, and supportive of this research study, took on this role.

5. Arrange for an external audit to provide evidence and meet the requirements of dependability and confirmability: As dissertation supervisor, Dr. Dennis Kimberley, undertook the role of external auditor.

B. The logistics of field excursions prior to field excursions.

1. Meetings with gatekeeper: Contact with this study's gatekeeper, Ms. Fraser, was undertaken via telephone prior to my entry into the field. Contact in the field was maintained via email, through mutual consent. Noteworthy here is that Ms. Fraser was identified as a potential participant via snowball sample, and upon contact by the referring participant agreed to participate. Lincoln and Guba (1985) reference the participation of a study's gatekeeper as acceptable and in fact encouraged.

2. Contact with peer advisor: This was ongoing from the point of entry in the field, up to and throughout the writing of the case report.

C. The logistics of activities while in the field.

1. Arrange for regular contact with supports: This was carried out through ongoing meetings with my peer advisor during all phases of the inquiry. Contact was in person, with the exception of time spent conducting interviews during which contact was via telephone. Contact was also made with my dissertation committee members as required.

2. Arrange for journaling and analysis on a daily basis: Journaling and analysis began with the development of this study, and continued throughout, until completion of the case report, and finalization of dissertation.

D. The logistics of activities following field excursions.

1. Preliminary drafts of the case report were made available for member checking, following completion of all interviews, and in final report form.

2. Audit process was completed in consultation with my auditor and dissertation chair, Dr. Kimberley.

3. Arrangements were made for the production and distribution of the final report via email to all participants.

3.3.3.10 Planning for trustworthiness.

Trustworthiness is imperative to the naturalistic inquiry. Lincoln & Guba (1985) have established a framework of specific techniques to establish trustworthy criteria, inclusive of credibility, transferability, dependability, and confirmability. These techniques, which were undertaken throughout this study, are summarized in Table 2, Techniques for establishing the four criteria of Trustworthiness in the naturalistic inquiry, followed by an explanation of each technique.

3.3.3.10.1 Credibility.

1. Credibility of this study was enhanced by a number of field activities and specific techniques. The following field activities were utilized.

a. Prolonged engagement, defined as continued or sustained attention, is a technique that is required to develop safeguards against distortions that may arise from the inquirers presence or involvement with participants. It can also safeguard against bias on the part of either, or from the manner in which data gathering techniques are employed. I used this technique in terms of my engagement with participants both in-person and through media, and via the study's member checking processes which sought input throughout the data collection process and following the analysis.

Table 2. Techniques for establishing the four criteria of Trustworthiness in the naturalistic inquiry.

Criterion	Technique	Implementation
Credibility	Field activities:	Prolonged engagement via member checks Persistent observation. Triangulation of participant interview information, and resources provided and/or referenced. Methodological Safeguards Description of researchers background, qualifications, & experiences Familiarity with professional association of participants
	Peer debriefing	Utilization of peer support and debriefing, throughout the research process, and the analysis process.
	Referential adequacy	Selecting and reserving data for later recall when tentative findings are reached.
	Member checks	Completed, in writing, following each individual interview, and at the end of the interview process as a group.
Transferability	Thick description	Provision of background data to establish the context of the study. Use of thick description of background information, data collection, and data analysis
Dependability	A dependability audit, including the audit trial	In-depth methodological description to allow study to be repeated. Availability of resources for examination of the process and product of inquiry.
Confirmability	A confirmability audit, including within the audit trail	Triangulation to reduce researcher bias. Availability of resources developed throughout the research process for the audit trail.
All of the above	Reflexive journaling throughout the research project	Use of diagram to demonstrate audit trail (see Fig.1) Journaling completed throughout the data collection process and the analysis process

b. Persistent observation is a technique that is used in the field to identify and focus on characteristics most relevant to the research. In this study observation was limited to interactions with participants, although interviews were conducted in settings of their choice, none chose their offices or play rooms for location of interview.

c. Triangulation, a technique that utilizes several information sources, was also utilized to validate each piece of data against at least one other source so that no single piece of information was given serious consideration unless it was triangulated. As stated earlier,

sources of information included interviews, resources, member checking, and audit trail documentation.

d. Methodological safeguards included the use of the same grand tour question to begin each interviews, and the use of triangulation of all new data prior to consideration of same.

Other techniques used to enhance credibility were the sampling techniques utilized; familiarity with participants professional association (CACPT); and provision of information on the researchers background, qualifications, and experiences. Specific techniques utilized to enhance credibility included peer debriefing, referential adequacy, and member checking. The following is a discussion of each of these techniques.

Peer debriefing is a technique that utilizes the use of a non-involved professional peer with whom I had open conversations at periodic intervals. As indicated previously, a coworker, Angela Seaward, was identified for this role. I contacted her by telephone as needed throughout the data gathering process, and throughout the analysis process. In-person meetings were held as needed. A written record of all debriefing discussions is included in the audit trial.

Referential adequacy is accomplished by reserving a portion of the raw data to be archived, and later recalled for comparison, when tentative findings are reached. Its purpose is to test if the constructions that have emerged are adequate. This was accomplished by preserving all resource material until the data analysis was completed. At that point comparisons were positively made between the findings and the resources.

Member checks are the most crucial step in establishing credibility and confidence. This was carried out both formally and informally, and occurred

continuously and repeatedly. Participants were given the opportunity to respond to this researcher's reconstruction as a way to establish supported meanings of the findings and interpretations. In the first member checking process all members responded positively, with 4 (four) participants providing feedback. In the second member checking process 8 (eight) participants responded positively with refinement suggestions from 5 (five) participants.

3.3.3.10.2 Transferability.

Thick description was utilized so as to enable transferability. This is a form of writing which enables the final product to specify everything that a reader will need to know in order to understand the findings, and transfer them to a comparable study in another setting. As such, a sufficient base is provided by thick description to enable a person contemplating application in another setting to make comparisons of similarity.

3.3.3.10.3 Dependability.

Developing and maintaining an audit trail through documentation established dependability. An audit trail is the single most trustworthiness technique available. An external auditor(s), specifically my dissertation supervisor examined both the process and the product of the inquiry. This auditing examined the data, findings, interpretations and recommendations, thus determining confirmability of the product of the inquiry, to arrive at trustworthiness and dependability.

3.3.3.10.4 Confirmability

Confirmability was established by maintaining field journals. The types of journals that were kept by this researcher include; a journal of day-to-day activities; field notes; a personal log, including reflexive and introspective notations; a peer advisor record of contacts and discussions; a record of hypothesis and questions that were followed up on; cathartic journaling; and methodological writing to record decisions made in accordance with the emergent design. Additionally, all analysis notes were maintained and kept for the study's audit trail. (Lincoln & Guba, 1985).

The final technique for establishing trustworthiness was the use of a reflective journal, which was developed and maintained throughout the interview process. This journal was used to note findings, reflect on those findings, and to reflect on the interview process overall, inclusive of questions and concerns identified during the process. Reflective journaling was a way for me as a researcher to identify issues, and find ways to process these issues in keeping with the naturalistic method.

There was a continuous interactive process of all ten (10) elements of the naturalistic inquiry (See Figure 1) as the design was implemented. The interactive and circular processes of data collection, data analysis, and design review, continued to the point of redundancy (Erlandson et al, 1993). From this process the final shape and boundaries of the study in terms of structure, processes, and contents gradually emerged. Enabling this emerging design was fundamental to the naturalistic inquiry.

3.4 Final steps

There were three final steps to this naturalistic study that lead to its termination. These were the completion of a case report, and subjecting this report to a comprehensive member checking process. Lastly, an external audit was facilitated with my dissertation supervisor. The following is a discussion of each of these steps.

3.4.1 Completing the case report (dissertation)

The reporting mode for the naturalistic inquiry is that of case report, or as in this case that of a dissertation. The goal of this dissertation is to contribute to the readers understanding of the processes of therapeutic change in play therapy, within the context of treatment of complex trauma for children. According to Lincoln & Guba (1985), there are a number of advantages of reporting the naturalistic inquiry. These include the following: "it enables analysis by the reader, while building on the reader's tacit knowledge; it demonstrates the interplay between inquirer and respondents and provides the reader with opportunity to probe for internal consistency; it provides thick description, which is necessary for judgments and transferability; and lastly, it provides a grounded assessment of context, for readers understanding of the study" (Lincoln & Guba, p. 359-360)".

3.4.2 Comprehensive member checks.

While the first member check was carried out throughout the inquiry with individual participants to seek their review and feedback on their interview, the terminal member check (Appendix L) was carried out at the end of the analysis process and

provided opportunity to test the credibility of the report as a whole with participants. Through this process, credibility was confirmed. This outcome of such monitoring is of critical importance to the trustworthiness of the study.

As a follow up to the terminal member checking process, each participant will be provided a copy of the final case report. This was a request made by each participant following the interview process. This final step will be carried out through email following completion of the dissertation and the defence process.

3.4.3 Facilitating an external audit.

An external audit is imperative to establish the dependability and confirmability of the naturalistic inquiry (Lincoln & Guba, 1985). The audit is intended to examine the process of inquiry, and finding it acceptable attests to the study's dependability. The auditor examines the product of the inquiry, its findings, interpretations, and recommendations, attesting that these are supported by the data, thus establishing confirmability of the inquiry (Lincoln & Guba, 1985).

Because this study is being undertaken as a doctoral dissertation, the chair of my supervisory committee, Dr. Dennis Kimberley, took on the role of auditor. His involvement from the beginning of the inquiry process was seen as advantageous as he was fully informed throughout the inquiry process, thus avoiding paucity of information. Additionally, he helped define what was to be included in the audit trail. The auditing role was intended to ensure all phases of the inquiry process were carried out as per the study's design, as planned and as reformulated in process.

3.5 Critiques of the naturalistic inquiry

There are a number of critiques of this form of inquiry. A major one lies in its concept of emergent design. The planning and carrying out of the naturalistic study is cyclical, not linear as in a conventional study, and thus does not fit the customary information requested by dissertation teams or funding agencies. However, these issues were addressed with a design statement (see Appendix A), which is a component of the naturalistic inquiry that is submitted with as much information as was available.

Another critique of this form of inquiry is that it is often confused with the interventionist approach, which is one whereby the researcher alters the service to a client in favour of gathering research data (Tyson, 1995). In the naturalistic inquiry the researcher seeks data that has not been altered in any way. Only then can conceptualizations and understandings be utilized in the truest form of study.

Also critiqued is the vantage point of the story, which is told from the eyes of the researcher, not from the participants and thus it becomes the inquirer's conceptualizations and interpretations of the information provided. I would contend that social workers as researchers are well positioned to gather, interpret, and present other professionals knowledge from a position that lends professional credibility. This is what clinical social workers do on a daily basis. As a social worker I have gathered information, interpreted it, and presented it to management teams, medical specialists, courts of law inclusive of family court, youth court, and even in open court. I have also presented to groups, communities, and classrooms. I have presented at conferences, locally, provincially, and nationally. The interpretation and presentation of information is greatly enhanced if the

person doing this comes from a position of being both an insider and an outsider (as I am) and has the flexibility to use both positions interchangeably (as I do).

A final critique that has been identified with this type of study lies in the sampling procedures, and specifically that of purposive sampling. This can be seen as a plan to be exposed only to dependable sources of data. In my study only a purposive sample of participants would have the training, experience and expertise required for the depth of detail being sought. It is only from such a sample that richness in detail and understanding could be found.

Because the naturalistic inquiry is emergent, time management can be seen as a concern. However, quality research of this type requires dedication to time and process. Knowing this up front makes time management less problematic. Detailed planning, supported by flexibility is important as there is always a risk of premature closure because of haste to get the job done, and this can shortcut the richness of the process and reduce the confidence in the outcome. Resistance to this requires patience and insightful assessment, both of which are qualities of a good clinical social worker. I feel confident in the outcome based on the completeness of the process and richness of data before saturation.

Chapter 4: Data Presentation

4.0 Introduction

The purpose of this chapter is to tell the story of my research data, highlighting and emphasizing details that are most relevant to answering the research questions:

1. What practices have play therapists found to be effective in assessment and treatment of children exposed to complex trauma?
2. What practices have play therapists found to be effective in reducing the long-term impacts of complex trauma?
3. What are play therapists' understandings of therapeutic change processes in which they have confidence?

The chapter provides details of individual interviews with each of the nine participants, utilizing thick description, which is characteristic of the naturalistic inquiry. It also highlights the process of theory development beginning with the first data collected and ending when the data set became saturated, in this case after 9 (nine) interviews. Theory development is presented by highlighting the conceptual-theoretical findings at the end of each interview, culminating in a final synthesis on theory development, at the end of the chapter. Each interview began the same, with the grand tour question of "What do you consider to be the therapeutic change processes within your treatment of children who have experienced complex trauma?" Information from each interview was utilized in subsequent interviews so as to shape those interviews towards details identified in previous interviews.

4.1 Interview process

As indicated in chapter 3, there were three successive phases within my interviews: orientation and overview, focused exploration, and member checks and closure. Orientation and overview was the beginning phase in which my focus was on the theme of 'I don't know what is known about the topic of change processes within the treatment of children who experienced complex trauma'. An unstructured interview format was utilized, allowing for initial discussions of this topic, which lead to more exploration of the research questions, not only in individual interviews, but also across subsequent interviews as the process evolved. As stated, each interview began with axiological exploration of the grand tour question. This was followed by the next phase of the interview, which was that of focused exploration, which enabled me to focus on some of the more salient aspects of the interviews to seek deeper understandings resulting from a move in thinking to 'I know what I don't know'. The following is a detailed description of all nine interviews.

4.1.1 Participant 1.

This participant identified as a play therapist and a social worker who has been certified and practicing play therapy for 4 (four) years. She has completed a number of formal trainings in trauma work. She works in both public practice and private practice where many of the referrals she receives are for children as young as age 3 (three), and youth up to the age of eighteen (18), who have experienced complex trauma, inclusive of sexual abuse, domestic violence, neglect, physical abuse, infliction of harsh discipline, and emotional abuse. In her work as a play therapist she uses a combination of directive

and non-directive play therapy, and noted that she additionally uses a lot of expressive art therapy with youth.

She described children who have experienced complex trauma as *"kids who tend to lose everything*". She described complex trauma as being in a category of its own and therefore "*...we have to treat them* (*children*) *differently…as their presenting issues are different".* She equated complex trauma to "*a form of loss".*

This participant highlighted the need for good holistic assessment, prior to treatment, saying "*I always find that doing a really good assessment – not just with the child – but getting to understand their whole environment; school, and home life, and the different caregivers – basically seeing the picture of their life – really helps understand which area(s) need work".*

She saw the role of the play therapist as being both external - as an advocate for children in all areas of their world, and internal - as their counsellor. She cautioned that assessment and intervention can occur only when children are in an emotionally and physically safe environment, *"where they can be creative, be playful and bring out… their sense of self".* She identified relationship building as paramount to success throughout the whole therapeutic process and often is a very lengthy process when working with complex trauma. She articulated that relationship building does not start and stop, but it is continuous throughout treatment. Also, she explained that the keys to establishing a successful therapeutic relationship are: having a child-centred focus, proceeding at pace that is tolerable to children (pacing) during sessions, allowing whatever time children need, incorporating sequential treatment, and addressing attachment - all of which are essential prior to beginning the processing phase of

treatment. She stated that the processing phase of complex trauma requires a combination of skills and creativity by the play therapist. This participant uses TF-CBT with modalities of play, art, sand tray, DBT, and circle of support. She stated she uses TF-CBT mostly "*to give them the grounding they need and to put them in touch with themselves*". However she also uses it for coping strategies and emotional regulation, and regulating their body affect... "*and then I would use narrative in terms of helping them tell their story, and help them document what's going on in therapy, and bring in art, music, and play*". She stated that "*for kids with trauma it can be difficult because they are so out of touch with their body and their emotions…and you have to really be creative, and playful, and be able to switch it up*". She identified a child who was in the process of reconnecting with her feelings, who stated to her mother *"what is a feeling…I can't touch it…I can't see it…I don't even know what it is…what is it"*? So for a child like this the concept of 'being sad in her body' became a very difficult one to understand.

This participant added that in work with complex trauma it is really helpful to have a list of tools in your head, so you can pull from them as needed and be creative in terms of your own intervention, because "*sometimes I have to go where they are at…and let them do what they need to do… I may go totally nondirective, or I may do a mix of nondirective and directive play therapy*". This participant stated, "*there is healing in play*" and that therapeutic change "*can differ for everyone".* She identified a child who,

> *had the same play every single time for several weeks (…sometimes repetitive play can be cathartic…), but then there was one week where it changed, and it got…like there was healing in it, and I felt like I was facilitating that process*

for him to kind of do the play over…and over again, so that he could develop some mastery.

She talked of her varied experiences with children with complex trauma in terms of their progress. She stated that,

for some kids it is a certain activity, or something that you do to facilitate that …with a lot of kids I use scrapbooking. The scrapbook is kind of their life story, they are going through the story they have those ah-ha moments, around…this is what I did…and this is what I used to be like…and they can talk about the change.

In discussing a particular child, his healing developed through being able to play out and replay his trauma, and expressing anger (which he was not able to do anywhere else), stating *"…this is what he needed…to heal*" until he developed some mastery… "*and then I started to see changes…I was giving him the ability…the space to bring out what he saw or what he heard or what he remembered or what he felt…and this worked for him".* She identified attunement, listening skills, and awareness of yourself as a therapist (reflecting common factors theory) as factors required to determine what would be the best intervention, and what are the outcomes you are looking for, in order to support children to do the work they need to do (reflecting child centred theory).

She identified the need for adequate time for children to process their trauma, but the reality is that often there are a limited number of sessions provided. In such cases she uses the limited time provided to focus on developing coping, identifying supports, and enhancing and building upon children's successes and strengths. She talked about the different ways she would do this depending on age. For a very young child she explained

that she would use play and playfulness to discuss "…*who loves you…who's in your life …who's there to talk to*…". She stated that for older children she would use a lot of narrative work, in terms of helping them understand their own stories through the stories of others, utilizing any of the many resources developed for this purpose, such as Davis' *Therapeutic Stories that Teach and Heal* (1990), or resources she has developed herself.

Analysis of her interview found that she intervenes with the processing of trauma in a step by step process, first preparing children for trauma processing by teaching and reinforcing skill development, and emotional regulation. She moves then to processing the trauma, using a number of trauma processing techniques, and finally reinforcing the gains made throughout the process. However, she stated that the processing of complex trauma is very difficult work, and,

> *sometimes…we may not work on the trauma. We may work on storytelling… but in terms of going through…understanding your triggers…dealing with flashbacks…and all that stuff. We may not be able to go into that (the complex trauma) or be able to recall a lot of the very details of the things that they feel stuck in…we may not be able to do all that work.*

She stated that often,

> *the work begins not by trying to fix the issue, but in validating that it exists. In doing so, there is acknowledgement of the shame, acknowledgement of the guilt, and acknowledgement that it's so difficult for them to harbour that guilt into relationships or into how they feel about themselves. Therefore, the goal has to be to build up their self-esteem, their sense of self, helping them feel good about*

themselves, acknowledging what they do well…looking for the positive…the small gains.

This work is then supported by teaching the parent/caregiver to do the same, to focus on children's competencies, making them feel good about good choices, and providing them with relational and emotional support.

This participant stated that she trusts the play therapy process for children, so that when they get older they will return to treatment because "*more stuff is going to happen …and they will get triggered…or changes will happen at different stages of their life",* referring to ages/stages of childhood development. She indicated that she does not see therapy as a one-time thing for children of complex trauma but *"sees therapy as a journey of getting better in life…and of healing"*.

She highlighted the importance of children's environment in the healing process, stating,

I want to give credence to the environment…so the child has support…so it's not just me, it's the teachers who validate him, and are open and available to him when he needs to talk about what is happening…so it's a whole range of people and support systems that help bring about the change…these supports are like a multidisciplinary team…which is always best for them (children).

To reduce the long-term impact of complex trauma, this participant believes that processing has to incorporate the development of new skills to enable children to revisit their trauma within a safe therapeutic relationship. This participant stated that *"kids with trauma are out of touch with their body and their emotions…and therefore you have to switch up your interventions, being creative and playful".* Through using these new

skills, and gradually moving through their trauma story, children can develop mastery. This is followed by reinforcement, a step which is key to reducing impact, as it provides opportunity to practice new skills within children's processing abilities, with both new and renewed confidence. She identified *"therapy as a journey of getting better, and of healing"*. An example she used was of a child who had experienced complex trauma and the focus in therapy was helping her develop insights into relationships and providing psychoeducation to help her connect past experiences with what she was going through at present. This child began to connect the two and in discussing her new adolescent relationships she stated "*Oh, I remember you telling me about this attachment piece, and every time I am in a new relationship with someone I have difficulty with trust"*.

A key factor this participant identified in sustaining changes made in therapy is through working in a parallel process with the parents, teaching them, educating them, modelling a type of therapeutic relationship with them, and focusing on their competencies. In discussing change processes she stated,

> *it's like you are planting seeds…and sometimes…some days… I may do an intervention and that seems to click for them, and other days it may not… depending on the child…depending on their history…and their environment… their personality…and if they are ready or not ready to do the work. If they are not ready, then you have a lot of building to do before you can bring them to the next step.*

Change processes discussed by this participant highlighted a combination of factors. These are as follows: (a) therapeutic factors inclusive of: a positive therapeutic relationship, adequate time to proceed at their own pace, opportunities to feel good,

validation of who they are, positive recognition, and resilience, and knowing there is confidentiality in the process; (b) factors specific to complex trauma, inclusive of: advocacy, understanding behaviours as a reflection of trauma, creating safe spaces, teaching the effects of complex trauma, teaching parents the need for consistency and support; (c) pre-processing requirements inclusive of: grounding, learning coping strategies, regulating emotions, regulating body effect, narration, documenting (writing the story); (d) factors specific to play inclusive of: repetition, developing mastery, practicing tolerance, permission, space, use of creative modalities including art and music; and (e) external factors inclusive of: a supportive environment, adequate time to process the learning that occurs in therapy, support in building children's competencies, and having child-centred supportive people in their lives.

In working specifically with complex trauma, she highlighted the need for the therapist to do a lot of advocating,

> *to provide training…to parents, caregivers, and/or foster parents, helping them to see differently...talking to teachers and social workers at the child's school to help them develop a really safe place for the child in the school system …building up the child's support network because that needs to stay intact and stay healthy for that child…because sometimes the child's unhealthiness…their own kind of trauma spills over into these areas…and they can then understand that the child is struggling, so they need to be consistent and supportive*.

This participant identified the urgent need for more trauma specialists to work with children. In her experience, many counsellors do not know how to intervene in this

area, as they are used to using CBT, and even though that is an evidence-based model, *"it doesn't always work with these young children"*.

Following this interview a member checking process was carried out. This participant confirmed the findings as identified by this researcher. Upon completion of both the interview and the member checking process, my initial theory began to formulate. Initial tenants of this theory are as follows: a combination of factors specific to the therapist, the client, and the process combine in the context of play therapy and the expertise of the play therapist – to create the seeds of change.

4.1.2 Participant 2.

This participant identified as a play therapist/psychologist, who has been practicing as a certified play therapist for 12 (twelve) years. She has formal training in the treatment of trauma and loss in children.

This participant uses a number of modalities inclusive of nondirective play therapy, filial therapy, theraplay, and pet therapy. She trusts the play therapy process in the treatment of children who have experienced complex trauma, recognizing the multilayered and complicated factors within this type of trauma, inclusive of abandonment, rejection, and trauma bond. She also identified that there is a huge grief component to be worked on with complex trauma, requiring a good assessment and treatment approach based on children's needs. She identified that the treatment of complex trauma and its resulting behaviours requires the therapist to be flexible, to be willing to try new techniques, and the therapist to have good supervision. Effective treatment also requires specific skills by the therapist to be able to build a therapeutic

alliance, to teach children and caregivers through focused play, to develop safety and trust, to support children in learning how to play, and to recognize change moments when they occur.

This participant used a number of case examples to illustrate her work with children who experienced complex trauma. One case, in which a child was referred at age 2.5, was particularly long in duration as the abuse inflicted by his caregiver was further complicated by the need for multiple and invasive medical interventions. This child required a lengthy period of intervention. In sessions, she often reenacted the abuse she suffered. As she grew and was going through different developmental stages, "s*he processed it differently as her little brain was developing*". Play therapy techniques were utilized based on her age. In working with sandtray and miniatures, this child repeatedly chose the same miniature figure and in "*her own little way, re-enacted her trauma*", speaking in a child's language of "*this bad person was always hurting me" and "no one would help*". Through repetitive play, she was able to successfully process her trauma as her age and abilities allowed. This participant identified that through play, this child experienced cathartic mastery evident by statements toward the offender (through miniatures) such as "*you hurt me….what you did was wrong…you need to go to jail".* This was the beginning of a breakthrough or change process, evident by expressing feelings of vindication, self-confidence, and no longer being stuck in the role of a victim. This play therapist stated that *"play is their language...and toys…that's how they communicate with us…and let us know what is going on in their world".* Here the participant identified the need to have adequate and appropriate play resources available to support this child in working through her trauma. This child's trauma was further

complicated with the many surgeries required as a result of the abuse and therefore needed to feel safe. Play resources related to hospitals were used very creatively to enable this child to address and process her medical issues. This participant further stated that there are specific patterns seen in the presentations of children with complex trauma; they do not trust – especially adults; they have experienced loss; and they present either as victims – or as fighters. Similar patterns become magnified in children who have had multiple traumas, rejections, and abandonments.

This participant talked about interventions with the family being provided in parallel sequence with those provided to their child. In this case the participant provided filial therapy, a structured format of intervention aimed at supporting families in their relationship development. In family work she provides information on brain development to help members understand the effects of trauma on the brain. She informs families of what the trauma has done stating "*that it is almost to the point that you say it's almost like brain damage…the synapses, they've been cut…there's no connections because of this*". She uses diagrams of the brain, showing the differences between normal brain development and the development of a brain whereby severe neglect and abuse were inflicted. She also utilizes a model skull and brain to further educate on the effects of trauma on the brain. She has found that such visuals are very powerful, especially when the discussion leads to '*reconnecting the neurons'* and how this is accomplished.

This participant identified relationship building as key to the therapeutic process, stating, "*without it, you don't have anything".* Within this she identified building trust, being attuned, being patient with the process, and being present. One of the ways she does this is through creative use of her dogs in sessions, a type of pet therapy. She has

used these strategically to model caring, trust, attachment, safety, and protectiveness. She is cognizant of the fact that at times children who have been severely abused will repeat the behaviours inflicted upon them, and so she is careful to protect children (and her pets) from same, after having one child intentionally inflict harm. This became a teachable moment for her as a therapist, and her child client who very much wanted to maintain access to the pet. However, a lot of teaching, learning, safety, trust, and behavioural changes had to be made before this was allowed to occur.

This participant identified the role of advocacy as being very important with children in general but especially with complex trauma, stating that you have to advocate to families, agencies, and referral sources. She stated " *you have to advocate a lot for kids and teens because people think…oh they will be fine…they are resilient…they did not see (hear) (feel) anything"*. She also identified educating as a major role, as it relates to the brain and its development, "*which isn't fully developed until you are twenty-one (21) or twenty-three (23)*". She stated, "*the frontal cortex is not developed…so as a kid…you can't do it" (talk about it)*.

This participant talked at length about the frustrations of knowing that a child requires extended services, as is most often the case with trauma work, however referral sources attempt to limit the number of sessions based on funding, which this participant counters by supporting her requests for extra sessions on research in the field of children's therapy which recommends same. She highlighted that children's therapy is very different from adult therapy, whereby the latter is talk therapy and the former is much more child-centred, child paced, and time friendly. She stated,

I always say to colleagues of mine that working with children is a whole lot more difficult than working with adults. Adults…you get to talk…and you get to exchange…and you get to do verbal therapy…you can't do that with children… so if you weren't to use play, how would you do that?

This participant discussed how she structures children's sessions, following the intake and assessment phase of treatment. She begins with nondirective, for very young children, in that the session starts out with very quick feelings games, so as to identify feelings, and then she allows her client to lead, and waits to be invited into their world, no matter how long this process takes. It is inclusive of time, space, developing trust, developing relationship, and allowing children to do the work they have to do in the session. For older children, she starts with activity games, moving then into a child-chosen activity, and then allowing free time towards the end of the session, which is where she will often get the most information. She will then strategically begin teaching coping strategies, which is a prelude to the processing phase of treatment.

Practices identified by this participant as being key to reducing long-term impact of complex trauma include the following; (a) relationship building, inclusive of safety, trust, attunement, modelling, nurturing, attachment, and alliance; (b) working through the trauma, which requires processing, mastery, reinforcement, and transference; (c) flexibility within sessions such that you go where the client needs to go using various approaches as required, and; (d) identifying supports in children's lives that can continue to support their progress outside of the therapy room. She indicated that the play therapist's role is to use play to teach, advocate, and coach parent work – all in parallel sequence with the play therapy sessions.

According to this participant change processes are multiple and interwoven. They are internal to children (inner strength, personality). They are within the therapeutic relationship (a positive relationship inclusive of trust). They are external to children (support systems) and external to the therapy process (referral and funding systems). Advocacy is a major role of the play therapist. Education is also a key and is required so as to teach about the brain, about trauma behaviours, about trauma play, about new skills, and about working through trauma to mastery.

Following this interview a member checking process was carried out. This participant confirmed the findings identified by this researcher and added some clarifications as to the coping strategies she encourages outside of sessions consisting of playful physical activities, but also encouraged participation in relaxing activities as well, noting their importance. At the end of this process my initial theory was further built upon, to add the following: **"**the use of children's language, appropriate toys of the trade, the addition of advocacy, all as part of the play therapy process".

4.1.3 Participant 3.

This participant identified as a play therapist/psychotherapist, and a PhD(c) in Social Work, who has been practising as a certified play therapist for 20 years. She has multiple formal trainings in trauma work with children, plus has completed multiple workshops with trauma specialists.

This participant identified the use of an integrated model of play therapy, in that she uses both nondirective and directive play therapy. She identified the structuring of sessions as being important, as they must proceed step by step. Each step has key

components within. She stated that it is important to have a sense of where we are going in treatment, stating that "*ethically it is important that we have a sense of where we are going, how have we gotten there in the past, and that we know how to get there again*…". She identified assessment as a key component of this in that biopsychosocial assessment should include identification of both risks (things are likely to get worse before they get better) and benefits (child recognizes that changes have taken place within himself), and goal setting. She strongly supported a team process when working with complex trauma. Her assessment begins with the caregiver(s), to get a sense of what the trauma is, and what they are hoping therapy will do. She then meets with her client to talk about why s/he thinks they are there, and in the process explains her work to them, that "*I work with children who have had experiences in their lives that left them feeling physically hurt, emotionally hurt, confused, upset…or somehow…that they are bad*". She then talks about confidentiality, and in doing so is preparing her client for the therapeutic process.

This participant sees therapeutic work with children who have experienced complex trauma as "*taking place not only in the playroom anymore*". She states that, based on recent work by professionals in the field, it is becoming clear that the idea of an hour a week for therapy is probably not as effective as being able to meet with children and then meet with caregivers to teach them skills to support their child with activities to helps them down-regulate (regulate their emotions). Based on this she meets with caregivers at the end of every session with a child, and "*gives them some of the tools (that the child learned in session) to take with them*".

She uses children's language to discuss goal setting, which is an important process for children. "*Are they coming because they want to feel better about what*

happened, or because they may be struggling in school, or because they don't want to have bad dreams or thoughts anymore"? She uses scaling exercises with them to ask about knowing when they feel better,

> *Kids often need something that is visual and concrete, so I will hold up a hand and say…if all the fingers mean you are not having those bad dreams anymore, or you're not feeling scared anymore, or you are not feeling confused, or you are not feeling bad at all anymore, and no fingers is…lots of bad dreams, lots of memories, or feeling like you are not there (dissociating), then what are you feeling now, and where do you want to be?*

She then uses this process throughout treatment to do check-ins and to determine when therapy is coming to an end. She concluded that this monitoring serves the therapist to know where they want to go, but it also gives children an understanding of when they're going to recognize that a change has taken place, which imbeds in them a sense of hope.

She added that in the first phase of treatment, safety is key physically, psychologically and relationally. She recognizes that in cases of complex trauma, primary attachments are lost, or compromised, and therefore "*for some kids, attaching is too dangerous*". She stated these are children "*who want to hug me right away, and I have to set an appropriate boundary, or they don't want to talk to me at all*". She identified that "*complex trauma kids understand relationship in a very different way than the norm, because their trauma happens within the context of a known person…a caregiver*". Therefore to begin working with a child with the experiences of complex trauma, she begins by creating a safe place for the work and a safe relational context. She is transparent with children as to what treatment entails and if children are not able to

identify why they are there, she will explain what she knows about their experience of abuse, who did it, how long it went on for, and the known effects of the abuse. She acknowledges this is often met with resistance as a child's "*mind may not be able to remember, but their body does, and their emotions remember as well*". She gently explains that she knows this is hard to talk about and explains that "*It's like you put it in a box and locked it away and you never look in that box*" (she noted this is one purpose behind treasure chests in the play room). However even within a safe place and a safe relationship, she has had experiences with children who still could not tolerate targeting specific behaviours. When this occurs, the focus goes to what children are able to tolerate, and not attempt processing until tolerance has increased. These clinical judgments require the ability to read cues and miscues, and knowing when a child is mentally unprepared to process. She described having to back-up the process for one child who linked anger and abuse at the hands of a parent by asking her "*if she could pretend that there might be a time when she could imagine that there might be a time when it would be safe to feel angry feelings about what happened*". By framing the question in such a safe, child-friendly way, this child was able to experience distance and tolerance, and was able to respond.

This participant talked of the attachment work that goes within complex trauma interventions. She stated that for some children attaching is just too dangerous as "*their primary attachments have been at best compromised, and at worse…may not be existent*". She works with caregivers to help them understand "*that the child's behaviours are not malicious in intent – but are an attempt to communicate a need…and it is your job as caregivers to learn to read the cues*", so things like comfort and protection can be

accepted, which children with complex trauma often push away. She identified that her work will often require that she use play with caregivers to help them understand the effects of trauma. An example she used is as follows:

> *when we are born we are like little ping pong balls covered with the soft fuzzy side of a velcro strip – and the grown- ups have the sticky side of the strip, so they can grab us and hold us. When children have experienced enduring and repeated abuse and varying forms of trauma…the complex trauma cases…it is like all of that soft fuzzy velcro is worn off…and they are bouncing all over the place. So part of our work as caregivers is to help them regrow that soft fuzzy velcro part*.

She then uses a model to physically show the caregiver this process having them throw the ball at the velcro, and it not sticking.

In treatment she utilizes; goal setting with children, use of children's language, continued focus on creating safety throughout treatment, confidentiality, transparency, check-ins (inclusive of scaling, check-back, and miracle question), and creating a sense of hope. She also identified that not all children can tolerate trauma work in that they may flood, dissociate and/or hyperventilate. Therefore multiple skills are required to teach self-regulation skills, coping skills, and grounding.

This participant spoke of the requirement to create relationship but not dependency. She builds fun into the work process by using different types of play. Recognizing that complex trauma damages self-esteem, she creates opportunities for developing competencies and confidence. She also attempts to build on past competencies, recognizing that particular skills are required to recognize when this is

advantageous. She used an example of a child who because of her skills in art was seeing an art therapist who had her draw pictures related to her trauma, which became re-traumatizing for her and caused her to become unable to control or contain her emotions (flooding) in therapy. Work with this child required rebuilding of trust in the therapeutic process, and finding creative ways to help her process her trauma that were safe for her.

This participant gave an example of a child who had experienced chronic neglect, abuse, physical abuse, and was exposed to domestic violence, resulting in his removal from his parents, and placement in foster care. His play was repetitive and violent, which was indicative of "*his need to play out and re-experience*". Her training has taught her to find safe ways for a child to do what it is they need to do. Thus she allowed this aggressive play and in doing so facilitated his need for sufficient time to enable a sense of mastery within the physical space, to become familiar with what was there, and to get to know her as a therapist. When she felt he was ready she introduced a creative solution to the impasse, which he was open to, thus changing his play to incorporate same, and began developing creative solutions of his own. This participant saw this as her ability for "*planting seeds*", to enable her client to make changes, one small step at a time.

This participant teaches parents the skills required to help their child to emotionally regulate. She teaches them how to read cues and miscues. She teaches them how to support their child through times of hypo or hyper arousal, knowing that children exposed to complex trauma need help with this. She teaches parents that trauma is often activated and reactivated, and a child's behaviours – which are often misbehaviours, resulting from this are their way of telling us that they are not OK. She helps parents understand that children with complex trauma don't want to get close and therefore they

push away. She is an advocate for children within the school environment. She is also an advocate of sequential treatment for children with complex trauma.

Change processes or what this participant referred to as "*the magic of change*" were seen as interwoven, and included the following; book-ending sessions with theraplay thus increasing nurturing; starting therapy with nondirective play and moving into directive play – within a child's tolerance level; implementing trauma work in stages; "*titrating emotions such that you work up to the big stuff*"; preparing children in one session for work in the next; working simultaneously with children, their parents/ caregivers, and their school. She highlighted the need for trauma work with children to be carried out in stages: preparatory stage, processing stage and post processing stage, noting that each of these stages have individual steps within. She identified 'hope' as key to working with complex trauma, and the ability to help build safe spaces within each child. She noted that complex trauma damages self-esteem and self-worth, and therefore, substantial efforts have to be made to counter this through activities that create confidence and competence. She also identified "*complex trauma as loss*" which has to be acknowledged in therapeutic work. She noted as well that a therapist has to be able to identify when a child 'is not available to learn because of triggering events", and be able to relay this effectively within the school and home environments.

At the end of this session some patterns were evident inclusive of relationship development, developing safety, the steps within the processing phase and what children need to be able to do this work – or to do it within their own ability to do so. This participant repeated phrases such as 'planting seeds' and 'the magic of change' in discussing her view of therapeutic changes.

In the initial member checking process, this participant clarified a number of comments made by this worker in the narrative summary of our interview, to ensure clarity. In the terminal member check, she stressed the importance of teamwork in the field of complex trauma, stating this work requires the support and input of a multidisciplinary team, and should never be undertaken in isolation. This third interview built upon my evolving theory with the addition of "the seeds of therapeutic change processes are planted upon a child's entry into therapy and strengthen as the relationship develops and the therapeutic process unfolds".

4.1.4 Participant 4.

This participant identified as a play therapist/social worker. She has been practicing as a certified play therapist for 9 (nine) years. She has completed formal training in trauma and loss. She works with children under the age of twelve (12), the majority of whom are under the age of 6 (six).

She identified as being eclectic in her work, in that she uses many forms of play therapy, identifying directive, nondirective, sandtray, water play, sensory play, narrative and art. She identified teamwork and assessment as the starting point of play therapy, where children are invited to identify "*what they need to feel better*", and where both caregivers and children are invited to identify strengths and weaknesses. She stated that in her agency, they "*are now thinking about what works and why it works, and for how long, plus how much is required, and what determines readiness",* indicating that it was the congruence of these questions and the topic of my study that peeked her interest in participating. She indicated that the goal of therapy for her is to set children up from the

beginning to "*have someone witness their trauma with them"*. She utilizes a trauma checklist and a behaviour list in the assessment phase for planning her treatment, stating "we need to know what works and why".

This participant spoke of the requirement to spend a lot of time upfront, creating safety and establishing boundaries, noting, "*every child is different".* The relationship development process includes parents/caregivers and their child, especially very young children, as the goal is for to parents to witness their child's trauma. Therefore, from the very beginning they are taught to read cues appropriately, and learn about establishing safety. She stated, "*although the child's name is on the referral, it's the parents we are often working with, and teaching them to not be triggered by their child's behaviours in the play room".* As with the last participant she stated that "*not all the therapy happens in the play room*", referring to the work with the parents that they take home with them. She clarified that "*therapy is important as it brings a new understanding – a reframe of some of the behaviours*". She also stated that for younger children, the goal is to have the parent in the playroom from the beginning, but cautioned that sometimes this is too difficult for them or for their caregiver to do. For older children, the goal is to have them invite their parent into the playroom, and share the process and progress with them.

She sees assessment as a major component of treatment, as it is foundational and determines the map of services. Assessment is identified as the play therapist getting to know children, their issues, and their ability to do the work. Formal and informal assessments are utilized (trauma checklist, behaviour checklist, assessment of all past traumas). Assessment with a young child includes a series of questions about "*how they*

are sleeping, how they are eating, and what school is like". Parents and collateral resources are involved in the assessment process to identify strengths and weaknesses.

This participant introduced sensory work and teaching vocabulary as key elements of working with complex trauma. She stated "*I think that lots of times it is hard for kids to give words to their experiences*". Through sensory work they learn words for their feelings, and then they can share those feelings with their caregiver. She noted that "*often times they're intent on finding a feeling that fits their trauma, and often that feeling is anger*". She uses this affirmation as a segue into relationship building, developing trust, getting to know her client, and then teaching skills such as deep breathing, coping, and relaxing. She highlighted the importance of attachment work, with caregivers as part of the process. She talked of her work in coaching caregivers/parents in a way to enable play, using engagement, challenge, structure, and nurturing activities.

In supporting children to work through their trauma, this participant makes use of "*narrative through play experiences (drawings, puppets), which provided a structure for the child to tell their story, label her trauma, and introduce new possibilities. Her story has a beginning, a middle and an end…so does the therapy*".

This participant used a case example to explain her role as client advocate.

> *He was having difficulties with the plans made for him to return to a school different than his own. He did not want this and was able to express himself by saying he just wanted to be normal and return to the school and grade he should be in. She advocated for this, and supported this with a treatment plan that*

relayed the concerns of all those involved, including his parents who agreed to booster sessions for themselves. *Based on this, the child got his wish.*

She noted that children with complex trauma often have multiple traumas of various kinds, inclusive of the attachment breach/rupture. However, often times these may not be known. "*Sometimes traumatic events happen pre-verbally, and they do not have the words for it, but even though the child's mind does not remember, the body does*", a sentiment expressed by other participants as well.

This participant believes that processing trauma at a child's pace can reduce the long-term impact of complex trauma. Processing is broken down into three steps: preparation, processing, and letting go. Within each step many elements are required to support children in working through in the ways they need to do so. Work has to continue concurrently, or in parallel, with the caregivers, to reinforce the learning and have confidence in this process. She stated that "*I just can't imagine using talk therapy – I don't think I could do my work without play*".

This participant identified change processes as: witnessing a child's trauma; setting him/her up for success; teaching caregivers to read both cues and miscues; teaching the effects of complex trauma to both child and caregiver; and, celebrating successes. She noted that external change processes are important as well, referring to home environments, school environments, and social environments. As with the last participant she stated, "*I am not a forever program, so I think about being no longer involved, right from the beginning*".

This participant identified that children exposed to complex trauma are "*not at starting line*", thus a lot of upfront work is required to get them to this place. She noted,

"*these children just want to be normal, and want to be able to have hopes and dreams of the possibilities of life".* She repeatedly noted that the processing phase of trauma work can only be attempted if children are ready to do the work.

In the initial member checking process, this participant clarified a number of comments made by this worker in the narrative summary of our interview, to ensure clarity. In the terminal member check, she stressed the importance of teamwork in the field of complex trauma, stating this work requires the support and input of a multidisciplinary team, and should never be undertaken in isolation.

Following this interview, a member checking process was completed in which this participant provided clarification of points highlighted in the summary provided for her review. During the terminal member check, she also took the opportunity to add new information, recommending,

> *creating a time line of early negative life events. This activity is completed both with adults who hold the information and with the child/youth in the playroom through the use of a variety of materials, pictures, sand, etc. This allows the therapist to link the events assessing the derailment of developmental tasks, functional impairments, and risky behaviour. This type of assessment allows for reframing behaviour as typical responses to the traumatic experiences of the child/youth. The notion of triggers includes both explicit memory and the awareness in the body and emotions (triggers conscious & unconscious). This information is crucial to enhance empathy by reframing behaviour for caregivers and teachers and for creating care/safety plans.*

In reviewing my theory development, I found this interview had more to add especially in terms of working with parents. This was incorporated as follows: the play therapy process spills outside of the playroom into roles of advocacy and collaboration, especially with families and caregivers.

4.1.5 Participant 5.

This participant identified as play therapist/psychologist, who has been a certified play therapist for 9 (nine) years. She has completed formal training in trauma work.

She spoke of the many losses in childhood that come with complex trauma, and how children who have experienced this, also experienced grief and loss. She identified that a common activity used with such children is life story work. However, she has found that this is very painful for these children as it brings back their losses and thus can be triggering for them. Before this type of work can be attempted a therapist has to create safety and focus on symptom reduction. She noted that children with complex trauma often bring secondary and tertiary issues, such as anger, confusion, pulling and pushing away behaviours, and I love you and I hate you issues. She identified the work of Howard Bath in his article, *The Three Pillars of Trauma Informed Care* (2008), as being foundational in her work with complex trauma. These three pillars are safety, connections, and managing emotions. She talked at length about building safety for a child with trauma through *"repetition, repetition, repetition",* which is a major component of trauma resolution (Perry, 2009). She describes making connections as pivotal for a child in treatment. She then elaborated on the concept of managing emotions, also known as self-regulation.

This participant was well versed on the effects of complex trauma. She spoke about how it interrupts a healthy building of attachment. She identified that children who have experienced complex trauma are in a fear state all the time, and by doing treatment, that fear is actually increased. Therefore, she will often begin her work with the caregivers first, beginning with psychoeducation. Her goal here is twofold; one is to teach the effects of complex trauma, and the other is to begin the development of a common language, to be able to proceed with trauma work. She explained to parents that this work is much more than extinguishing poor behaviours, as without getting at the root cause, such behaviours will continue. For example she explained,

> *a kid says F-you, and a behavioural program will recommend a 5-minute time out, or a monetary fine – but you have to ask what is really going on. Maybe it is – I am too scared right now and I need to go for a walk outside. You need to work up front with a kid of complex trauma using explanations such as … our limbic is out of whack or the amygdala is hijacked - we have to find out something to do it - it cannot involve talking, as the frontal cortex is shut down. So it has to be vestibular intervention – music or movement or sensory.*

She explains to caregivers the need to do this upfront because it allows opportunity for a child to identify what he needs you to do for him during these outbursts, because he won't remember it. She explained this is why verbal therapies do not work with such children, as they cannot process how they are feeling when they are feeling it. Therefore, play therapists' first phase of psychoeducation has to be bigger than just the client. It has to involve all the other systems involved.

A case example used by this participant was of a child who had experienced multiple abuses by multiple perpetrators. In addition to the abuse, he experienced forced isolation. Understandably, this child came with many symptoms that proved to be challenging both in the home and within therapy. However, building safety and connections proved to be too difficult for him initially. The focus went to relationship building and symptom reduction. By focusing on this work, specifically his relationship with a new caregiver, the pressure on him was reduced. He was able to identify that he had been hurt by other caregivers, but identified that he did not want to talk about the details. By hearing this and acknowledging it, this participant was able to relay his concerns, and move the focus to building safety so that this child did not have to disclose or relive his trauma, but was given permission to talk about how the trauma affected him, how he felt about it, and identifying what he felt he needed to do to feel safe. Previous participants highlighted this theme of a child not having to disclose specifics of their abuse, as well.

In doing parent work first, this participant identified opportunity to explain that in trauma work the initial goal is to increase safety, which initially causes a reduction in negative behaviours. However, she identified that as treatment progresses, behaviours often get worse. By engaging caregivers in this discussion she is preparing them for the treatment journey. She sees their role as key to working with a child as "*you are only working with a child for one hour a week, and that is a drop in the bucket unless you engage caregivers*". She further stated "*if you're going to do attachment work with complex trauma, you cannot do it on your own…you need to be working with primary*

care givers". This includes taking on multisystemic interventions, including family work and couples' counselling, so as to ensure stability and support. She explained that,

> *families are living with the symptoms of complex trauma, much like families of alcoholics live with the symptoms of alcoholism, whereby the alcoholic is blamed for the behaviour, and so will the child with complex trauma be blamed for the impact of behaviours on the family*.

This participant identified the work between sessions as being a major part of therapy, especially caregiver work, as caregivers are children's biggest support. She believes strongly in 'in-vivo' work, which is part of her assessment process. Assessment involves children, caregivers, the referral source, schools, and any significant others or systems involved, noting that '*hearing the child's experiences are important*" from as many sources as possible. Psychoeducation is a major component of her work, as is knowing and understanding the language of behaviours and what children's behaviours are saying. She uses a number of assessment activities inclusive of: the tree of life, baby picture activities, and life story work. For psychoeducation with caregivers she starts with having them complete online courses offered free of charge by Dr. Bruce Perry, a trauma specialist, through Child Trauma Academy (childtrauma.org). She also provides psychoeducation at the school level, so as to ensure all are on the same page with a particular child. She gave an example of a child who…

> *learned to self-regulate by rocking – he did this during sessions and at home – and I was instrumental in assuring that he could do it at school as well, as this child was not about to tell people in his school of the horrific abuse he suffered –*

and therefore he needed an advocate to help ensure that when he was triggered he could safely regulate his own emotions.

She has had 'lived experience' with multiple children who have been exposed to complex trauma and therefore has learned that structure is very important to their healing, as are boundaries, and consistency, each of which she implements in the play room and within the play process.

She identified the many roles of a play therapist, and the many skills required to do complex trauma work. She stated that children are the clients; however the caregivers and the family become clients as well. Caregivers are often in need of services themselves by the time they seek services for their child, based on their exhaustive efforts to manage their child's negative behaviours. She stated,

it isn't just about being a play therapist. You have to do couple stuff. You have to do family stuff. You have to understand the substance-abuse stuff (overcoming challenges and patterns of treatment). You have to do psychoeducation. And you have got to be comfortable knowing when to step in and when to step back.

She noted "*for a play therapist to work specifically with complex trauma, they have to have many tools in their toolbox and know which one to use when, because this type of trauma rarely fits into prescribed and structured models*". She recognized the need for pacing to allow the brain adequate time to process the work, and the importance of the work being done between sessions.

This participant stressed the flexibility required as a play therapist in order to find what will work for each individual child stating, "*no family is the same and no child is the same"*. Therefore in her work she does not follow a prescribed model but she does

follow protocol and procedures for trauma work. She is very well versed on the behavioural presentations of children who have experienced complex trauma. She identified the need to have knowledge and expertise in a range of interventions, and knowing when to utilize each. She pared this with extensive knowledge of the ages and stages of development, and knowing what to expect from children at each age and stage, but also knowing how complex trauma changes this such that you can have a child at age 9 (nine) having tantrums as if he were aged 3(three), reflecting the age at which he experienced his trauma.

She gave a case example of a child who became triggered by having his caregiver smile at him. Intervention focused on self-regulation. It also focused on changing cognitive distortions, and learning relaxation skills. This child explained to his caregiver,

> *you were smiling at me and I think to myself – that is what my other parents used to do right before they hurt me –they smiled at me. You smile all the time and I was scared every day. Now I know that you smile because you are happy to see me. I just have to stop and remind myself when my body starts to get tense that the smile is really because you love me*.

This participant believes that the long-term impact of complex trauma is reduced through safety, trust, and processing within a child's ability to tolerate. Building supports, sequential treatment, working at a child's pace, teaching children and caregivers about the effects of trauma on the brain and how the brain reacts, and teaching a child how to regulate their emotions, are all practices effective in reducing long-term impact. She gave an example of her work with a child who did not speak English, and who had a very small number of funded sessions.

My intervention became providing education in a way that the child understood, and his family understood. I introduced education about the brain and the concepts of fight, flight, or freeze, with age appropriate explanations as to how the brain reacts when we are scared and what it feels like in your body, and what you have to tell people that you need. I reinforced this through the use of a 3D brain app (for iPhone) because the child was all about his iPhone. Along with this intervention, I educated him on his reactions to triggers and how he could use breathing to get through these reactions. This was educational for him and his family who often reminded him to breathe when he would forget.

This participant identified change processes within different aspects of therapy. This included: narration, re-storying, learning to self-regulate, and learning the effects of trauma. For the family, change processes include working with the couple and the family, parallel family work to support changes in therapy, and psychoeducation on trauma and its effects on the brain. For the therapist, a major change process is teamwork with all those involved. This participant identified change processes as being primarily external to the client, but which were required to support processing of the trauma within the therapeutic setting.

Following this interview, a member checking process was completed in which this participant confirmed the synopsis of the interview. Later, during the terminal member check, she also took the opportunity to add new information, stating,

sometimes the pacing of the work is as important as the work.... sometimes we need to take two steps back and pause because the child had been triggered and, given it is complex trauma, the source of the reaction may be unclear. Therefore,

a clinician may need to work with child and folks in their various life spaces but also know when to go fast /slow or pause.

In reviewing my theory development, I found this interview highlighted the work both inside and outside of sessions, with both the client and caregivers, especially psychoeducation. This was incorporated as follows: It also requires parallel work with caregivers so they understand the concepts inherent in complex trauma, and therefore learn to recognize trauma re-enactments, triggering, dysregulation, and attempts by children to regulate themselves and keep themselves safe.

4.1.6 Participant 6.

This participant identified as play therapist/psychotherapist. She has been practicing as a certified play therapist for 7(seven) years. She has informal training in trauma work through her employment.

This participant talked about the many systems in children's lives and how each of these need to be stabilized before children can process their trauma. She identified her assessment process, identifying children's stories, their symptomology, their triggers, and knowing what the plan by protective services is for children, both in the short and long term (going home, foster care, alternate care, etc.). Knowing this plan will determine her treatment plan. She has found that her treatment plan can be influential with protective services in that they will often consult to determine what may be best for children in terms of either moving (relocating), or not.

In terms of actual intervention, she specifically highlighted work within the treatment process. She identified safety as the beginning point of therapy with children

who have experienced complex trauma, stating "*the most important and primary pieces of work is to provide the opportunity for the child to feel safe – physically within the play room, but also relationally with the therapist, as well as mentally and emotionally*". The second piece of work is building attachment and therefore a safe therapeutic relationship

> *which assures the child that if they get too flooded, too dysregulated, or too immersed in a flashback per say, then the therapist is able to regulate them, help soothe them, and help work through whatever the trigger was for them*.

She stated that "*many of my clients are in foster care or in kinship care, and therefore already in a safe place. Therefore I use theraplay as it is a really great treatment for the child because it really does help to regulate the trauma with a safe caregiver*".

In discussing moving through the complex trauma treatment process, she identified "*rapport, relationship with the therapist, and feeling safe enough to play out their trauma*" as steps in the process, identifying that "*children are resilient and they have the tools and the inner resiliency to play out their trauma" although often times, external factors may get in the way of this".* She noted *"theory depicts the kinds of toys that should be in a playroom: for example, acting out aggression toys = toy guns".*

A key role of the play therapist is *"to invite the child to process their trauma, using well selected therapeutic toys*. She gave an example of a gun, and children not being allowed to have toy guns in school, and often not at home. However, in the playroom a gun can be cathartic, especially for children who have experienced complex trauma so as to be able to master control and play out their experience. While children play through their trauma, it is the role of the play therapist to reflect back what is

happening in their play, and to label their actual emotional state while in that play, so as to be able to "*shift the play, resolve the play, add to it, and start to mold the play to a resolution".*

She identified that often children become stuck in trauma play, noting, "*there is no storyline, no beginning, middle or end, no resolution…only dysregulated play*". This pattern is often seen with complex trauma. However, after a number of sessions when there is no resolution to the fighting (as is often evident in trauma play), the therapist has to intervene to help. She indicated this is where the therapist models resolutions for children. She noted this is where play therapists require creativity and playfulness, to offer possible help to resolve the impasses, for children to move past this play. She stated, "*We know how to fix trauma, but if we can't get into the play and the child doesn't let us play with them, then it's not going to work*". She identified that the play is the work, and that is what distinguishes play therapists from other therapists, "*because there is so much more going on in play sequences that there is just in dialogue*".

She described another concern with children of complex trauma, which is children who are frozen. "*These children can't walk into a play room and play – they become overwhelmed and have no idea of where to start*". They depend on the therapist for direction, and it is their trust in the therapist that helps them to gradually explore, and become increasingly more secure in themselves. "*For such children consistency in the playroom from session to session is important, as they are so hypervigilant that they will notice immediately if a toy is missing or a new one added, which can be disruptive for them*".

In discussing the actual identification and open discussion of the trauma, this participant identified that the process of oral discourse on trauma is dependent on a child's age.

> *For a 4(four) year old that has experienced complex trauma, their talk is their play and they process this way. However, for a child who is 10, not being able to talk about their trauma would be maladaptive, and therefore there is some big pathology behind those defence mechanisms which is preventing that child from doing so*". She further stated "*that what often happens is that if the child does not process their trauma, we know that when she hits puberty, her triggers will come up again…bringing with it more risk factors for triggering more issues for her at that point*.

The participant reiterated that, regardless if a child can talk about the trauma or not, "*it needs to come out in their play – which is why play therapy is so fabulous…because the play is the children talking about it*".

She often uses narrative therapy as a major component of processing trauma and thus identified it as a change agent. This type of therapy is supported by the therapist's use of reframing and re-storying, and children's acceptance of the proposed changes. Also key for change to occur is assimilation, integration of the trauma into a child's life story, mastery, and resolution. These need to be supported by consistent weekly sessions, predictability in the play room, and caregiver commitment to learning through psychoeducation, so as to understand the effects of trauma, and how to support their traumatized child. This participant stated that a child does not present…

in isolation. Children are children...they are not in isolation… there are so many people and so many systems, and supports, and so many different things that are part of their day, that if all of these are stable and where they need to be, children feel safe, secure and confident, and thus are able to do the treatment they need to do, and play out their trauma. The best therapies won't work without this….

She further stated that even with all these things firmly and securely in place,

it still takes the child a significant amount of time to be able to overcome the trauma. This makes sense because when you think of the brain and all the synapses and the memories and the assimilations, the trauma, the cortisone, and the adrenaline, and all those pieces that are going on…it does not just change in sessions. Time is needed to change neuro-pathways. This also highlights the importance of the external systems of the child's life needing to be consistent, in place, and attuned to the child's needs so that every experience of dysregulation throughout the child's day can be dealt with therapeutically.

Change process that this participant has confidence in include in-session processes such as narration (either play or verbal), playing out the trauma, and a child knowing/learning their own life story. Involvement of all systems in children's lives is essential to reduce long-term impact of complex trauma. External change processes of significant importance include support systems completing their work, caregivers participating in theraplay, and when Children's Protection Services are involved, maintaining consistency in children's lives.

Following this interview, the member checking process was carried out. This participant clarified some points and elaborated on others to ensure full understanding. For the terminal member check, she confirmed the findings identified. Theory development continued to evolve, with additions made following this interview to include the importance of the play process as a child's way of working through their trauma, inclusive of the concerns of trauma play and frozen play. The following was added to the developing theory: therapeutic work and psychoeducation are carried out parallel to work with children. The work with children in the playroom is centred towards the goal of successful trauma processing, through play, narration and/or narrated play, ending with success with mastery and resolution. Challenges such as trauma play and frozen play are expected and skillfully worked through.

4.1.7 Participant 7.

This participant identified as a play therapist/psychologist. She has been practicing as a certified play therapist for 20+ years, and has completed multiple trainings in trauma, notably with specialists in the field of children's trauma.

She noted the key requirements for a child of complex trauma to have within the therapeutic process, include "developing and maintaining safety, (children have to trust that the therapist is not going to expect anything from them until they are ready), and time to be comfortable within this new relationship" noting that the therapist is not the one who will bring about the change – children will, if provided with what they need.

The play therapist provides the safe environment, the time, the patience, the unconditional acceptance, the respect, and the calming strength required to walk with

children through their traumatic experiences. This participant believed "*this work is for the most experienced therapists, who have the personal and professional strengths to work with dark energy, without being negatively affected*". She identified the qualities required to do this work, as being: "*kind, caring, warm, having positive things in your own life, giving, empathetic, and objective".* She stated "*you have to believe in these children so they can believe in themselves*". She added that "*kids who are traumatized often look at the negative side of things, and this has to be countered by the play therapist, so as to shift the child onto the path they need to take*". She summarized "*they need to learn that there are people in this world that can be trusted, and we are asking them to trust us, so that we can then safely help them revisit events they don't want to even remember let alone relive*".

This participant initially uses non-directive play therapy and then moves to directive play therapy to the degree that a child is able to tolerate this. She uses filial therapy and theraplay in the order she feels necessary, however highlighted the work of theraplay:

> *Theraplay is attachment based and you are trying to increase attachment between the child and parent. The parents are directly involved, first just observing for 3-4 sessions, and then they are right in the room with the child. The therapist is role modelling and forming an attachment and building rapport with the child. Then the parents become directly involved under the guidance of the therapist. The basic underlying principles are structure, engagement, challenges, and nurturing. She noted this becomes tricky with complex trauma kids as they have been sensitized to be afraid of physical contact.*

This participant identified theraplay as an effective intervention for children of trauma, as they have to be "*deconditioned and desensitized*".

She identified the development of safety (physical, psychological, emotional, mental, and therapeutic) and relationship building as being very important foundation work. She described the roles of the play therapist to teach, model, attune, and attach, all prior to entering the processing phase of treatment. She identified using different treatments in a prescribed sequence as being effective. In doing so she implements treatment aimed at lower brain functioning, and slowly moves towards frontal cortex functioning and treatments which are most effective at this level. She discussed the work of Bruce Perry, and "*how trauma work has to begin in the lower part of the brain (sensory work) and progress to the upper part, the frontal cortex, where verbal therapies are used*". Incorporated into this discussion was the use of various types of therapies and using the model of Perry's work with the brain, knowing what therapies are appropriate to what parts of the brain, as well as knowing what interventions to use and at what point, inclusive of such as music, movement, rocking, feeding, drumming, dancing. She highlighted that "*for all children play is essential as it is the language of children*".

This participant emphasized the importance of pacing, such that therapy is progressing at a rate tolerable to each child. She gave an example of the importance of this.

> *There may have been some hard things that happened in your life that you have not been able to reenact in your mind as it is just too painful and you have repressed it. But later on when you are older and in a happier state, maybe in*

your daydreams you are able to go back there and some of the old feelings have been stirred up, but not so painful that you couldn't really look at it again.

We need to be careful to allow children to be able to process their complex trauma at their own time and pace as well.

She described the following practices as being effective in reducing long-term impact: timing, pacing, allowing the process to come from within, trust, hope, and knowing when a child is ready to terminate. She described phases of treatment that must be followed in order to most effectively work within a child's window of tolerance. She reiterated that this work is for the most experienced therapists, as it requires multiple skills and qualities. She spoke to "the future cost of not getting it right".

This participant's understanding of change processes include; giving hope, believing in children, pacing, timing, unconditional acceptance, walking with children through their trauma (either through play, verbally, reenacting, or through silent processing –meaning a child does not have to verbally relive their trauma). She noted that believing in children helps children believe in themselves.

Following this interview, member checking was completed, and the synopsis provided was confirmed. In the terminal member check, the same response was provided. Theory development continued to evolve, this time adding new information about the importance of the therapist's qualities, which in effect play a large role in both relationship development and trauma processing. Thus the following was added to the evolving theory: this work is enhanced by the professional training and personal qualities brought by the therapist to the treatment process.

4.1.8 Participant 8.

This participant identified as a play therapist/mental health counsellor/art therapist. She has practiced as a certified play therapist for 4(four) years. She has completed a number of formal trainings in trauma work. Based on her work specifically with a high-risk population she chose to decline permission for this researcher to use direct quotes (as per Letter of Informed Consent, p.8). Therefore, no direct quotations have been utilized.

This participant has a protocol in which she structures her initial meetings with both children and caregivers, in the order in which she interviews each, and in how she develops and completes her assessment. She uses her assessment to determine what a child was like before the trauma compared to after. Inclusive to this process is an inventory of children's natural coping strategies with the goal being to build upon these to incorporate them into times when they had not remembered to use them, especially in emotionally-charged situations. Her focus is on having children tell their own story in the safety of the therapeutic relationship. This relationship is seen as being less about technique and more about building connection, which is key to trauma work. Within this relationship, play techniques and therapeutic toys are used to assess and determine treatment. Her approach is to begin treatment using nondirective play therapy, which makes use of toys, puppets, and comics, gradually leading into directive play therapy, which utilizes games, and other mediums to help self-expression. She works towards stabilization, utilizing existing and developing new coping strategies, together with self-regulation. Her agency offers parental support through filial parenting groups, which have the added benefit of participants obtaining the shared community experience of

other parents. Additionally she stated there is a lot of education provided to parents about trauma and its effects, plus education on normal childhood development. Work with children of complex trauma often includes work with parents to help them deal with their own trauma history and talk about how that impacts their parenting style. This developmental history theme highlighted the issues of multigenerational trauma and how its effects continue from parent to child and on down the generational line. Concern within this process is for the need to support parents to view their children in a positive healing light, not as a victim. Viewing a child as a victim affects how a child is parented, which can often engrain a belief of eternal victimization. This participant recognized the negative impact of such parenting on children as they become teenagers.

This participant identified her use of the bottom up approach (whereby children are the experts), during the processing phase of trauma work. She identified this phase as that of bearing witness to children's trauma. Within the processing phase this participant utilizes a child's natural strengths, remains child-centred, uses grounding work, narration, and the use of 'ah-ha' moments to enable children to effectively process their trauma. She highlighted children's specific ways of communication, and noted that children talk in many different ways, yet the adults in their world often do not understand what is being communicated to them.

Within the playroom, this participant identifies changes in children's play, especially those who have experienced physical abuse. She noted that a child can move from being the aggressor within a play scenario, to inviting her into their play, and then allowing her to be the aggressor, thus opening up the play to a change process initiated by

the therapist. This increased comfort with complexity and uncertainty is the beginning of a child changing their narrative and moving towards mastery and resolution.

This participant spoke specifically of her use of play therapy with adolescent clients. She noted there is more of a sense of play in the play room and more permission by the therapist to allow the adolescent to engage in things that maybe their parents would not approve of as they may not seem to be developmentally appropriate. However, she recognized that if a child has been through neglect they may not have had opportunity to utilize these materials previously, and therefore she successfully provides that opportunity within the context of therapy.

Much of her work is focused on parent education to help them understand the effects of trauma, so as to understand their child's adaptive behaviours. She noted that often times she has to work with parents and/or caregivers to help them with their past traumas, in tandem with their child's work. She identified the 'many hats' that a play therapist requires, inclusive of individual counsellor, couples counsellor, family counsellor, and at times a community counsellor.

Change processes identified include: parent training and education, advocacy, the treatment of multigenerational trauma, work by parents between sessions, advocacy with collateral resources, teaching the effects of trauma on family, and teaching about the effects of trauma on childhood development. She stated that signs of change become evident when children regain pleasure in daily activities, and areas of previous pleasure.

Following this interview the member checking process was carried out, with the participant confirming the synopsis presented by this researcher. She also agreed with the material presented in the final member check. Theory development continued following

this interview, utilizing the concepts of preexisting skills and multigenerational trauma, as follows: therapeutic work, inclusive of that specific to multigenerational trauma, and psychoeducation are carried out with parents/caregivers parallel to the work with their children.

4.1.9 Participant 9.

This participant identified as play therapist/social worker. She has practiced as a certified play therapist for 9 (nine) years. She is also a certified trauma specialist.

She talked of the many skills required by therapists to provide trauma counselling. Key components identified are: working within children's window of tolerance; carefully preparing children as required for trauma processing; and recognizing when a child is ready to stop therapy. Attachment rebuilding, trust, safety, and skills are all necessary for children to trust the therapist and trust themselves. These dimensions pave the way for trauma processing. Play, which is the language of children, is used throughout. Specifically with complex trauma, she identified the middle phase of treatment as being much longer than with other issues "*as the child has to develop the ability to trust themselves, to be able to feel their feelings, and to be able to face their trauma*".

She discussed the importance of "*the therapeutic dance"* in attuning to children's abilities to emotionally regulate, to their experience of therapy, and their "*therapeutic trust*". She stated there is a fragility of relationship in working with complex trauma, and therefore it is vital that the therapist mirror healthy relationships, and work only at a child's pace. She stated that "*complex trauma children have to learn to feel their own feelings again, which requires time, trust, and attunement*".

A parallel process is undertaken with caregivers at the same time as work is progressing with children, involving validation, education, and attunement. This includes teaching parents to attune to their child's behaviours, through understanding the effects of complex trauma and how it has impacted their child's behaviours.

This participant addressed the issue of educating parents on "*the use of traditional behaviour management techniques and how they are absolutely contraindicated for kids with complex trauma"*. She stated that,

> *the role of the parents is to teach the child emotional regulation, teach the child the anatomy of a meltdown, help the child integrate information on how the brain is affected by trauma and complex trauma – therefore the therapist's role is to help the parent get to the level of this integrated parenting model*.

To prepare for processing with children she uses: building and adaptive information, resourcing, building self-esteem, building on experiences of mastery, building a sense of being loved and protected, all continuous with the concept of safety. She agrees with findings from other participants that "*children do not have to relive their trauma…as this can be dangerous and can lead to flooding, and thus adding more trauma, with the consequence that therapy has been a re-traumatizing experience*". She does suggest however, "*with the appropriate "degrees of distance" kids can get closer to the actual processing of their trauma"*. This requires starting the process using less threatening forms of intervention such as sandtray, and moving closer and closer to discussions as children are able to do so. The goal of the processing phase is "to integrate the trauma and put it away."

She provided a case example of a child…

who experienced complex trauma at the hands of a family member, who inflicted life threatening knife wounds upon her, requiring emergency response, and invasive medical interventions resulting in visibly extensive scarring, but lifesaving. This young child had many protective factors inclusive of her strong attachment to her mother, the quick work and validation by emergency services, and her experiences of support within the hospital as she recovered. Because of these, she was able to quickly identify and process her complex trauma, from the lens of being a survivor, and how she herself did what she had to do to survive.

This example highlighted the positive impact of support to be able to move children from victimization to adaptive functioning. This was then compared to children who suffer complex trauma silently, and within the secrecy of the family, without any accessible supports. The period of time such children require to process their traumas are quite extensive comparatively, as their traumas have been suppressed, thus requiring it to be brought to the surface in order to be processed.

This participant uses multiple practices to reduce long-term impact including: nondirective play therapy, directive play therapy, EMDR, sandtray, developmental sequencing, openness and transparency with children about their trauma, and psycho education with children and their caregivers about the effects of complex trauma and abuse.

Change processes identified by this participant include; parallel work with the family while working with their children; creating a 'good enough' attachment using mirroring, attunement and pacing, and working within children's tolerance levels. This participant sees trauma work as following a protocol of preparation, processing, and

integrating, with specific elements within each. Also, she stated that a 'recipe approach' cannot be used in treating children with complex trauma, as this is a unique form of trauma that requires specialized intervention.

The member checking process was again carried out, with this participant confirming the synopsis provided. In the terminal member check, she added the importance of safety within the therapeutic process. Theory development was reviewed and added to, based on the issue of contraindicated therapies as identified by this client. The reviewed theory, also the final review based on findings within this interview resulted in the completion of emergent theory as specified in the following section.

4.2 Theory formulation

Within the naturalistic inquiry, theory emerges from the data, with revisions completed until all the elements interviewed are represented. My theory began with the first interview. Following each successive interview, new findings were identified, which were grouped together at the end of the interview process and carried forward through the analysis process, culminating in theory development. The following theory represents the data set of my study:

A combination of factors specific to the play therapy setting/ the play therapist/ child / caregiver/ parent, and the therapeutic process, combine in the context of play therapy and within the expertise of the play therapist to create "seeds of change" using children's existing strengths, their understandings, and their language, with primary attention to the language of play, in combination with the appropriate age/stage interventions and toys of the trade, all as part of the play therapy process. Play therapy

has been found to be effective in working with complex trauma where other therapies – specifically those that are behaviourally based – are contraindicated. Play therapy is enhanced by the professional training and personal qualities brought by the therapist to the treatment process. Therapeutic work, inclusive of that specific to multigenerational trauma, and psychoeducation are carried out with parents/caregivers and parallel the work with their child. The work within the playroom is primarily centered on the goal of successful trauma processing, either verbally or silently, through play, narration and/or narrated play, ending with mastery, self-regulation, and resolution. Challenges such as trauma play and frozen play are expected and skillfully worked through. The role of the play therapist goes beyond the playroom and into roles of advocacy and collaboration. It also requires parallel work with caregivers so they understand the concepts inherent in complex trauma, and therefore learn to recognize trauma re-enactments, triggering, dysregulation, and attempts by children to regulate themselves and keep themselves safe. The seeds of therapeutic change processes are planted upon children's entry into therapy and strengthened as the relationship develops and the therapeutic process unfolds.

Change processes identified within the play therapy process are multifaceted: they are internal and external to children, and internal and external to the therapeutic process. In work with complex trauma, the processing phase, or working through phase is comprised of identifiable steps. There is no delineation of the end or beginning of these steps, as they are interwoven. These patterns are akin to the phases of therapy (beginning, middle, and end) whereby features of one phase are foundational to the next, and therefore cannot exist independently. Each of the phases in processing is supportive of moving forward, however requires the flexibility to move back and forth depending on a number of factors. Child

work, parent work, therapist's skills, external factors, and psychoeducation have all emerged as key components that underlie trauma processing.

4.3 Conclusion

This chapter has provided the raw data obtained from all nine individual interviews, and all nine member checking processes, using thick description. It also outlines the process of theory development, which began with the first data collected and concluded at the end of the data collection process, with a theoretical representation inclusive of data provided by all participants. Information provided included key concepts of trauma and trauma interventions, which are key to the juxtaposition of theory and practice in complex trauma work. At the end of interview nine and its member checking process, it became evident that little new information was identified, signalling the end of the data gathering process. This researcher's focus then moved to the data analysis phase of the inquiry, the results of which are discussed in chapter five.

Chapter 5: Analysis and Synthesis

5.0 Introduction

Chapter five provides an analysis of the study's data set and interpretations of commonalities and divergences within the study's findings to arrive at meaning and conclusions related to change processes within the context of treatment of children who have experienced complex trauma and associated sequelae. The question "What were the lessons learned" from Lincoln & Guba (1985) was used to guide the analysis and interpretation. Lessons learned developed from a combination of my understandings and insights brought to the study based on personal and professional experience, history and culture, and on meaning derived based on a comparison of the findings from this research study to those from related research and previous studies. Making connections between the study's findings and relevant literature provides a way to acknowledge the unique contribution of this study to the understanding of the treatment of complex trauma and the therapeutic change processes within the context of the treatment of children.

Synthesis is the process of pulling everything together. In qualitative inquiry, the study process begins with a holistic perspective, and moves to analysis of individual parts, then back to a holistic look, or synthesis, of the data (Bloomberg & Volpe, 2008). Synthesis of this research shows how the research questions are answered, to what extent the findings from the data collection can be interpreted in the same way, and how findings relate to the literature.

As indicated in chapter 3, thematic analysis was utilized to discover meaning in the data. This type of analysis is based on induction, whereby the researcher starts with a

large data set and gradually narrows it down without using predefined categories, but allows the categories to emerge from the data. Analysis consists of several steps: familiarization with the data through immersion; the development of categories of information; generating initial codes; searching for and developing themes; reviewing, defining and naming themes; and, producing a research report which, in this case, is a dissertation. It is within this analytic framework that the data was formed into patterns, which then became information, which in turn became a key ingredient in the formation of knowledge. The process of knowledge development began with the interview process. The interview process was followed by a transcription process, fully completed by this researcher, which although timely, provided opportunity for immersion in the data set as a whole. These processes were followed by a manual coding process of each individual transcript, which was then followed by a re-coding process as discussed in chapter 3. Recoding entailed many steps for data labeling, reduction, coding, summarizing and interpreting. The coding processes followed the many recommendations of Bloomberg & Volpe (2008), Braun & Clarke (2006) and Salanda (2009). These included; writing notes both in the margins and on the transcripts, using notes to highlight patterns, then using colour coding to highlight theme development, matching, sorting, collating, combining and recombining, then sorting, grouping, and categorization within and between themes. Subsequently this entire process was repeated, as recommended by Lyons & Doueck (2010), Braun & Clarke (2006), and Saldana (2009). The resulting host of codes from the second recoding process was categorized based on similarities and commonalities. Through the coding and categorization process, I focused on emerging themes and patterns from the data by comparing data of all participants separately, and then

collectively, to identify similarities in their perceptions. The coding scheme is presented in Appendix M.

In total, eleven categories emerged which were then applied to organize the data from each interview. These categories then underwent a theming and re-theming process, resulting in three overarching themes, which provided the conceptual foundation for analysis. These overarching themes will be discussed in this chapter. The first, theme 1, *therapeutic tools*, articulated the training, skills and resources identified by participants to undertake counselling with children who have experienced complex trauma. Theme 2 is *building the therapeutic foundation*, which was identified as an essential component of trauma work. It identifies the requirements of the first phase of treatment with children, highlighting the importance of this phase to the entire therapeutic process. Theme 3 is *working through complex trauma*, which identified a detailed three-step process within the processing of complex trauma. It is within these three themes that six therapeutic change processes were identified, each of which will be identified and discussed.

Analysis of the three themes enabled examination of their prevalence within the data, their location in the therapeutic process, their relevance to the research question(s), and their interconnections to each other and to the data set. This chapter represents a culmination of code development from the data set, and theme development that emerged from analysis of the codes, and resulted in findings that speak to the study's research questions, which will serve as a framework to organize discussion of the findings. These questions are:

1. What practices have play therapists found to be effective in assessment and treatment of children exposed to complex trauma?

2. What practices have play therapists found to be effective in reducing the long- term impacts of complex trauma?
3. What are play therapists' understandings of therapeutic change processes in which they have confidence?

It became evident very early into the interview process that the topic of therapeutic change processes could not be discussed in isolation of the therapeutic process and all this entailed. As a group, participants identified the tools they used in their work, the steps they followed specific to trauma work, how they prepared children for the therapeutic journey, and how they, as play therapists, supported children throughout the process. Many participants stated they had not consciously considered what changes were happening within their treatment process, but in talking through how they did their work, they were able to identify signs of change. Through analysis of their individual interviews and the interviews as a whole, a combination of change processes was identified. Also identified was a working model for the treatment of children exposed to complex trauma. Such findings serve to add to literature on clinical social work. Throughout its development up until present day, social work has identified the need for the study of practice and practice processes (Anastas, 2014; Axline, 1967; Robinson, 1934).

As with the interview process, the presentation of the findings will follow patterns established by the participants so as to bring meaning to the findings. The following is a discussion and elaboration of the themes, (themes 1, 2 and 3) and sub-themes within each, utilizing the three research questions as a framework, and ending with a discussion

of the therapeutic change processes that were identified. Each theme was identified through a triangulation process whereby items of information were validated against at least one other source, either one or many other interviews, or resource information provided by participants. Table 3 will guide the reader through the findings.

Table 3 – Findings: Themes and therapeutic change processes

Theme 1 Therapeutic tools	**Theme 2** Building the therapeutic foundation	**Theme 3** Working through complex trauma	**Therapeutic Change Processes**
1. Practices	1. Assessment	1. Using trauma specific play interventions	1. Fostering a renewed ability to attach
2. Skills	2. Developing Safety	2. Processing the trauma Step 1 –Pre-processing: Skill development Creating success Step 2 – Working through: Mastery Resolution Step 3 – Post-processing	2. Fostering a renewed ability to trust
3. Resources	3. Building relationship		3. Instilling hope for the future
	4. Allowing children 'time'		4. Providing age appropriate time & pacing for processing
			5. Facing the trauma together
			6. Promoting mental health and resilience

5.1 Theme 1: Therapeutic tools

The theme of therapeutic tools was used to identify practices, skills, and resources identified by participants within the treatment of children exposed to complex trauma. These tools naturally grouped together during analysis. Play therapists identified their own unique tools, common tools, and diverse tools, converging on an overall understanding of what they bring to the therapeutic process of working with complex trauma.

5.1.1 Practices.

This sub-theme was used to identify all the various forms and types of specialized interventions utilized by participants. It captures the many types of interventions and pairings of interventions utilized by play therapists, in their treatment of complex trauma, and knowing how/when to use each. This includes: Trauma Focused – Cognitive Behavioural Therapy (TF-CBT), Cognitive Behavioural Therapy (CBT), Circle of Security, Eye Movement Desensitization & Reprocessing (EMDR), Sandtray, Erica Method, Theraplay, directive play therapy, non-directive play therapy, Emotional Freedom Technique (EFT), art therapy, filial therapy, narrative therapy, life story work, use of therapy dogs, and an approach utilizing integration of some or all of these approaches in combination. Many of these interventions require advanced training, over and above the requirements of becoming a play therapist and trained trauma therapist.

Participants identified their individual choice(s) of practice, however, stressed that a "one-size-fits-all" approach does not exist for working with complex trauma and for working with children. A number of factors determine which approach is used, with the most important consideration being what works best for children. Unanimously, participants highlighted the need for multiple types of intervention, applied in an integrated fashion, as well as training to work with the identified population.

Inclusive within each type of practice and underlying all therapeutic work is respect for children and for their individual stories. Participants reinforced that children have a right to their story, and to share it with whom they choose. If the recipient in any way challenges the details of that story, or causes a child to regret telling their story, the outcome may be detrimental to the therapeutic process, and to that child.

Despite all the skills brought to the therapeutic process by therapists, one factor alone was identified as a determinant of progress and success. This is a child's willingness to engage in the therapeutic process. Participants identified cases where children may not have been ready for therapy, or they were told they had to attend despite not wanting to, or they had seen the therapist(s) repeatedly without engaging. It was recognized that some children might have to engage in therapy in stages until they are ready to more fully engage. Allowing this process to play out through patience and child-centred pacing are ways of building trust with children, and thus respecting their *"window of tolerance",* which determines how much they can tolerate within the treatment process.

5.1.2 Skills.

This sub-theme was utilized to identify the skills groups required by play therapists to provide trauma intervention work with children, among which are included; attunement, mirroring, pacing, use of silence, bearing witness to childhood trauma, teaching, advocacy, modelling (relationship development, and a trusting relationship), developmentally appropriate intervention skills, creative solutions, relational connection, experience, openness, and transparency. Additionally therapists have to be well versed in complex trauma, its presentations, its effects on children and their caregivers, and its effects on all areas of children's lives. As complex trauma presents differently in every child, the play therapist has to be very skilled in recognizing the effects in each individual child, and at determining their role as therapist both inside (therapeutically) and outside (advocacy, collaboration) the therapy room, with each being equally important. A key

finding in this area has been the requirement for the therapist to be able to work with all client systems: individuals, caregivers, couples, families, siblings, schools, child protection agencies, foster care systems, community systems, and any other system their client may be involved in (multi-systemic practice) – therefore, highlighting the diverse skill set required to work in the area of integrating complex trauma work with play therapy.

5.1.3 Resources.

This sub-theme was used to identify the individual and combined array of therapeutic resources referred to, utilized, and recommended by participants. Traditional resources included those found in play rooms, such as art materials, miniature toys, sandbox, therapeutic toys, musical toys, doll houses, dress up clothes, games, and children's books. However, it was found that in working with complex trauma, therapists had to be creative in finding resources to meet specialized needs. One participant found that with traumatized children, work had to begin on the sensory level. She used non-scented shaving cream to initiate play with a child who was hesitant to engage with other sensory objects. This unique accommodation was effective and proved not only to be a lot of fun, but also promoted engagement on a level that enabled this child to begin to trust. Participants often noted that they had to be creative in what they used, and in the absence of resources being readily available, they would create intervention supports that they needed. This included; the use of a toy resource – a plastic scull with an interlocking plastic brain, used to inform and educate children and parents about the brain and the effects of trauma on different parts of the brain; the use of an computer application called

'3D brain' for adolescents who had either a computer or iPod available to them, but who had a limited number of sessions available to them to learn this information in detail; a book on childhood trauma and attachment disruption authored by a participant who identified the need for such a resource in her work with caregivers of traumatized children; a children's story book on the effects of trauma, authored by an EMDR specialist; a children's colouring book written and developed by a participant (who secured funding for same) focusing on safety and the effects of trauma; a power point presentation developed and used by a participant in her work with professionals to teach on the effects and symptoms of trauma on children who experienced complex trauma; and, instructional notes on trauma and attachment used to teach from a play therapy perspective. Each of these resources was examined in detail so as to be able to incorporate the findings into the study, which is identified as referential material.

Age/stage appropriate play material is required for trauma work throughout all stages of intervention. If these are not readily available, a skilled play therapist uses their creativity and resourcefulness to improvise. These creations parallel the tools of childhood, and cannot be underestimated in their value. They often are the means by which children express themselves, as they are safe, familiar and fun. As stated repeatedly *"play is their language and toys are their tools"*.

5.2 Theme 2: Building the therapeutic foundation

A foundation for therapeutic work with children who have experienced complex trauma, has emerged as a crucial component of trauma therapy in that trauma processing can proceed only if the components of relationship building and establishing safety are

successful in phase one of treatment. This theme speaks to the first research question, "*What practices have play therapists found to be effective in assessment and treatment of children exposed to complex trauma*"? The following dimensions identify the requirements of the first phase of treatment with children, highlighting the importance of this phase in enabling the therapeutic work and its influence throughout the entire therapeutic process.

5.2.1 Assessment.

The assessment sub-theme was used to capture details of the assessment process, in the beginning phase of treatment, within a play therapy context. All participants discussed assessment as not only the gathering of information required to develop an individualized treatment plan, but also functions as the beginning of the treatment process in that it is the initial contact with not only caregivers and collateral providers, but with children, who having experienced complex trauma brings a host of symptoms, inclusive of a lack of trust, especially towards adults.

Participants identified that complex trauma work is significantly about attachment repair, and *"about grief and loss"*. It is not only the event itself that is traumatic, but that it occurred within what children understand to be a safe and protective relationship. Assessment and treatment require an understanding of both the trauma and the resulting losses to children, which together require a reworking of the earliest gains in attachment and bond capabilities, and the development of new foundations for relationship building and the regaining of trust. Modern attachment theory (Schore & Schore, 2008) supports

the notion that internalized maladaptive relational models can be replaced by more adaptive and healthy relational models

Assessment of complex trauma has to be undertaken with an understanding and working knowledge of an attachment framework which acknowledges and understands the damage that is caused by the breaching of this attachment and the repair work that has to be the focus of intervention inclusive of *"re-pairing, re-framing, re-attaching, re-configuration, re-conceptualizing, and re-focusing"*. For some participants there was a relationship between attachment repair and increasing affect regulation strengths. This work has to be undertaken within the underlying and ongoing development of a therapeutic relationship that mirrors children's strongest attachment relationship(s). It is built on a number of types of safety (as discussed later) and at no point is ever completed within the treatment process but remains ongoing from the beginnings of therapy to the end. Trauma work requires a specific component of work within the therapeutic process called 'trauma processing,' which can best be entered into as relationship development and safety development is progressively successful.

The issue of having a team approach when working with children of complex trauma was discussed throughout interviews, and was identified in both the initial and the terminal member checking processes, as being of significant importance. Teams may be multidisciplinary, and they may consist of the key people in children's lives. Either way, it was repeated often that a therapist should never work in isolation when working with complex trauma. Given the multifaceted nature of the issues within complex trauma, the sometimes-unpredictable symptoms that children may present with, and the need to ensure that the therapist is intervening using the most appropriate practices, the

requirement of good clinical supervision was repeatedly highlighted as well.

5.2.2 Developing safety.

The therapeutic relationship has to begin by building safety, which has emerged under theme 2 of the findings (building the therapeutic relationship) as identified in Table 3. Contrary to an interpretation that safety is a single concept, analysis has discovered that safety is established in different ways, each one unique and significant to supporting therapeutic progress. This finding was new and unexpected in the study, as although research found many references in the literature that spoke to this issue, very few of these references were developed in depth. My analysis discovered that there are dimensions of safety, which support intervention work with complex trauma. The themes discovered include; (a) physical; (b) emotional; (c) mental; (d) psychological; (e) therapeutic; and (f) relational safety. The following is a reflection of these types of safety, discovered and refined through negotiated outcomes and analysis of the data set.

(a) Physical safety.

Children need to know that the therapist's office and/or playroom is a safe place where no physical harm will occur, even if they become physically dysregulated, or alternatively they decide to 'test the limits' of what the therapist will tolerate. Safety is first and foremost a basic need of all children as indicated in Maslow's (1954) hierarchy of needs, and Charlotte Towle's (1957) *Common Human Needs*. Children who experience complex trauma have difficulty trusting adults; building a therapeutic relationship has to take into account physical safety as one of the many security needs of children (Shulman, 2015b). A traumatized child will not fully be able to work through

thoughts regarding major events without the presence of a competent and trustworthy counselor who is accepting of posttraumatic play, consistent with limits, and responsive to feelings (Jordan et al, 2013).

(b) Emotional safety.

For children with complex trauma, emotions will likely be dysregulated, and therefore their actions and reactions may not be congruent with expectations (Shulman, 2015). This results in part, from not feeling in touch with their bodies, one of the many sequelae of complex trauma. One participant explained that a child she worked with became upset when asked to display visual representations of multiple emotions, a concept she could not relate to, as she related only to being happy, mad and sad. The therapist therefore had to help this child identify a repertoire of emotions so as to be able to recognize others that she had previously experienced. Children need to learn to label or otherwise give meaning to their emotions, within a safe and secure therapeutic relationship. They need to feel accepted and understood (Jordan et al, 2013). The reflection of actions, thoughts, and feelings in the play room create a safe environment for children to express all of their experiences (Baggerly & Exum, 2008). Children need to know that it is safe for them to talk about their trauma using their words, their actions, and their ascribed meanings for both.

(c) Mental safety.

Mental safety entails allowing children to ask questions and process information in a way that feels right for them, within their life as lived, contrary to children's ages and stages of development. This requires active sharing between the child and the therapist (Crenshaw & Kenny-Noziska, 2014) in which the therapist uses creativity to provide

psychoeducation to support children's learning and understanding of some of their challenges. One example used by a participant was that of using a toy brain with removable parts to explain to a child how the brain grows in stages and how trauma can interfere with that growth, and therefore some 'relearning' has to occur.

(d) Psychological safety.

This type of safety is achieved when children are accepted and respected for who they are, and only then will they take risks to move forward to process their trauma. This specific type of safety was first addressed in *Play Therapy* by Virginia Axline (1947), which remains one of the best-known resources in the field of services to children. Axline highlighted the need to accept a child exactly as they are. An example of this used by one participant was her transparency in discussing a child's symptoms of trauma and her way of explaining, without judgment, how her symptoms were negatively impacting her choice of friendships and activities, both of which continuously got her into trouble. This child was then able to link this discussion to her life and lifestyle choices, without feeling judged, following which she expressed a desire to work on her trauma symptoms.

(e) Therapeutic safety.

Many children with complex trauma have had to keep secrets and because of this will find it difficult to trust that they can disclose their experiences to a therapist. Therapists need to help children determine that it is safe to express themselves and to share secrets, and that the therapeutic process is a safe one. Therapists also have to help children have confidence that it is safe to share their experiences while their parents or caregivers are in the room, after it is determined by the therapist that it is most likely safe to do so. According to Ogawa (2004), a sense of safety and security can be established

"through several key conditions in play therapy, including the therapist's confidence in him or herself, a therapist's eagerness to be fully with the child, and consistency and predictability in the relationship between the therapist and child" (p. 24).

(f) Relational safety.

Children need to know that it is safe to talk within the therapeutic relationship, and that they are not being manipulated to define an unsafe relationship as being safe. The therapist must signal both relational safety and social support through working with children initially to determine their ability to develop trust, and based on their identified abilities to slowly move forward from there. It is important to be cognizant of children's attachment breaches and their compromised ability to bond and to trust, each requiring repair work before relational safety can become actualized. According to Crenshaw & Hardy (2007), "if the child does not have a trusting relationship with an adult perceived to be caring and capable of responding to their pain in an empathic way, they will not feel safe and little that is therapeutic will happen" (p. 173). Relational safety is a common theme in the social work helping process (Perlman, 1957; Shulman, 2015b).

Identifying these six types of safety is an important discovery in that it highlights the complexity of working with children, especially with children who have experienced complex trauma. Such complexity required the therapists to be cognizant of the initial safeguards that need to be implemented in the provision of therapeutic services to children. As pointed out by participants in this study, these children start the therapeutic process far back from the starting line, and therefore we need to get them safely to that line before beginning more complex work towards processing of their trauma. Future research is recommended into the many types of safety identified as being desirable in the

field of services relevant to children, especially in the area of resolving complex trauma.

5.2.3 Building relationship.

Analysis of this sub-theme in great detail was required based on the unanimous belief by all participants that it is a key element of trauma work. Processing trauma requires a safe and supportive therapeutic relationship, which could not be separated from any of the three phases of therapy, as its development remains continuous and clinically significant throughout the therapeutic process. It is this relationship that will guide children through processing their trauma and therefore has to be strong, secure, safe, and trustworthy. There was much discussion about this, and a consensus that with a strong therapeutic relationship, change work can be accomplished, but without it, it is very unlikely that trauma processing would progress at all.

Therapeutic relationship development is a very important component of attachment work as it is aimed at rebuilding trust and thus instills *"hope that things can get better"*, which has emerged as a key change agent. Attachment work is modelled in the therapeutic relationship, for both children and their supporting caregivers. There was consensus by all participants that positive attachment work is essential in order to process complex trauma. It is important to recognize that some participants reflected on the dynamic created by joining with children through play, as contributing to the therapeutic alliance.

5.2.4 Allowing children 'time'.

This theme was used to capture the many references made to the concept of

allowing children adequate time to progress at their own pace, and matching the therapeutic process to that pace. In discussing the concept of time, participants unanimously indicated that trauma work with children does not fit the model espoused by providers of typically 6-8 sessions. It was highlighted that children "*need and deserve*" the time they themselves require to do this very difficult and emotionally demanding work. Many risks were identified when time was not utilized to the benefit of the therapeutic process, including increased risks of harm to self, and/or harm to others. Some participants identified that when given a minimal number of sessions, they proceeded very differently than if they had an adequate number of sessions, so as to meet unique child-centred contextualized needs. This included *"multiple shorter sessions"* to make the best use of time allotted, focusing on education only, or *"focusing on symptoms rather than the trauma itself".* However, there was consensus that time, patience, and processing were all key to traumatized children moving forward in the treatment process with more confidence in sustained gains. Also there was consensus that preparation work should continue until assessment determines a child is prepared to move into more complex change processing.

5.3 Theme 3: Working through complex trauma

This theme was used to identify how trauma is processed inclusive of what practices, resources, and therapeutic components are used to help traumatized children work through the processing of their trauma. It developed in response to research question 2- "*What practices have play therapists found to be effective in reducing the long- term impact of complex trauma"?* The working through process, also known as the

middle phase of treatment, is where a number of therapeutic change processes were identified. These findings are identified in the following discussion, however, will be discussed in greater detail, in the section that follows (section 5.4).

Discussion of theme 3 begins with the topic of the play process, and its importance as identified repeatedly by participants based on its importance in the treatment of complex trauma. This discussion is followed by what emerged as a pattern within the middle phase of treatment, a three step process, strategically rolled out by the therapists in such a skillful way, being respectful of the needs of children who experienced complex trauma. This sequencing of steps is:

1. pre-processing (stabilization)
2. processing- trauma processing, mastery, and resolution.
3. post-processing (integration)

Within each of these steps, specific goals were identified. These goals were established sequentially, so that one became the foundation for the next, resulting in mastery through trauma processing tasks and optimal resolution of the trauma by the end of middle phase of treatment. A number of change processes were identified within this phase of treatment as will be discussed throughout.

5.3.1 Utilizing trauma specific play interventions.

This sub-theme captured the many references to the type of work taking place through play, under the guidance of experienced therapists. Specific therapeutic play work proceeds within the safety of the newly developed therapeutic relationship, inclusive of required child-centred safety features. A safe, playful, and helping

therapeutic relationship serves as a model for other relationships in children's lives, and it offers the hope and possibility of a renewed ability to attach, which has emerged as a change process. The clinically significant value and impact of play became evident within participants' descriptions of their work. It is here that play therapists began to the process of teaching many of the skills required by children in preparation for processing their trauma(s). Concurrently, therapists were creating opportunities for children to experience success.

Utilization of trauma specific play interventions was highlighted as key to providing trauma counselling with children. A therapist has to have an understanding of the therapeutic value of play, ages and stages of development, the effects of complex trauma on this development, what trauma work entails, and the education and training to implement each of these simultaneously and concurrently. Participants often spoke of various therapists attempting trauma work unsuccessfully, reinforcing their belief that this type of work with children is a specialized area and needs to be identified as such. As one participant concluded, "*there is a huge cost to getting this wrong"*.

5.3.2 Processing the trauma.

Processing complex trauma was found to have a series of sequential steps, which are interconnected such that they could be implemented individually or concurrently, based on children's needs for pacing, and on the therapist's goals towards processing. Allowing adequate time and pacing for children to progress through trauma work has emerged as a change process. The goal of processing is for children to work through their trauma, to gain mastery over the sequelae and to progress to resolution of the trauma. The

steps identified within this process, as discovered through data analysis, are pre-processing also referred to as stabilization, processing or stabilization, and post-processing, also referred to as integration.

5.3.2.1 Step 1 – Pre-processing / Stabilization.

Preprocessing, also referred to as stabilization, is required to prepare children for the actual processing of their trauma. After building a strong therapeutic relationship, and establishing the safety requirements, the therapist begins the process of preparing children for the actual processing of their trauma. This requires children to have developed a trust in the therapist and in the therapeutic process, which includes play and playfulness. It requires teaching children new skills, or helping them rediscover skills that were lost because of the trauma. Repetition or the practicing of newly acquired skills, is a major component of children's learning, to help overcome their well-established defence mechanisms, to enable processing of their trauma, in order to gain mastery.

Emotional regulation skills include a number of strategies that the therapist teaches children. Children learn at a young age to regulate their own emotions through connecting emotions with behaviours. Sad children will cry, happy children will laugh and smile, and scared children will seek out comfort. However, children who have experienced complex trauma are often out of touch with both their bodies and their emotions, thus, they often 'loose' their ability to successfully connect relevant emotions with appropriate behaviours, and therefore often become 'dysregulated'. Behaviourally, such children can fluctuate between being hyperactive and hypoactive – even dissociative. Children who are dysregulated will laugh when they are sad, they will cry

when they are happy, and in seeking out comfort they will push caregivers away. As one participant recalled, children will send messages to their caregivers, saying, "*Yes I love you, but No I hate you"*. Such dysregulation can threaten relationships, placements, and therapeutic interventions.

Participants in this study identified emotional regulation as a primary requirement of trauma work. It is also a requirement of play. Without it, processing of their traumatic experience will not be possible. However, prior to working on emotional regulation crucial foundation work must be completed which includes: safety in the play room; emotional, physical, and psychological safety within the therapeutic relationship; and, a safe, caring, supportive caregiver who can support and reinforce the work outside of the play room. Many of this study's participants included caregivers in the therapeutic process, with the goal to model for them what is required, especially in terms of emotional regulation through play. As stated by one participant: "*We know how to fix trauma but if we can't get into the play and the child doesn't let us play with them, then it's not going to work"*. It was within the step of pre-processing that the need for skill development (such as distress tolerance, and emotional regulation) and the need to create opportunities for success (relearning what they are good at, or learning new skills such as art and/or music) were identified.

5.3.2.1.1 Skill development.

Skill development is key to the preparatory work required for trauma processing. The therapist teaches children skills required for the processing trauma and related content, inclusive of coping skills and self-regulation skills. The capacity to self-regulate

is a necessity for trauma processing and integration (Schore & Schore, 2008). Repetition of newly acquired skills, which is a major component of children's learning, is utilized in order for them to gain mastery, and begin to overcome their well-established defence mechanisms prior to starting the processing of their trauma. Skill development includes: deep breathing exercises (such as square breathing, bubble breathing, belly breathing, blowing out the candles); relaxation exercises (use of music, robot – ragdoll exercises, progressive muscle relaxation exercises); sensory exercises (use of water, sand, clay and in one case the use of shaving cream); and grounding (learning how to recover from memories of past experiences by returning to the present place and time, facilitated by therapists voice, tapping exercises, and/or becoming mindful of physical sensations of the present moment). Self-regulation skills include emotional regulation (recognizing changes in mood resulting in changes in behaviour and being able to overcome this); behavioural regulation (being able to control ones behaviour especially in times of emotional dysregulation, and to be able to self-regulate to return to baseline); cognitive thinking regulation (thoughts that might be changed to support behaviour, and emotive changes in support of "mastery"); self-efficacy & self-perception (having confidence in ones abilities and positive sense of self, which is especially important with teenagers).

Recent trends in therapy with children have been to incorporate body/expressive therapies within the treatment. It is often recommended that children who are clients partake in activities aimed at building skills and competencies, to "*help them feel good about themselves*" based on adaptive gain and "*to support resiliency*". Expressive therapies such as yoga classes, painting classes, and musical expression serve to encourage expressing feelings and other free expressions of self, including anger and

aggression. The goals of these are twofold: to gain a sense of mastery and accomplishment so as to experience success and to utilize such positive and adaptive experiences as foundation work for ongoing treatment.

5.3.2.1.2 Creating success.

Creating success has emerged as a very important aspect of preprocessing. Success is aimed at identifying children's strengths, instilling confidence in those strengths, and building upon them towards promotion of positive mental health growth, enhancing resiliency, and focusing on celebration of the child's progress and successes. Opportunities are initiated through matching children's strengths and interests with activities that position them for success, using support, encouragement, praise, playfulness, and excitement. The goals are to support children in finding purpose and meaning. Efforts may include activities inside the therapy room (art, clay work, projects) and outside such as restarting social work a past fun activity or starting a new one. It was noted that physical activity was encouraged often, with focus specifically on expressive body activities (yoga, dance, music activities).

5.3.2.2 Step 2 - Working through/Processing.

Working through, is the culmination of the work preceding it, beginning with first contact. It is the stage within the therapeutic process where children have accepted the safety of the treatment process, have developed a safe relationship with the therapist, have become comfortable with the play process, have felt a sense of success, have learned to regulate emotions and actions, and have learned to be able to cope with

emotions, all in preparation for the very difficult work of working through their trauma. Working through complex trauma experiences is a unique experience for every child. However, what remains consistent is the supported processing of the trauma, whereby the therapist joins with children and *'bears witness to their trauma'* so that they do not feel alone in the process. Supported processing of trauma or 'facing the trauma together' emerged as a change process. The goal of trauma processing is to strategically work with and support children towards narration of their trauma. As stated by one participant, the goal is "*to reconfigure, re-story, and rebalance*", first by increasing stress tolerance, then by managing emotions, and then by revisiting and processing the complexities of their trauma, all within the safety of the therapeutic relationship. This is achieved primarily through narration which can come in many different forms, limited only by the imagination and creativity of the therapist. Participants in this study outlined their own specific preferences for narration, inclusive of sandtray, art, and restorying.

Sandtray is a method of intervention that involves the use of miniatures, sand, sandtrays, and the guidance of the therapist to surface the children's unconscious thoughts through play, imagination, and transference, via the creation of a sandtray story. Participants verified the success of this modality with children but also indicated it has also found its way into adult therapy in recent years, evident by the use of miniature sandtrays and other forms of play therapy in work with adults with complex trauma (Olson-Morrison, 2017).

Art is a method of intervention that includes drawing, colouring, use of mandelas, hand/finger painting, collages, and other activities, all fuelled by the therapists creative use of children's natural curiosity and quest for accomplishment. Participants identified

that in latency stages this can also include photo-art, clay modelling, and mask making. Art as a therapeutic intervention was also identified as having found its way into adult therapy in recent years evident by the recent surge in adult colouring books

Storytelling is a craft that has its therapeutic roots deep into history, and spread across multiple disciplines. Many participants identified storytelling as children's way of expressing themselves that allows them to narrate their traumatic experience in their own words, without risk of not being believed. In parallel, many stories have been written for use in therapeutic settings with children for use when they need support with narration. Participants identified that storytelling has various forms such as *Life Story Work and scrapbooking.* However, regardless of the form used, the goals are to help children work through their trauma and to master their experience so as to no longer feel victimized, and to recognize and understand that they are not at fault.

There were two differing views by participants as to the necessity of children "*reliving their trauma".* Some participants believe children can process only through reliving, a view shared by the majority of participants. However, there were differing views as to the best means of processing. Some participants preferred the use of sandtray and miniatures as a means for children to verbalize their story, through their sandtray play. Others used narration alone. Others used art, and still others used creative ways to enable children to tell their story through the use of toys and/or other play materials. Others believed that through the play process children could *'silently process'* with success evident by their abilities *'to move on'*. Participants who used non-directive play therapy identified this as children processing their trauma through play. However, both groups indicated that trauma processing is a very delicate process that has to be led by

children themselves, progressing at their own pace, with ultimate goals of mastery and resolution.

5.3.2.2.1 Mastery.

Mastery is a very skilled piece of work in which therapists parallel their work with children to their work with parents, so that each is in receipt of individual work that is aimed at supporting the work of the other. Through this parallel work, therapists can pair various components (attachment, trauma education, education on developmental ages/stages), so as to enable parents to support their children beyond the clinical setting. Also, as children are processing their trauma, parents (who often times are present in the play room and witness the trauma processing) are learning attunement skills and self-regulation skills (Sarina et al, 1998). They are developing a new understanding of trauma behaviour, and learning about the effects of trauma on the brain. Meanwhile, children's therapy (where children take the lead) involves the use of play for the following; narrating their trauma, re-storying for new possibilities into the future, change of cognitive distortions, gaining mastery over the trauma, moving from victim to relinquishing self-blame, receiving validation, becoming empowered, and enhancing competencies. This therapy is paired with psychoeducation on trauma, trauma brain, and trauma behaviour, all within children's developmental ability to understand the information and apply it to their own situations.

5.3.2.2.2 Resolution.

By processing their trauma experience(s) children begin moving towards adaptive resolution, whereby the trauma ceases to be debilitating (Siegel, 2009). The goal of pairing children's work with caregivers work is to support the "transference" of the gains made in therapy beyond the play room to children's life at home, at school, with their peers, and in other areas of their lives that are key to their continued positive development. The processing phase ends when children experience mastery, yet work continues into the post-processing phase. A change process identified within the mastery and resolution process was that of instilling hope for the future, which develops gradually but presents when children feel a sense of being able to move beyond the trauma.

5.3.2.3 Step 3 - Post-processing / Integration.

This step reinforces gains made in the processing phase, and serves to promote and follow-up on the transfer of gains made in therapy into day-to-day lives, at home, at school, with peers, and in normative social environments. It is within this phase that mental health growth and resiliency, which has emerged as a change process, become key factors in children taking on developmentally appropriate tasks and interests. It provides opportunity for review, repair, and correction of prior learning, and repetition as necessary. In this step, self-reports and reports from parents and teachers serve to determine if a child has been successful in transferring clinical gains into their day-to-day lives.

5.3.3 Termination phase of treatment.

This is the final stage of therapy, whereby the gains made during the treatment process are highlighted, and celebrated. It is the saying good-bye and letting go phase. At this stage of treatment change has been effected, evident by children *"moving on"*. The beginning of the termination phase is often recognized by patterns as identified by several participants. These include requests for appointments to be spaced further apart, by cancellation of appointments, missed appointments, or by requests to *'have a break from counselling'*. Participants highlighted the need to be able to identify the individual stages of treatment, and movement to subsequent stages so as to be able to recognize when children have the work completed and are ready for termination of services. In doing so, this phase is normalized and celebrated as the end of the therapeutic process.

The issue of follow-up services was identified by participants, in terms of impacts at different developmental stages, and how each stage brings with it new insights. Participants identified sequential treatment as often being required for children as they process through the various stages of development, most notably puberty, when they have new questions, concerns, or understandings of their past experiences.

5.4. Therapeutic change processes

This theme speaks to research question 3, "*What are play therapists' understandings of therapeutic change processes in which they have confidence"?* This question takes into account all of the preceding discussions on the steps involved within phases one and two of the therapeutic treatment process. It is this question that seeks to articulate therapeutic change processes as identified through data analysis.

To identify the change processes, all categories, themes, and sub-themes were further studied to find meaning within them. The therapeutic work described by participants was broken down into categories of work by children, by their parents, and by the therapists. What was found was each grouping was interwoven with the others. It became evident that work with children and the parents/caregivers has to be undertaken as a parallel, and at times interactive process, to prepare both for the treatment process and for children to be able to successfully process the trauma through to resolution. It is within these groupings and within the three overarching themes identified above, that the processes of therapeutic change were identified. Analysis of each of the themes within and throughout the treatment process identified the six therapeutic change processes. These are: fostering a renewed ability to attach, fostering a renewed ability to trust, instilling hope for the future, providing age appropriate time and pacing, for processing facing the trauma together, and promoting mental health growth and resiliency. The following is a discussion of each of these change processes.

5.4.1 Fostering a renewed ability to attach.

Complex trauma occurs within the confines of a trusting caregiver/child relationship, thus breaching children's attachment to their caregiver, and likely damaging children's ability to feel safe in any other relationship. Therefore, one of the biggest requirements within therapy is creating a positive relationship building experience that enables children to generalize this experience beyond the playroom. Accomplishment of this task is a correcting factor for children who have believed that caring people will hurt them, and is key to children benefitting from the healthy supportive relationships

available to them outside of therapy. As one participant *stated "my goal is not to create dependence – but to teach the child"*.

5.4.2 Fostering a renewed ability to trust.

Children who have lost trust in the people whose job it is to protect them, also loose trust in themselves. They second-guess themselves, their abilities, their strengths, and their hopes of being successful. They have to learn to trust not only others, but themselves. This begins with the development of a therapeutic relationship (inclusive of the many forms of safety identified earlier) and *"the planting of seeds"*. These seeds grow within children, challenging them to trust not only in their therapist, but themselves. Some acknowledged that this trust building implies that child-centred empathy is being experienced in the therapy process.

5.4.3 Instilling hope for the future.

This emerged as a therapeutic change process in that, by children recognizing their therapist's faith in them and their ability to master and resolve their traumatic experience, they are able to renew their own inner strength, and look to the future. Loss of hope robs children of this ability, evident by their shortened view of the future which is one of the symptoms of complex trauma.

5.4.4 Providing age appropriate time and pacing for processing.

Within the therapeutic process, factors (i.e. such as limited number of sessions) and pressures (i.e. court ordered counseling) align and create expectations for trauma

processing to be a time limited experience However, therapy with children who have been violated, who no longer trust, who no longer believe in themselves, requires adequate time and age-appropriate pacing compatible to that which can be tolerated by children. Any more or less carry the threat of children retreating from services. A participant who identified a child client who had previous therapy experience provided one such example. She explained

> *"in previous therapy it was quickly discovered that the child was skilled at drawing. She was encouraged to draw a series of pictures depicting her trauma, and in doing so was overwhelmed by the visuals and flooded in the process. She refused to return to therapy identifying it as a threat. When she did return to a new therapist, time and pacing were implemented to allow her to proceed as she was able, but also the elements of preparing her for processing were implemented such that when she was ready she was able to successfully process her traumatic experience".*

5.4.5 Facing the trauma together.

The importance of facing the trauma together emerged as a change process in that it was identified that therapists joining with children to support them through the processing stage of their trauma, helps to curtailed children's fears of having to face their traumatic experiences alone. According to Herman (1992), the role of therapist as bearing witness to the trauma story and holding hope for the survivor is a central part of the healing from the relational challenges implicated in the trauma. This is reinforced by mastery and resolution, both of which therapists work through with children, all the while

believing them, and ensuring they are aware of this. These processes take away secrecy, shame, and self-blame, which are all components of complex trauma, and replaces them with a sense of healing and positive potential. The therapist's ability to believe in children allows them to believe in themselves.

5.4.6 Promoting mental health growth and resiliency.

Mental health growth and resiliency emerged as change processes in that they reflect children's success in overcoming enough of their traumatic experience to be able to return to developmentally appropriate tasks. This is not to say that children are finished with therapy. It is often the case that when children enter a new developmental stage they will return to therapy for '*check-ups'*. One participant identified a client she saw as a young child, and now sees as a young adult. This client has returned often to deal with new conceptualizations of her complex trauma as she matured. She was able to successfully process these conceptualizations at each new stage of development.

The identification of these six therapeutic change processes has challenged me as a researcher and as a practitioner to consider alternate explanations for success within the therapeutic change process. In doing so, I reviewed previous and new literature on the topic of therapeutic change processes in the treatment of children who experienced complex trauma. I found there was existing and new information on treatment models being used with traumatized children (Boyd Webb, 1999; Gil, 2006, 2010, 2011; Herman, 1997; Struik, 2014; Terr, 1990, 2010), which supported the practices identified in my study. In fact the 'gold standard' for therapeutically addressing complex trauma is

phase based treatment, whereby phase I is stabilization & safety, phase II is processing, and phase III is integration (Kezelman & Stavropoulos, 2012). The three themes which evolved from this research study, mirrored this gold standard, and it was within these themes that six therapeutic change processes were identified. Identification of change processes within treatment of children with complex trauma lends towards learning what treatments work and why. The findings are supported by theory development that helps with understanding the processes that account for therapeutic change. Theory is important to help understand what is important in treatment and how it can be utilized.

5.5 Conclusion

This chapter reviewed the themes that emerged through individual and collective thematic analysis of interviews with this study's participants. Three overarching themes emerged: (1) therapeutic tools, (2) building a therapeutic foundation, and (3) working through complex trauma. Each of these themes emerged from specific phases and stages within the therapeutic process. The findings of themes being located in different stages of treatment are reflective of previous findings that identified phased models of treatment for children who have experienced trauma and complex trauma (Gil, 2011; Herman, 1997; Struik, 2014). Further analysis of these themes enabled the identification of six therapeutic change processes. These processes were: fostering a renewed ability to attach; fostering a renewed ability to trust; instilling hope for the future; age-appropriate processing time and pacing; facing the trauma together; and promoting mental health growth and resiliency.

Discussion of themes, sub-themes, and the subsequent findings of therapeutic

change processes within the framework of the research questions, brought meaning and understanding to this study. Findings concluded that therapeutic change processes do not exist in isolation, or as individual entities. They exist deep into the therapeutic process, where they are interwoven with each other, and interconnected both within and throughout the therapeutic process. Identification of these change processes required this researcher to conduct a second level of analysis, thereby going beyond the anticipated single level of analysis. Such caution and care are understandable given that the issue of complex trauma is multifaceted, as is its treatment, and therefore requires in-depth understanding even before the search for change processes can begin. Participants in this study were very well versed in the process of treatment, the treatment phases, and the steps within each phase. It is within the sharing of their practice-based experience that the processes of therapeutic change were identified.

Chapter 6: Conclusion and Recommendations

6.0 Questions Answered

Chapter 6 provides a retrospective and reflexive view of this practice relevant dissertation. It summarizes the research study and its findings, highlighting its implications and conclusions. The findings of this study represent the voices of a homogenous sample of certified play therapists with specialized training and/or experience with complex trauma, who work on the front lines of therapeutic services to some of society's most vulnerable and compromised children. These play therapists identify with the professions of social work, psychology, psychotherapy, and mental health counseling.

Within the field of social work (Doyle, 2011), and its neighbouring disciplines of psychotherapy (Kazdin, 2003), psychology (Gennaro, 2011), and play therapy (Kenney-Noziska et al. 2012), there have recently been new calls to action, to move forward with research to ask the question of 'What happens during the therapeutic process in order to produce change?' in an attempt to understand the change processes of interventions within these fields. The functional school of social work has historically made calls such as this for research related to change within the therapeutic process, specifically through the study of common factors (Cameron, 2013; Shulman, 2015a).

This study is significant in that it seeks to answer questions related to understanding therapeutic change processes specifically in treatment of children who have experienced complex trauma, in order to determine 'what works'. Meeting the therapeutic needs of children has historically been the specialty area of play therapists,

who today continue to utilize the language of play to intervene therapeutically with children (Gil 2010; Schaefer, 1976), even within todays context of an evolving definition of play (Riedel-Bowers, 2016). Within play therapy interventions there are change processes that can inform therapeutic work with children, and identification of these change processes holds promise for informing clinical social work in the treatment of children who have experienced complex trauma.

The use of play in therapy has strong historical roots, which were traced back to Anna Freud and Melanie Klein, with play therapy's first pioneer being Virginia Axline. Her publication in 1947, *Play Therapy: The Inner Dynamics of Childhood*, became a classic in the field of play therapy, and was soon followed by the work of Elaine Dorfman with her publication *Play Therapy* (1951). Correspondingly, the roots of social work were traced back to its pioneers', Mary Richmond and Jane Addams. What was discovered in tracing these historical roots was a parallel development of both professions, each having overcome challenges and divisions to their own growth, both externally and internally, which both professions were able to overcome. Therapeutic work with children and caregivers are the connecting factors between the two professions.

Clinical interventions with children have challenged some of the foremost experts since the beginning of the helping professions (Mamor, 1987). The beginning of therapy with children started with child guidance clinics, a movement shared by both professions of play therapy and social work (Dorfman, 1951; Rogers, 1951). However play therapy is the only field that has focused most exclusively on intervention with children's mental health. Play therapists have creatively used children's language, which is the language of

play, to develop developmentally appropriate interventions. This is in stark contrast to talk therapies used by other professions, which research continues to confirm to be developmentally and neurologically incongruous for children (Boyd Webb, 2011; Davies, 2011; van der Kolk, 2005) and therefore are of limited effect with children (Levine & Klein, 2007).

One of the key areas that play therapy has taken a lead role in is the treatment of complex trauma. A promising pathway for the treatment of children exposed to complex trauma lies within the active therapies, which historically have been applied within the play therapy field, yet are rarely found within traditional mental health services for children. Assessment and treatment of children who have experienced complex traumas must address symptoms, dysregulation, and impairment in the affected domains of functioning: emotional, behavioural, cognitive, somatic and relational (Briere, 2005, 2012; Cook, et al., 2003, 2007; Lanktree, et al., 2012; Schore & Schore, 2008). According to Riedel Bowers (2013), "play can be a catalyst for change and consequentially, has become a major contributor to the methods of psychotherapy for children" (p.19). This dissertation study examined practices within play therapy interventions with children within the context of complex trauma with a view to better understanding the processes of therapeutic change. The research findings supported the need for developmentally congruent interventions for children who have experienced complex trauma, and thus are not likely to benefit from talk therapy.

The study of complex trauma within the field of play therapy is evident in the many exemplary publications on the subject in *The International Journal of Play Therapy,* (Fitzgerald et al, 2012; Green & Myrick, 2014; Myrick & Green, 2014: Norton

et al, 2011; Vicario et al, 2013) and by individual play therapists who have produced major publications (Boyd Webb, 1999; Gil, 2006; Goodyear-Brown, 2010; Herman, 1997; James, 1996; Terr, 1990). Both the historic and ongoing work specific to treatment of children and trauma within the field of play therapy provided opportunity to study processes of therapeutic change in a field that is on the leading edge of developmental, age appropriate and contextually appropriate services that are child centred.

In addition to developing age and developmentally appropriate interventions, and historic and current work in the area of complex trauma, the field of play therapy has also been active in seeking to identify change processes within treatment. This is evident in publications such as *Moments of Change* (Terr, 2008), *Trauma and Recovery* (Herman, 1997), and *The Healing Power of Play* (Gil, 1991). Within such publications which are focused on healing trauma, the field of play therapy offers a fertile location to study and build upon work that is seeking to identify therapeutic change processes. This has been identified as an area in need of research (Jensen, et al., 2010; Kazdin, 2001, 2002; Kenney-Noziska, et al., 2012) to answer the question of 'what works'?

The purpose of this dissertation's naturalistic inquiry was to identify and understand therapeutic change processes with children who were exposed to complex trauma.This purpose was explored utilizing participants' extensive training experiences, practice experiences, tacit knowledge and practice wisdom, in combination with those of this researcher. The conclusions of the study flow from its findings in answering the research questions, and therefore addresses three areas: (a) the practices that play therapists found to be effective in assessment and treatment of children exposed to complex trauma, (b) the practices play therapists found to be effective in reducing the

long-term impact of complex trauma, and (c) play therapists understandings of change processes in which they have confidence. In addition to summarizing the study's findings and conclusions, this chapter reviews theory development. It also identifies limitations of the study's design, and implications of the study, followed by concluding thoughts and a final reflection by this researcher..

6.0.1 Research findings.

The following is a discussion of the major findings and conclusions drawn from this research in which the findings tell the story of the research, and the conclusions become the beginning of a new story evident in the resulting recommendations. The findings are explained through the use of three overarching themes that emerged from the data. These are: Theme 1: therapeutic tools (practices, skills, and resources), Theme 2: building the therapeutic foundation (assessment, developing safety, building relationship, and allowing children 'time', and Theme 3: working through complex trauma (using trauma specific interventions, to process the trauma in uniquely identified steps, with each step having its own specific components). Finally, it was found from analysis of the entire data set that within the treatment process there were six identified change processes: a renewed ability to attach, a renewed ability to trust, instilling hope for the future, providing age appropriate time and pacing for processing, facing the trauma together, and promoting mental health and resilience.

6.0.2 Grand tour question.

The grand tour question used to direct this research by beginning each individual interview was *'What do you consider to be the therapeutic change processes within your*

treatment of children who have experienced complex trauma?' This question guided the three supporting questions used in this study, which were used as a framework to discuss findings and conclusions. As a group, participants identified the tools they used in their work, the steps they followed specific to trauma work, how they prepared children for the therapeutic journey, and how they, as play therapists, supported children throughout the process. It is important to acknowledge the 'tools of the trade' identified by participants as a group, in order to understand the enormity of the preparation work, in terms of practices, skills, and resources, that precede intervention.

The first major finding, identified as *theme 1, therapeutic tools,* was used to identify practices, skills, and resources identified by participants. Within this theme, participants identified findings of common, diverse and unique tools and practices in their work, specifically with complex trauma. Findings encompassed not only the tools and practices that were used individually and as a group, but highlighted the extensive training, skills, expertise, and unique approaches participants brought to the use of these tools and practices (Crenshaw & Hardy, 2007). This confirms literature findings identifying that work with traumatized children is not conducive to a 'one-size-fits-all' approach. Participants highlighted multiple different forms of advanced trainings they completed (See Appendix K), highlighting the importance of advanced and ongoing education to the assessment and treatment of complex trauma, with a view to having specific forms of intervention available to meet the therapeutic needs of children. A conclusion to be drawn from this finding is that therapeutic work with complex trauma requires advanced education and training specific to the treatment needs of complex trauma. Treatment within this area is specialized and requires training specific to the

complexities of work with children who have experienced complex trauma. Based on this it is recommended that further research be undertaken to develop trauma-informed training programs specific to social work. This type of programming has been requested by clinical social workers to meet their needs as the largest single group of professionals that provide mental health services in America (Anastas, 2014; Gambrill, 2003). Such programming would advance the treatment of trauma and complex trauma by clinical social workers that work with this population, to assist with skill development, resource development, and practice development, each of which requires upfront, ongoing, and advanced levels of training. Further to this, it is highly recommended that social work programs include academic courses specific to identified groups such as traumatized children, so as to prepare students for the clinical role many will undertake within their social work practices. With adequate training programs available within their academic training, students can be better prepared for this very intensive form of therapeutic work.

6.0.2.1 Answering question 1.

What are the practices that play therapists' found to be effective in assessment and treatment of children exposed to complex trauma?

The second major finding is identified as *theme 2 – building the therapeutic foundation.* This theme addressed findings within the first phase of the treatment process and its importance as the foundation of the entire therapeutic process. Within this phase participants identified the key components to be: assessment, building safety, building relationship, and allowing children 'time'. These findings were expected and are supported in literature on the importance of therapeutic foundations, and how they are the

underlying strength of the ongoing development of the therapeutic relationship and the intervention that flows from this relationship. Literature supports development of the therapeutic relationship process as not only foundational, but imperative to the whole therapeutic process (Bath, 2008; Riedel Bowers, 2009; Webb, 2011). A conclusion that can be drawn from this finding of building the therapeutic foundation is the importance of understanding the extreme significance of intentionally and skillfully building a secure foundation to support the therapeutic process. This is a skilled strategic piece of work that has implications for the success of the entire therapeutic process. Each of the foundational components requires skillful mastery in order to successfully implement them with children who most often do not trust adults. Developing this mastery requires experience with the therapeutic process, with the selected population, experience with grief, loss, and attachment breaches, in addition to knowledge of childhood development.

However, unexpected findings of 'safety' dimensions emerged during the analysis of this theme. Safety was defined not as a single concept, but as a multifaceted concept. Many types of safety were identified as being required to work with children who have experienced complex trauma. These included: (a) physical, (b) emotional, (c) mental, (d) psychological, (e) therapeutic, and (f) relational safety. A conclusion that can be made from this finding is that safety in its many forms cannot be underestimated in terms of its importance to child clients. Clinicians who work with this population have to be aware of these many types of safety, and they require the skills to successfully implement each one. This finding has implications for future study. As a trauma-informed profession, it is recommended that social workers endeavour to take a lead role in further research in this area, so as to inform their clinical practice and future practice within the field of

trauma work.

6.0.2.2 Answering question 2.

What practices have play therapists' found to be effective in reducing the long-term impacts of complex trauma?

The third finding*, theme 3, working through complex trauma,* was identified within the middle phase of treatment, also known as the working through process. This finding identified how trauma is processed inclusive of what practices, resources, and therapeutic components are used to help the traumatized child work through the processing of their trauma. Getting to this point in treatment requires successful progression from the beginning point of treatment, inclusive of implementing the treatment components, in combination with children's readiness and willingness to proceed, and the therapist's skills to support them through the change process. Within theme 3, a three-phase process was identified inclusive of pre-processing (also known as stabilization), processing (working through), and post-processing (resolution). Within each of these phases, there are sequential steps in which participants guided the traumatized child skillfully through acknowledgement of their trauma, to processing of their trauma, then towards mastery and resolution. Literature does identify phase-based approaches to treatment (Gil, 2010, 2011; Herman, 1997), and outlines the different phases, however the detailed steps within each phase identified in this study offered a unique in-depth view of the specifics within each step. It can be concluded from this finding that the middle phase of treatment is much more that a single step. It is a single phase with multiple steps and activities that requires knowledge, expertise, confidence,

patience, tolerance by the therapist, child centred flexibility, and a fluidity of process that enables children to move back and forth between the steps at their own pace. A further and related conclusion is that the study of clinical practice is a complicated endeavour. It requires detailed analysis of the process, the therapist, their skills, experience, tacit knowledge, and expertise, and the client and the many strengths and challenges they bring to therapy. Further study of clinical practice and its individual components is highly recommended so as to inform theory, concept refinement, and practice, especially in the area of services to children.

6.0.2.3 Answering question 3.

What are play therapists' understandings of therapeutic change processes in which they have confidence?

It was within the steps in the middle phase of treatment that the third question was answered. It was found from analysis of the entire data set that within the treatment process there were six identified change processes. These were identified as follows: fostering a renewed ability to attach, fostering a renewed ability to trust, instilling hope for the future, providing age appropriate time and pacing for processing, facing the trauma together, and promoting mental health and resilience. This study has endeavoured to build on early social work foundations of process research, and in doing so identified these change processes, which are unique in that they inform practice with children, specifically trauma work. It can be concluded that these change processes represent components of treatment that may underlie the entire therapeutic process from beginning to end. Based on this, further research, specifically process research, which was a focus

of early social work but which faded into the history of the profession, is recommended to support these findings. Social work is on the leading edge of trauma informed interventions (Kimberley & Parsons, 2017; Levenson, & Grady, 2016). , and as such carries with it a responsibility to identify and support findings of effective therapeutic change processes that can inform direct social work practice.

6.1 Theory Development

Central to the naturalistic inquiry is the search for grounded theory, which follows from the data rather than preceding it (Lincoln & Guba, 1985). In this study, grounded theory evolved through analysis of each participant's understanding of therapeutic change, each of which would have remained isolated if not for the intervention of this researcher. Each interview was completed and analyzed for theoretic components, all of which were aggregated at the end of the interview process. The grounded theory that emerged explains the complexities of treating complex traumas, the components of therapeutic process and how they evolved, the back and forth flows between the phases of the treatment process, and the many factors underlying trauma processing. Thematic analysis surfaced the change factors within the treatment process and ongoing analysis demonstrated how these supported the grounded theory that evolved.

The new theory that developed from this research has proved to be congruent with the comprehensive multi-theory integrated framework utilized in this study. This transtheoretical and integrated convergence includes theories of: psychoanalysis and psychodynamics, attachment and relational theories, family systems and support systems theory, trauma theory, affect regulation theory, and theory of play, as well as life course

perspectives. The convergences also included developmental processes and the biopsychosocial perspective, the synthesis of which formed the overall conceptual framework for this study. By combining the frameworks, the association of theory and practice becomes evident, with the theory being the supporting foundation of the practice component of trauma work. By combining the emergent theory and findings from this study, the juxtaposition of theory and practice becomes significant, and transferable to the work of others, specifically social workers that provide therapeutic interventions to children exposed to complex trauma.

6.2 Contributions to social work.

Within the field of social work (Doyle, 2011), and its neighbouring disciplines of psychotherapy (Kazdin, 2003), psychology (Gennaro, 2011), and play therapy (Kenney-Noziska et al. 2012; Webb, 2011), there have recently been calls to action, to move forward with research to ask the question of 'What happens during the therapeutic process in order to produce change?' in an attempt to understand the dynamics of change processes within these fields. Yet, very few doctoral dissertations in social work specifically address practice or service delivery issues (Anastas & Videka, 2012). However service delivery processes became my intention as I wished to focus on practice concerns faced by professional social workers, with a view to enhancing practice knowledge in the field of children's mental health services, where services are provided to children, identified as society's most vulnerable, most oppressed, and least powerful population, (Devine & Kimberley, 2012). This study specifically explores play therapy concepts, theories and practices with children exposed to complex traumas and its related sequelae, in an effort to inform the clinical interventions of social workers who work on a

daily basis with this high risk population. The study's findings highlights the need for skill and creativity in dealing with human relations, most notably with our most challenging clients, children, a silent population that depends on the voices of others in order to receive support and services. In doing so, social workers must feel empowered to use their creativity and spontaneity to take chances, and follow client leads (Gitterman, 2015), and therefore move beyond the 'one-size-fits-all' approach to service programs.

Historically social workers have been involved in issues specific to children, beginning with concerns about children's protection and their mental health, as evidenced by the work of the profession's earliest pioneers and leaders, Jane Addams and Mary Richmond (Addams, 1917; Richmond, 1917). Social workers have thus dealt with the impact of child maltreatment, and in doing so have also been committed to the disciplined and creative development and use of knowledge (Gitterman, 2015) focused on the treatment of children and their families. Social workers have also focused attention on the victims and survivors of abuse, inclusive of trauma and complex trauma and its sequelae, and in doing so had established its identity as a trauma-informed profession (Gitterman, 2015; Kimberley & Parsons, 2017).

Within the social work profession the demand by social workers is increasing for knowledge of trauma and effective interventions to provide help in ways that are currently less known or unrecognized (Stephen & Murphy, 2014). My study on the application of play therapy within the context of complex trauma is poised to increase professional awareness of complex trauma in children and adolescents as recommended by Cook et al, (2003), its treatment protocols and the therapeutic change processes associated with play therapy which can guide interventions specific to the needs of

children and youth. Identifying change processes holds promise for informing the practice of clinical social work with children.

My study is grounded in practice research, and informed by clinical experiences. It privileges the knowledge and practice experiences of therapists who have specialized within the field of children's therapy, specifically in the area of complex trauma, and highlights the benefits of such attention and specialization. The study's findings of therapeutic change processes will contribute to the broader social work literature in the field of children's mental health as expressed in the wishes of those on the front lines of social work.

My study is poised to make a significant contribution to the field of children's mental health services where, as outlined in Chapter 1,talk therapy has been found to be less effective than active play based treatment, and one-size-fits all approaches have not met the needs of children and youth. This study's findings hold promise for informing social workers of the challenges of intervention with traumatized children, their treatment needs, and their age/stage developmental needs. By recognizing these challenges and needs, social workers can utilize the strengths of their child clients to move towards successful processing, healing, and recovery from their trauma experiences. Findings from this study can be used to advocate for the development of practice protocols to guide assessments in children's mental health services for early identification of complex trauma. Such protocols could lead to recognition of the need for early age/stage appropriate intervention and treatment, and recognize the need for longer terms of treatment than other mental health issues. At the same time such protocols must have

built in flexibility so that unique and diverse needs of children may be addressed in child-centred and context-relevant actions.

This study's findings support the need for children's therapy that is age, stage, and developmentally appropriate. Such therapy requires adequate time and pacing, utilizing approaches that adhere to children's needs and rights as are embedded in a child's rights approach. It is recognized that this falls outside the widely accepted bureaucratic processes of cost restraint, which has an underlying approach of minimal services and care, as opposed to optimal services and support (Devine & Kimberley, 2012). However, as indicated by a repeated concern expressed by participants in this study,' there is great cost to not getting this right', thus sounding an alarm bell to policy makers and service providers.

6.3 Limitations of the study

All research inherently has limitations that have to be acknowledged and discussed. This study is no exception. Such limitations are to be taken into account in terms of the study's findings, and transfer of these findings to similar contexts and needs. One perceived limitation of the study may be its full reliance on qualitative methods as a key criticism of qualitative inquiry is its focus on subjectivity. However, subjectivity allowed for the ontological assumption of multiple realities, which informed my research. Also, qualitative inquiry does not allow for broad generalization from the participants in the study (a relatively small number) to the general population. However, use of thick description coupled with the layered meanings attached by the play therapy experts, assists readers to draw conclusions for themselves as to the applicability of the results to their client's lives as lived, their situations, and their contexts.

Another limitation of the study's design relates to the subjectivity of the data. This design focuses on data obtained from in depth interviewing with participants, which is based on subjective interpretations of the questions. Participants answered questions based on their own practice experiences. However, their subjectivity was informed by a combination of their education, experience, ongoing training, and tacit knowledge, in combination with the education, experience, ongoing training, and tacit knowledge of the researcher. This, in addition to their common, unique, and diverse perspectives served to provid a very fertile ground from which to draw both questions and answers to the research questions, thus assuring increased confidence in the study's findings.

Another concern is that when participants self-select to participate, as was evident through the study's web-blast method, it is difficult to know why they chose to participate, as there can be any number of reasons, not all of which directly relate to the study. However, the design of this study incorporated privacy of participants and responses and therefore participants did not obtain any recognition or distinction for their participation.

Finally, even though careful measures were taken to remove identifying information from the data, total anonymity can never be guaranteed, especially when the data is aggregated following each interview. Knowing this, some participants may have limited the information they were willing to share in order to protect their confidentiality within their own professional community.

6.4 Practice implications

A social work practice paradigm is defined as "the commonality of perspective which binds the group of practitioners together in such a way that they may be regarded

as operating within the same broad world view" (Kuhn 1970 as cited in Sheppard, 2006, p. 239). Such a paradigm is contingent on shared learning through research findings, which has implications for current and future social work practice. In this study I have described and analyzed theoretical frameworks, key concepts, and key practice activities identified by certified play therapists addressing the needs of children within the confines of complex trauma. This knowledge can be used to inform social work practice with children and youth who have experienced trauma.

This study's findings will contribute to the broader social work literature in the areas of children's mental health, complex trauma, play and play therapy, and most significantly therapeutic change processes in therapy with children who have experienced complex trauma. My study is grounded in practice research, informed by clinical experiences. It privileges the knowledge, practice experiences, and tacit knowledge of therapists, who have specialized within the field of children's therapy, and in doing so, highlights the benefits of such specialization. Little attention has been given to the voice of practitioners within children's services. In fact, many practice models utilized with children have been adapted from adult models of services.

My study is poised to make a significant contribution to the field of children's mental health services. The need exists within the field of social work for the development of practice protocols to guide assessments in children's mental health services for early identification of complex trauma. Future research is required in this area. However, this study provides a solid foundation to support protocol development as it highlights the effectiveness of practices found to be effective in reducing the long-term impact of complex trauma. Such protocols could lead to policy development for early

intervention and treatment, and recognition of the need for such clients to avail of age and developmentally appropriate interventions for children, as well as longer time frames for efficacious child-centred treatment of complex trauma than those implemented for other mental health issues.

Clinicians are continuously seeking specialized skills and techniques to work with traumatized children in ways that are sensitive to both the unique needs of the issue and the diverse developmental needs of children (Drewes, 2009; Stephen & Murphy, 2013; Webb, 2011). This study provides evidence of the expertise of the participants in the provision of therapeutic interventions to children. In doing so, it highlights the practice needs and training requirements of clinicians in the field of children's mental health, specifically complex trauma, for age and developmentally appropriate interventions. Training in these areas can lead towards the development of expertise in trauma work, especially in social work, which identifies as a trauma-informed profession (Kimberley & Parsons, 2017).

6.5 Concluding thoughts

One of the last and longest denials by our society, which is still being challenged, is the lack of realization about the extent of complex trauma. Failure to acknowledge the reality of complex trauma in the lives of children and thus the long-term impact this can have in their lives first as children and later as adults is indicative of significant clinical deficits in the current mental health approaches. Presently, only about 20% of Canadian children diagnosed with a mental disorder ever receive care within our current mental health system, (Schwean & Rodger, 2013). Attention is required to the need for increased

services for children and youth within the mental health system as well as prioritization of services such that they are provided to the highest risk, highest need children, inclusive of children who have experienced complex trauma, who are arguably the highest risk children, who often develop into high risk adults. By providing age-informed and trauma-informed specialized clinical interventions, in a timely and sequential manner, the risk of these children growing up to repeatedly present as adults for mental health services, inclusive of addictions, will be reduced (Devine & Kimberley, 2012). In other words, the provision of child-centred and developmentally congruent trauma informed care to traumatized children is in fact an investment in their future, and the future of mental health services.

Many children experience complex trauma putting them at risk for serious psychological and behavioural consequences. Therefore, understanding the effects of this type of trauma is essential. The aim of my study was to contribute to childhood trauma treatment and intervention by focusing on practices, interventions and change processes identified within a select sample of professional child therapists and their work with children exposed to complex trauma. In doing so, this study serves as a significant step in bridging a huge gap between research and practice in the area of therapeutic services to traumatized children, and therefore by extension the gap between research and practice within social work, which has been a long-standing challenge within the profession, as well as within other professions.

The overall purpose of this study has been to gain a greater understanding of interventions used by child therapists, which could inform social work practice. Social workers have called for this type of research to support their clinical interventions with

traumatized children. A recent article in Clinical Social Work Journal (2015) by Knight focuses attention on trauma-informed practice in social work and positions social work as a trauma informed profession. A forthcoming chapter for a social work text, *Social Work Treatment: Sixth Edition,* co-authored by this researcher (Kimberley & Parsons, 2017), positions social work as a trauma-informed profession, specifically with children who have experienced trauma, highlighting the benefits of early intervention and treatment, which respects the complexities of the clients' lives as lived.

The findings of my study uncover the multiple practices, skills and resources developed and utilized for therapeutic work with children. Findings highlight the strategic components of the therapeutic foundation, inclusive of assessment, building safety, building relationship, and allowing children 'time'. In doing so it uncovered the many-layered safety and security requirements of traumatized children. It also identified, analyzed, and synthesized the many steps required for a child to actively work through their trauma towards mastery. These included practices, resources, and therapeutic components used to help the traumatized child work through the processing of their trauma. Finally, the study identified six change processes. These are as follows: fostering a renewed ability to attach, fostering a renewed ability to trust, instilling hope for the future, providing age appropriate time and pacing for processing, facing the trauma together, and promoting mental health and resilience. Together these findings contribute to the development of refined theory that encompasses therapeutic work with complex trauma.

Together these findings, although not conclusive, provide a foundation for further study of change process research, to form a basis from which to enhance current practices

with children exposed to complex trauma. This is an area in which clinical social workers have crucial roles, not only in identifying the trauma, but also in the provision of effective, age, stage, and developmentally appropriate trauma-informed therapeutic interventions directly to children affected to ameliorate the effects to their trauma, and the associated sequelae. Therefore, the findings of this research may be judiciously transferable to child and youth mental health services, policies, programs and practices. However, the need exists for continued research of change processes. The culmination of both the research findings and literature review has provided a greater understanding of the change processes within therapeutic interventions with trauma and within child-centred supports. However, continued research is required into both therapeutic change processes and therapeutic practice processes as is evident in the calls within the field of social work. I would recommend the use of the naturalistic inquiry method for such research as it privileges the voices, training, and experiences, inclusive of the tacit, explicit, and propositional knowledge, of those on the front lines of services to children. The transparency provided in this study can serve as an effective base for future researchers to undertake scholarly study in areas as recommended above. It can also assist in framing other qualitative studies aimed at further study of change processes within the field of children's mental health.

6.6 Final reflections

I complete my scholarship journey with a sense of great personal accomplishment, and a heightened sense of pride in my profession. The journey has been enlightening, encouraging, and meaningful. My findings have been informative in that

they have brought a new understanding to the complexities of therapeutic work with children. They confirm that despite the progress of those who came before us, the journey never really ends, and the search for scholarship to inform practice is a continuous and ongoing need. With every step forward, there exist more steps ahead in the quest for both the creation of new knowledge and the reorganization of existing knowledge. Social work has a long history of taking on the bigger challenges of breaking new ground, and I feel that my dissertation findings can, in a small but effective way, serve as breaking new ground to move forward with the building of even stronger services to children and youth. My journey has been both a privilege and an honour on both a professional and a personal level.

References

Addams, J. (1905). *Children in American street trades.* New York, NY: National Child Labour Committee.

Addams, J. (1912). *A new conscience and an ancient evil*. New York, NY: Macmillan. Retrieved from http://www.gutenberg.org/files/15221/15221-h/15221-h.htm

Afuape, T. (2011). *Power, resilience and liberation in therapy with survivors of trauma.* London, England: Routledge.

Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation.* Hillsdale, NJ: Erlbaum.

Al-Krenawi, A. & Kimberley, D. (2014). Palestinian youth and their families: Paradoxes of resilience in the cultural and sociopolitical context of conflict, stress, and trauma in the Middle East. *International Journal of Child Health Human Development*. 7(2). 101-112.

Allan, J. (1997). Jungian play psychotherapy. In K. O'Connor & L. Mages (Eds.), *Play therapy theory and practice: A comparative presentation* (pp. 100 -130). Hoboken, NJ: Wiley & Sons.

Allnock, D. & Hynes, P. (2012) *Therapeutic services for sexually abused children and young people: scoping the evidence base: summary report*. London, England: NSPCC

Alvarez, A., Pagani, M., Meucci, P. (2012). The clinical application of the biopsychosocial model in mental health: a research critique. *American Journal of Physical Medicine and Rehabilitation.* 91(suppl): S173Y -180. doi:10.1097/PHM.0b013e31823d54be

American Psychiatric Association. (1980). *Diagnostic and Statistical Manual of Mental Disorders* (3th ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (2000). *Desk Reference to the Diagnostic Criteria from DSM-IV-TR*. Arlington, VA: Author.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.). Washington, DC: Author.

Anastas, J. (2014). The science of social work and its relationship to social work practice. *Research on Social Work Practice.* 24(5), 571- 580. doi:10.1177/1049731513511335

Anastas, J., & Videka, L. (2012). Does social work need a practice doctorate? Cl*inical Social Work Journal.* 40, 268-276. doi:10.1007/s10615-012-0392-3

Andreae, D. (2011). General systems theory: Contributions to social work theory and practice. In F. Turner (Ed.), *Social Work Treatment* (pp. 242-254). New York, NY: Oxford University Press.

Applegate, J. & Shapiro, J. (2005). *Neurobiology for clinical social work. Theory and practice.* New York, NY: Norton.

Armstrong, L. (1978). *Kiss daddy goodnight: A speak-out on Incest.* New York, NY: Pocket Books.

Association for Play Therapy. (2016) Research & practice: Evidence-based practice statement: Play therapy. Retrieved from https://c.ymcdn.com/sites/a4pt.siteym.com/resource/resmgr/About_APT/APT_Evidence_Based_Statement.pdf

Athens, L. (2010). Naturalistic inquiry in theory and practice. *Journal of Contemporary Ethnography,* 39(1), 87-125. doi:10.1177/0891241609343663

Axline, V. (1947). *Play therapy*. New York, NY: Ballantine.

Axline, V. (1967). *Dibbs - In search of self*. New York, NY: Ballantine.

Baker, K. & Brandell, J. (2012). Special issue: Child and adolescent psychotherapy and psychoanalysis. *Psychoanalytic Social Work,* 19(1-2), 1-5. doi:10.1080/15228878.2012.666475

Baggerley, J. & Bratton, S. (2010). Building a firm foundation in play therapy research: Response to Phillips. *International Journal of Play Therapy,* 19(1), 26-38. doi:10.1037/a0018310

Baggerly, J., & Exum, H. (2008). Counseling children after natural disasters: Guidance for family therapists. *American Journal of Family Therapy*, 36, 79–93. doi:10.1080/01926180601057598

Bailey, P. (1918). War neurosis, shell shock, and nervousness in soldiers. *Journal of the American Medical Association*. 71(26), 2148-2153.

Barnes, M. (1996). *The healing path with children. An exploration for parents and professionals.* Ottawa, Canada: Victoria, Fermoyle & Berrigan .

Barth, F. (2014). *Integrative clinical social work practice. A contemporary perspective*. New York, NY: Springer.

Barrett-Lennard, G. (2007). *Carl Rogers' helping system: Journey and substance*. Thousand Oaks, CA: Sage.

Bath, H. (2008). The three pillars of trauma-informed care. *Reclaiming Children and Youth*. 17(3), 17-21.

Bebbington, P., Jonas, S., Kuipers, E., King, M., Cooper, C., Brugha, T. … & Jenkins, R. (2011). Childhood sexual abuse and psychosis: data from a cross-sectional national psychiatric survey in England. *The British Journal of Psychiatry.* 199(1), 29-37. doi:10.1192/bjp.bp.110.083642

Bell, C. (2006). Exposure to a traumatic event does not automatically put a person on a path to develop PTSD: The importance of protective factors to promote resiliency (Abstract). *Gift from within – PTSD resources for survivors and caregivers.* Retrieved from http://giftfromwithin.com/html/promote.html

Bengston, V. & Allen, K. (1993). The life course perspective applied to families over time. In P. Boss, W. Doherty, R. LaRossa, W. Schumm, & S. Steinmetz (Eds.), *Sourcebook of family theories and methods: A contextual approach.* (pp. 469-499). New York, NY: Plenum.

Bennett, S. & Nelson, J. (2011). Adult attachment in clinical social work: practice, research and policy. New York, NY: Springer.

Bettmann, J. E. & Jasperson, R.A.. Attachment research: contributions of social workers. In S. Bennett & J. Nelson (Eds.). Adult attachment in clinical social work: practice, research and policy. (pp. 217-254). New York, NY: Springer.

Bhatti, J. (2006). *Child therapy and non-directive play*. Florida. Taylor and Francis Group.

Blatt, S., & Auerbach, J. (2003). Psychodynamic measures of therapeutic change. *Psychoanalytic Inquiry: A Topical Journal for Mental Health Professionals*, 23(2), 268-307. doi:10.1080/07351692309349034

Blaustein, M., & Kinniburgh, K. (2007). Providing the family as a secure base for therapy with children and adolescents. DCP Briefing Paper No. 26. *Attachment Theory into Practice.* Section 3. Leicester, England: The British Psychological Society.

Bloom, S. (1999). Trauma theory abbreviated. *Final action plan: A coordinated community-based response to family violence*. Washington, DC: Attorney General of Pennsylvania's Family Violence Task Force.

Bloomberg, L., & Volpe, M. (2008). *Completing your qualitative dissertation. A roadmap from beginning to end*. Thousand Oaks, CA: Sage.

Bombay, A., Matheson, K., & Anisman, H. (2009). Intergenerational trauma: Convergence of multiple processes among first nations peoples in Canada. *Journal of Aboriginal Health, 5*(3), 6-47. Retrieved from http://search.proquest.com/docview/1138545041?accountid=12378

Booth, P., & Jernberg, A. (2010). *Theraplay: Helping parents and children build better relationships through attachment based play*. San Francisco, CA: Wiley.

Bowen, M. (1978). *Family therapy in clinical practice*. Lanham, Maryland: Jason Rowman & Littlefield.

Bowen, G. (2008). Naturalistic inquiry and the saturation concept: a research note. *Qualitative Research*. 8(1), 137-152. doi:10.1177/1468794107085301

Bowlby, J. (1969). *Attachment & loss, Vol. 1: Attachment*. New York, NY. Basic Books.

Boyatzis, R. (1998). *Transforming qualitative information*. *Thematic analysis and code development.* Thousand Oaks, CA: Sage.

Boyd Webb, N. (1999). *Play therapy with children in crisis. Individual, group, and family treatment*. New York, NY: Guilford.

Boyd Webb, N. (Ed.). (2006). *Working with traumatized youth in child welfare.* New York, NY: Guilford.

Boyd Webb, N. (2011). *Social work practice with children.* (3rd ed.). New York, NY: Guilford.

Brady, M. (2015). Cultural considerations in play therapy with Aboriginal children in Canada. *First Peoples Child & Family Review*, 10(2).

Bransford, C. & Bakken, T. (2002). The evolution of mental health care policy and the implications for social work. *Social Work in Mental Health*. 1(1), 3-26. doi:10.1300/J200v01n01_02

Bratton, S., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology, Research and Practice*. 36 (4), 376-390. doi:10.1037/0735-7028.36.4.376.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*. 3, 77-101. doi:10.1191/1478088706qp063oa

Breggin P. (2014). The rights of parents and children in regard to children receiving psychiatric diagnosis and drugs. In *Children & Society.* 28, 231–241. doi:10.1111/chso.12049

Breggin P. (2008). *Brain-disabling treatments in psychiatry*, (2nd ed.). New York, NY: Springer.

Breidenstine, A., Bailey, L., Zeanah, C., & Larrieu, J. (2011). Attachment and trauma in early childhood: A review. *Journal of Child & Adolescent Trauma*, 4(4), 274-290. doi:10.1080/19361521.2011.609155

Briere, J. & Scott, C. (2015). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment.* (2nd ed.). Thousands Oaks, CA: Sage.

Brisch, K. (2012). *Treating attachment disorders: From theory to therapy.* (2nd ed.). New York, NY: Guilford.

Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental Psychology*. 28(5), 759-775. doi:10.1037/0012-1649.28.5.759

Briere, J. (1989). *Therapy for adults molested as children: Beyond survival*. New York, NY: Springer.

Briere, J. & Lanktree, C. (2012). *Treating complex trauma in adolescents and young adults.* Thousand Oaks, CA: Sage.

Briere J. & Spinazzola, J. (2005). Phenomenology and psychological assessment of complex posttraumatic states. *Journal of Traumatic Stress.* 18, 401-412. doi:10.1002/jts.20048

Brom, D., Pat-Horenczyk, R., & Ford, J. (2009). *Treating traumatized children. Risk, resilience and recovery*. New York, NY: Routledge.

Brown, J. (1999). Bowen family systems and practice. Illustration and critique. *Australian and New Zealand Journal of Family Therapy (ANZJFT).* 20(2), 94-103. Retrieved from http://www.thefsi.com.au/wp-content/uploads/2014/01/Bowen-Family-Systems-Theory-and-Practice_Illustration-and-Critique.pdf

Bundy-Myrow, S., & Booth, P. (2009). Theraplay: Supporting attachment relationships. In K. O'Connor & L. Braverman (Eds.). *Play therapy theory and practice,* (pp.315-366). Hoboken, NJ: Wiley.

Burstow, B. (2003). Toward a radical understanding of trauma and trauma work. *Violence Against Women.* 9(11), 1293–1317. doi:10.1177/1077801203255555

Bussey, M., & Wise, B., (2007). *Trauma transformed. An empowerment response.* New York, NY: Columbia University Press.

Cameron, M. (2013). This is common factors. *Clinical Social Work Journal,* 42(2), 151-160. doi:10.1007/s10615-013-0467-9

Carroll, F. (2009). Gestalt play therapy. In K. O'Connor & L. Braverman (Eds.). *Play therapy theory and practice* (pp. 283- 314). Hoboken, NJ: Wiley.

Carroll, J. (2000). Evaluation of therapeutic play: A challenge for research. *Child and Family Social Work*. 5(1), 11-22. doi:10.1046/j.1365-2206.2000.00136.x

Carpenter, D. (2011). Constructivism: A conceptual framework for social work treatment. In F. Turner (Ed.), *Social work treatment,* (pp. 117-133). New York, NY: Oxford University Press.

CASW (2017). Canadian Association of Social Work website. http://www.casw-acts.ca/en/Code-of-Ethics

Cattanach, A. (2009). Narrative approaches: Helping children tell stories. In A. Drewe (Ed.), *Blending play therapy with cognitive behavioral therapy* (pp. 423-448). Hoboken, NJ: Wiley.

Charmaz, K. (2000). Grounded Theory: Objectivist and Constructivist Methods. In Denzin, N. & Lincoln, Y. (Eds.), *Handbook of Qualitative Research, 2nd edition* (pp.509-535). Thousand Oaks, Ca., Sage.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London. Sage Publications.

Chu, A. & Lieberman, A. (2010). Clinical implications of traumatic stress from birth to age five. *The Annual Review of Clinical Psychology*. 6: 469-94. doi:10.1146/annurev.clinpsy.121208.131204

Chubinsky, P., & Hojman, H. (2013). Psychodynamic perspectives on psychotropic medications for children and adolescents. *Child Adolescent Psychiatric Clinics of North America.* 22(2), 351–366. doi:10.1016/j.chc.2012.12.004

Coates, D. (2013). Impact of childhood abuse: Biosocial pathways through which adult mental health is compromised. *Australian Social Work*. 63(4), 391-403. doi:10.1080/0312407X.2010.508533

Cocoran, J., & Walsh, J. (2009). *Mental health in social work. A casebook on diagnosis and strengths-based assessment*. Boston, MA: Pearson/ Allyn & Bacon.

Corbin, J., & Strauss, A. (2008) *Basics of Qualitative Research. Techniques and procedures for developing grounded theory*. California. Sage Publications Inc.

Cloitre, M., Courtois, C., Charuvastra, A., Carapezza, R., Stolbach, B., & Green, B. (2011). Treatment of complex PTSD: Results of the ISTSS expert clinician survey on best practices. *Journal of Traumatic Stress*, *24*(6), 615–627. doi:10.1002/jts.20697

Cloitre, M., Stolbach, B., Herman, J., van der Kolk, B., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of Traumatic Stress*, *22*(5), 399–408. doi:10.1002/jts

Cohen, J. (2005). Treating traumatized children: Current status and future directions. *Journal of Trauma and Dissociation*. 6(2), 109-121. doi:10.1300/J229v06n02_10

Cohen, C., & Naimark, H. (1991). United nations convention on the rights of the child. *The American Psychologist, 46*(1), 60.

Cohen, J., Mannarino, A., & Anthony, P. (2010). Psychotherapeutic options for traumatized children. Current opinions. *Pediatrics.* 22(5), 605-609. doi:10.1097/MOP.0b013e32833e14a2

Collin-Vézina, D., Coleman, K., Milne, L., Sell, J., & Daigneault, I. (2011) Trauma Experiences, Maltreatment-Related Impairments, and Resilience Among Child Welfare Youth in Residential Care. *International Journal of Mental Health and Addiction*. 9, 577–589. doi10.1007/s11469-011-9323-8

Cook, A., Blaustein, M., Spinazzola, J., & van der Kolk, B. (Eds.) (2003). Complex trauma in children and adolescents. *White Paper from the National Child Traumatic Stress Network Complex Trauma Task Force*. Retrieved from http://www.nctsn.org/sites/default/files/assets/pdfs/ComplexTrauma_All.pdf

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M. … van der Kolk, (2005). Complex trauma in children and adolescents. *Psychiatric Annals*, 35 (5), 390-398. Retrieved from https://nursebuddha.files.wordpress.com/2011/12/complex-trauma-in-children.pdf

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Sprague, C., … & van der Kolk, B. (2007). Complex trauma in children and adolescents. *Focal Point.* 21(1), 4-8. Retrieved from http://www.traumacenter.org/products/pdf_files/Complex_Child_Trauma.pdf

Cosentino, C., & Collins, M. (1996). Sexual abuse of children: Prevalence, effects, and treatment. *Annals of the New York Academy of Sciences*. 789(1), 45–66. doi:10.1111/j.1749-6632.1996.tb55636.x

Courtois, C. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, Research, Practice, and Training*. 41(4), 412- 425. doi:10.1037/0033-3204.41.4.412

Courtois, C. (2008). Complex trauma, complex reactions: Assessment and treatment. *Psychological Trauma Theory, Research, Practice and Policy*. S(1), 86–100. doi:10.1037/0033-3204.41.4.412

Courtois, C., & Ford, J. (2009). *Treating complex traumatic stress disorders. An evidence-based guide.* New York, NY: Guilford.

Crenshaw, D., & Hardy, K. (2007). The Crucial Role of Empathy in Breaking the Silence of Traumatized Children in Play Therapy. *International Journal of Play Therapy*. 16(2), 160–175.

Crenshaw, D., & Kenny-Noziska, S. (2014). Therapeutic presence in play therapy. *International Journal of Play Therapy*. 23(1), 31–43.

Creswell, J. (2009). *Qualitative inquiry and research design: Choosing among five traditions.* (2nd ed.). Thousand Oaks, CA: Sage.

Crimson, M. & Aggo, T. (2009). The use of psychotropic medication for children in foster care. *Child Welfare*. 88(1), 71-100. Retrieved from http://search.proquest.com/docview/213808574?accountid=12378

Crisci, G., Lay, M., & Lowenstein, L. (2009). *Paper Dolls and Paper Airplanes Therapeutic Exercises for Sexually Traumatized Children*. Toronto, Monarch Books of Canada.

Crosson-Tower, C. (2015). *Understanding child abuse and neglect.* (9th ed.). Upper Saddle River, N.J.: Pearson.

Cunningham, J. & Booth, R. (2008). Practice with children and their families: A specialty of clinical social work. *Child and Adolescent Social Work Journal.* 25(5), 347-365. doi:10.1007/s10560-008-0133-1

Dass-Brailsford, P., & Myrick, A. (2010). Psychological trauma and substance abuse: The need for an integrated approach. *Trauma, Violence, and Abuse*. 11(4), 202-213. doi:10.1177/1524838010381252

Davies, D. (2011). *Child development. A practitioner's guide,* (3rd ed.). New York, NY: Guilford.

Devine, M., & Kimberley, D. (2012). Failures in children's protection in Newfoundland and Labrador: From the Hughes (1991) to Markesteyn and Day (2006) inquiries and beyond. *Canadian Public Policy*, 38(1), 55-70. doi: https://doi.org/10.1353/cpp.2012.0001

Davis, N. (1990). *Therapeutic stories that teach and heal.* Burke, VA: Nancy Davis.

Demause, L. (1974). *The history of childhood*. New York, NY: Psychohistory Press.

Denzin, N., & Lincoln, Y. (2000). Introduction: The discipline and practice of qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.*). Handbook of qualitative research* (2nd ed.). (pp.1-28). Thousand Oaks, CA: Sage.

Donaldson, G. (1996). Between practice and theory: Melanie Klein, Anna Freud and the development of child analysis. *Journal of the History of the Behavioral Sciences.* 32(2), 160-176.

Dorfman, E. (1951). Play therapy. In C. Rogers (Ed.), *Client-centered therapy. Its current practice, implications, and theory.* (pp. 235-278). Boston, MA: Houghton Mifflin.

Doyle, A. (2011). History of research on process relevant to clinical social work. *Clinical Social Work Journal*, 39(1), 68-78. doi:10.1007/s10615-010-0296-z

Drewes, A. (2009). *Blending play therapy with cognitive behavioral therapy. Evidence-based and other effective treatments and techniques*. Hoboken, New Jersey: Wiley & Sons.

Dunlap, K. (2011). Functional theory and social work practice. In Turner (Ed.), *Social work treatment. Interlocking theoretical approaches,* (5th ed.). (pp. 225-241). New York, NY: Oxford University Press.

Edgar-Bailey, M. & Kress, V. (2010). Resolving child and adolescent traumatic grief: Techniques and interventions. *Journal of Creativity in Mental Health.* 5(2), 158-176. doi:10.1080/15401383.2010.485090

Erikson, E. (1963). *Childhood and society.* London, SW: Norton.

Erikson, E. (1976). Play and cure. In Schaefer (Ed.), *Therapeutic use of child's play.* (pp. 475-486). New York, NY: Aronson.

Erlandson, D., Harris, E., Skipper, B., & Allen, S. (1993). *Doing naturalistic inquiry*. *A guide to methods*. Newbury Park, CA: Sage.

Eth, S. & Pynoos, R. (Eds.). (1985). *Post-traumatic stress disorder in children.* Washington, DC. American Psychiatric Press.

Fairbank, J. (2008). The epidemiology of trauma and trauma related disorders in children and youth. *PTSD Quarterly.* 19(1), 1-3.

Farrugia, P., Mills, K., Barrett, E., Back, S., Teesson, M., Baker, A., … Brady, K. (2011). Childhood trauma among individuals with co-morbid substance use and post-traumatic stress disorder. *Mental Health and Substance Use*, 4(4), 314–326. doi:10.1080/17523281.2011.598462

Felitti, V., Anda, R., Nordenberg, D., Williamson D., Spitz A., Edwards, V. … Marks J. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*. 14(4), 245–258. doi:10.1016/S0749-3797(98)00017-8

Figley, C. (1985). *Trauma and its wake. Vol.1. The Study and treatment of post-traumatic stress disorder.* Bristol, PA: Brunner/Mazel.

Finkelhor, D., Ormrod, R., & Turner, H. (2009). The developmental epidemiology of childhood victimization. *Journal of Interpersonal Violence*. 24(5), 711-731. doi:10.1177/0886260508317185

Findling, J., Bratton, S., & Henson, R. (2006). Development of the trauma play scale: An observation-based assessment of the impact of trauma on the play therapy behaviors of young children. *International Journal of Play Therapy*. 15(1), 7-36.

Fitzgerald, K., Henriksen, R., & Garza, Y. (2012). Perceptions of counselors regarding the effectiveness of interventions for traumatized children. *International Journal of Play Therapy*. 21(1), 45-56. doi:10.1037/a0026737

Flexner, A. (1915). Is social work a profession? Research on social work practice, 11(2), 152-165. In *Proceedings of the National Conference of Charities and Corrections.* Baltimore, Maryland.

Ford, J. & Cloitre, M. (2009). Best practices in psychotherapy for children and adolescents. In C.A. Courtois & J.D. Ford (Eds.), *Treating complex traumatic stress disorders; An evidence-based approach* (pp. 59-81). New York, NY: Guilford.

Fonagy, P., Target, M., Cottrell, D., Phillips, J., & Kurtz, Z. (2002). *What works for whom? A critical review of Treatments for children and adolescents*. New York, NY: Guilford.

Fonagy, P., Cottrell, D., Phillips, J., Bevington, D., Glaser, D., & Allison, E. (2015). *What works for whom? (2nd ed.). A critical review of treatments for children and adolescents*. New York, NY: Guilford.

Franklin, D. (1986). Mary Richmond and Jane Addams: From moral certainty to rational inquiry in social work practice. *Social Service Review*. downloaded from 134.153.184.170 on 11 May 2016 21:44:21 UTCAll.

Freud, A. (1991). A psychoanalyst's view of sexual abuse by parents. In P. Marzek & C. Kempt (Eds.). *Sexually abused children and their families* (p. 33-34). Elmsford, NY: Pergamon Press.

Freud, A. (1937). *The Ego and the Mechanisms of Defence*. Leonard and Virginia Woolf at the Hogarth Press, and the Institute of Psycho-analysis. University of Michigan.

Freud, A. (1976). The role of transference in the analysis of children. In Schaefer (Ed.), *Therapeutic use of child's play.* (pp.141-150). New York, NY: Aronson.

Freud, S. (1896). *The etiology of hysteria.* Retrieved from http://courses.washington.edu/freudlit/Hysteria.Notes.html

Freud, S. (1909). *Analysis of a phobia of a five year old boy*. In The Pelican Freud Library (1977), Vol. 8, Case Histories 1, (pp. 169-306).

Freud, S. (1965). *New introductory lectures on psychoanalysis.* (J. Strachey, Trans. & Ed.), New York, NY: Norton.

Freud, S. (1953). The analysis of a phobia in a five year old boy. *Collected Papers,* Vol. 3. (pp.147-289). London: Hogarth.

Fusch, P., & Ness, L. (2015). Are We There Yet? Data Saturation in Qualitative Research. *The Qualitative Report.* 20 (9), 1408-1416.

Gallager, M., Leavitt, K., & Kimmel, H. (2010). Mental health treatment of cumulatively / repetitively traumatized children. *Smith College Studies in Social Work*. 65(3), 205-237. doi:10.1080/00377319509517436

Gallegos, R., & Hillbrand, M. (2016). Integrative Treatment of Complex Trauma: Integrating Behavioral, Dynamic, and Attribution Models. *Journal of Psychotherapy Integration*. 26(3), 259–272.

Gambrill, E. (2003). Evidence-based practice: Implications for knowledge development and use in social work. In A. Rosen & E. Proctor (Eds.). *Developing practice guidelines for social work intervention*. (pp. 37-58). New York, NY: Columbia University Press.

Gennaro, A. (2011). The building of models as pathways to understand the therapeutic process. *Integrative Psychological and Behavioral Science*. 45(3), 355-365. doi:10.1007/s12124-011-9181-8

Germain, C., & Gidderman, A. (1996). *The life model of social work practice: Advances in theory and practice, (2nd ed.).* New York, NY: Columbia University Press.

Gil, E. (1991). *The healing power of play*. New York, NY: Gilford.

Gil, E. (2006). *Helping abused and traumatized children.* New York, NY: Gilford.

Gil, E. (2010). *Working with children to heal interpersonal trauma.* New York, NY: Gilford.

Gil, E. (2011). *Trauma-focused integrated play therapy*. *A 12-session play based treatment and research protocol*. Fairfax, VA: Gil Center for Healing & Play.

Gil, E., & Shaw, J. (2009). Prescriptive play therapy. In K. O'Connor & L. Braverman (Eds.) *Play therapy theory and practice* (pp. 451-488). Hoboken, NJ: Wiley.

Gilgun, J. (1994). Hand into glove: Grounded theory and social work practice research. In E. Sherman & W. J. Reid (Eds.), *Qualitative research in social work* (pp.115-125). New York, NY: Columbia University Press.

Ginsberg, B. (2002). The power of filial relationship enhancement therapy as an intervention in child abuse and neglect. *International Journal of Play Therapy.* 11(1), 65-78.

Gitterman, A. (2015). Social Work. A Profession in search of its identity. *Journal of Social Work Education.* 50. 599-607. doi:10.1080/10437797.2014.947898

Given, L. (2008). *The SAGE encyclopedia of qualitative research methods*. Thousand Oaks, CA: SAGE.

Glaser, B. (2002). Constructivist grounded theory? Forum Qualitative Sozialforschung / Forum: *Qualitative Social Research***.** 3(3).

Glaser, B. (2004). Naturalistic inquiry and grounded theory. *Forum: Qualitative Social Research.* 5(1), 1-15. Retrieved from http://nbn-resolving.de/urn:nbn:de:0114-fqs040170.

Goldstein, E. (2011). Ego psychology and social work treatment. In F. Turner (Ed.), *Social work treatment. Interlocking theoretical approaches*. (5th ed.). (pp.144-156). New York, NY: Oxford University Press.

Goodyear-Brown, P. (2010). *Play therapy with traumatized children. A Prescriptive approach.* Hoboken, NJ: Wiley & Sons.

Graeff-Martins, A., Flament, M., Fayyad, J., Tyano, S., Jensen, P., & Rohde, L. (2008). Diffusion of efficacious interventions for children and adolescents with mental health problems. *Journal of Child Psychology and Psychiatry*, 49(3), 335–352. doi:10.1111/j.1469-7610.2007.01827.x

Green, E. (2009). Jungian analytical play therapy. In K. O'Connor & L. Braverman (Eds.) *Play therapy theory and practice* (pp.83-122). Hoboken, NJ: Wiley.

Green, E., & Myrick, A. (2014). Treating complex trauma in adolescents: A phase-based, integrative approach for play therapists. *International Journal of Play Therapy*. 23(3), 131-145. doi.org/10.1037/a0036679

Greenwald, R. (2009). *Treating problem behaviors. A Trauma-informed approach.* New York, NY: Routledge.

Gregorowskia, C., & Seedata, S. (2013). Addressing childhood trauma in a developmental context. *Journal of Child & Adolescent Mental Health,* 25(2), 105–118. doi:10.2989/17280583.2013.795154

Groos, K. (1901). *The play of man*. New York, NY. Arnos Press.

Guerney, B., & Guerney, L. (1976). Filial therapy. In Schaefer (Ed.), *Therapeutic use of child's play.* (pp. 553-566). New York, NY: Jason Aronson.

Harper, J. & Hoopes, M.(1990). *Uncovering shame: An approach integrating individuals and their family systems*. New York, NY: Norton.

Hendrick, K. (1997). Constructions and reconstructions of British childhood: An interpretive survey, 1800 to the present. In A. James & A. Prout, (Eds.). *Constructing and reconstructing childhood: Contemporary issues in the sociological study of childhood*. (pp. 34-62). Abingdon, OX: Routledge.

Herman, J. (1992). *Trauma and recovery*. *The aftermath of violence – from domestic abuse to political power*. New York, NY: Basic Books.

Herman, J. (1997). *Trauma and recovery*. *The aftermath of violence – from domestic abuse to political power*. New York, NY: Basic Books.

Herman, J. (2007). Shattered shame states and their repair. *The John Bowlby Memorial Lecture.* MA: Harvard Medical School. Retrieved from http://www.challiance.org/Resource.ashx?sn=VOVShattered20ShameJHerman

Herman, J. (2008). Craft or science in the treatment of traumatized people. *Journal of Trauma and Dissociation*. 9(3), 293-300. doi:10.1080/15299730802138966

Heywood, C. (2008). *A history of childhood.* Malden, MA: Polity Press.

Higdon, J. (2012). *Psychodynamic theory for therapeutic practice*. New York, NY: Palgrave Macmillan.

Hindman, J. (1989). *Just before dawn*. Boise, ID: Northwest Printing.

Hollis, F. (1969). *Casework. A psychosocial therapy*. New York, NY: Random House.

Homeyer, L., & Morrison, M. (2008). Play Therapy. Practice, Issues, and Trends. *American Journal of Play.* Fall Issue, 210-228.

Hug-Hellmuth, H. (1920). On the technique of the analysis of children. *The International Journal of Psycho-Analysis*. 1, 361.

Hughes, S. (1991). *The royal commission of inquiry into the response of the Newfoundland criminal justice system into complaints*. St. John's, NL: Queen's Printer.

Hutchison, E., (Ed.). (2007). A life course perspective. In E. Hutchison, *Dimensions of human behavior. The changing life course. (3rd ed.).* (pp. 1-38). Thousand Oaks, CA: Sage.

James, A., & Prout, A. (Eds.) (1997a). *Constructing and reconstructing childhood: Contemporary issues in the sociological study of childhood*. Abingdon, OX: Routledge

James, A., & Prout, A. (1997b). A new paradeigm for the sociology of childhood? Provenance, promise and problems. In A James & A. Prout (Eds.). *Constructing and reconstructing childhood: Contemporary issues in the sociological study of childhood.* (pp. 7-33). Abingdon, OX: Routledge.

James, B. (1994). *Handbook for treatment of attachment-trauma problems in children.* New York, NY: The Free Press.

James, B. (1996). *Treating traumatized children. New insights and creative interventions.* New York, NY: The Free Press.

Jani, J., & Reisch, M. (2011). Common human needs, uncommon solutions: Applying a critical framework to perspectives on human behavior. *Families in Society: The Journal of Contemporary Social Services.* 92(1), 13. doi:10.1606/1044-3894.4065

Jensen, P., Goldman, E., Offord, D., Costello, E., Friedman, R., Huff, B., … & Roberts, R. (2011). Overlooked and underserved: Action signs for identifying children with unmet mental health needs. *Pediatrics.* 128(5), 970-979. doi:10.1542/peds.2009-0367

Jensen, T., Haavind, H., Gulbrandsen, W., Mossige, S., Reichelt, S., & Tjersland, O. (2010). What constitutes a good working alliance in therapy with children that may have been sexually abused? *Qualitative Social Work, 9*(4), 461-478. doi:10.1177/1473325010374146

Joffe, H. (2012). Thematic analysis. In D. Harper & A. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*. (pp. 209-223). Chichester, West Sussex: Wiley-Blackwell.

Jones, D. (2011). What should counselors do about DSM-5? (Discussion group comment). Retrieved from the American Counseling Association Weblog: http://my.counseling.org/2011/08/16/what-should-counselors-do-about-dsm-5/

Jordan, B., Perryman, K., & Anderson, L. (2013). A Case for Child-Centered Play Therapy With Natural Disaster and Catastrophic Event Survivors. *International Journal of Play Therapy*. 22(4), 219–230.

Joseph, S., & Murphy, D. (2014). Trauma: A unifying concept for social work. *British Journal of Social Work.* 44(5), 1094-1109. doi:10.1093/bjsw/bcs207

Jung, C. (1961). *Memories, dreams, reflections*. New York, NY: Vintage.

Kaufman, G. (1989). *The psychology of shame*. New York, NY: Springer Publishing.

Kazdin, A. (2002). The state of child and adolescent psychotherapy research. *Child and Adolescent Mental Health*. 7(2), 53-59. doi:10.1111/1475-3588.00011

Kazdin, A. (2003). Psychotherapy for children and adolescents. *Annual Review of Psychology,* 54(1), 253-276. doi:10.1146/annurev.psych.54.101601.145105

Kazdin, A. (2008). Evidence-based treatment and practice. *American Psychologist*. 63(3), 146-159. doi:10.1037/0003-066X.63.3.146

Kazdin, A., & Nock, M. (2003). Delineating mechanisms of change in child and adolescent therapy: Methodological issues and research recommendations. *Journal of Child Psychology and Psychiatry.* 44(8), 1116-1129. doi:10.1111/1469-7610.00195

Kardiner, A., & Spiegel, H. (1947). *War stress and neurotic illness*. New York, NY: Hoeber.

Kempe, H., Silverman, F., Steele, B., Droegemueller, W., Silver, H. (1962). The battered-child syndrome. *The Journal of American Medical Association*. 181(1), 17-24. doi:10.1001/jama.1962.03050270019004

Kempe, C. (1978*).* Sexual abuse, another hidden pediatric problem: The 1977 C. Anderson Aldrich lecture. *Pediatrics*. 62(3), 382-389.

Kenney-Noziska, S., Schaefer, C., & Homeyer, L. (2012). Beyond directive or non-directive: Moving the conversation forward. *International Journal of Play Therapy.* 21(4), 244–252. doi:10.1037/a0028910

Kessler, R., McLaughlin, K., Green, J., Gruber, M., Sampson, N., Zaslavsky, A., … Williams, D. (2010). Childhood adversities and adult psychopathology in the WHO world mental health surveys. *The British Journal of Psychiatry*, *197*(5), 378–385. doi:10.1192/bjp.bp.110.080499.

Kezelman, C., & Stavropoulos, P. (2012). *Practice guidelines for treatment of complex trauma and trauma informed care and service delivery*. Adults Surviving Sexual Abuse, Kirribilli, NSW: ASSA. Retrieved from http://m.recoveryonpurpose.com/upload/ASCA_Practice%20Guidelines%20for%20the%20Treatment%20of%20Complex%20Trauma.pdf

Kimberley, D. (2012, June 4). PhD advanced clinical practice class. Lecture presented at School of social work, Memorial University, St. John's, NL.

Kimberley, D. (2015). Compromised cognitive functioning in concurrent disordered parents: Implications for aboriginal children, foster care, mental health and addictions. In Neckoway, R. & Brownlee, K. (Eds.), *Child welfare in rural remote areas with Canada's first nations peoples: Selected Readings.* Thunder Bay, Canada: Lakehead University.

Kimberley, D. & Parsons, R. (2012, June 2). *Helping ameliorate child-youth complex trauma in the interest of increasing foster care success: reaching for the vulnerable children within the resilient child-youth.* Paper presented to the Canadian foster families association national conference, St. John's, NL, Ca.

Kimberley, D. & Parsons, R. (2017). Trauma-informed social work treatment and complex trauma. In F. J. Turner, (Ed.), *Social work treatment. Intersecting theories, (6th ed.)*. Toronto, Canada: Oxford University.

Kirby, J., & Keon, J. (2004). Mental health, mental illness and addiction: Issues and options for Canada**.** *Interim report of the standing senate committee on social affairs*, Science And Technology. Report 3. Retrieved from www.parl.gc.ca

Kitzinger , J. (1997). Who are you kidding? Children, power and the struggle against sexual abuse. In A. Prout and A. James (Eds.), *Constructing and reconstructing childhood* (pp. 161-186). Abingdon, OX: Routledge.

Kirby, J., & Keon, J. (2006). Canada. Parliament. Senate. Standing Committee on Social Affairs, Science Technology, & Canadian Electronic Library. *Out of the shadows*

at last. Transforming mental health, mental illness and addiction services in Canada: Final report on mental health, mental illness and addiction. Ottawa, Ontario: The Senate.

Klein, M. (1976). The psychoanalytic play technique. In C. Schaefer (Ed.), *Therapeutic use of child's play.* (pp. 125-140). New York, NY: Aronson.

Klika, J., & Herrenkohl, T. (2013). A review of developmental research on resilience in maltreated children. *Trauma, Violence, & Abuse.* 14(3), 222-234. doi:10.1177/1524838013487808

Kliethermes, M., Schacht, M., and Drewry, K. (2014). Complex trauma. *Child and Adolescent Psychiatric Clinics of North America, Disaster and Trauma.* 23(2), 339-361. doi:10.1016/j.chc.2013.12.009

Knell, S. (2009). Cognitive behavioral play therapy. Theory and applications. In A. Drewes (Ed.), *Blending play therapy with cognitive behavioral therapy*. (pp.117-134). Hoboken, NJ: Wiley.

Knight, C. (2015). Trauma informed social work practice: Practice considerations and challenges. *Clinical Journal of Social Work.* 43(1), 25-37. doi:10.1007/s10615-014-0481-6

Kohn, A. (1987). Shattered innocence. *Psychology Today, 21*, 54-58. Retrieved from http://search.proquest.com/docview/214480448?accountid=12378

Kool, R., & Lawver, T. (2010). Play therapy: considerations and applications for the practitioner. *Psychiatry (Edgemont).* 7(10): 19-24.

Kottman, T. (2009). Adlerian play therapy. In K. O'Connor & L. Braverman (Eds.), *Play therapy theory and practice. A comparative presentation* (pp. 237- 282). New York, NY: Wiley & Sons.

Kottman, T. & Schaefer, C. (1993). *Play therapy in action. A casebook for practitioners*. Lanham, Maryland: Rowman & Littlefield .

Krugman, R., & Korbin, J. (2013). (Eds.). *C. Henry Kempe: A 50 year legacy to the field of child abuse and neglect*. New York, NY. Springer. doi:10.1007/978-94-007-4084-6

Kutcher, S., Hampton, M., & Wilson, J. (2010). Child and adolescent mental health policy and plans in Canada: An analytic review. *Canadian Journal of Psychiatry*. 55(2), 100-107.

Kutcher, S. & McLuckie, A. (2010). (2010). *Evergreen: A child and youth mental health framework for Canada.* Calgary, AB: Mental Health Commission of Canada.

Lake, J. (1994). A comparative analysis of the impacts reported in the literature and by survivors of childhood sexual abuse in their victim impact statements. (*Memorial University of NL, 2007*). *Thesis*. Centre for Newfoundland Studies (RC569.5 .A28 L35 1994). St. John's: Memorial University of Newfoundland.

Lanktree, C., Briere, J., Godbout, N., Hodges, M., Chen, K., ,Trimm, L., … & Freed, W. (2012): Treating multitraumatized, socially marginalized children: Results of a naturalistic treatment outcome study. *Journal of Aggression, Maltreatment & Trauma*. 21(8), 813-828. doi:10.1080/10926771.2012.722588

Landreth, G. (2012). *Play therapy: The art of the relationship.* New York, NY: Brunner-Routledge.

Landreth, G. & Sweeney, S. (2009). Child-centered play therapy. In K. O'Conner and L. Braveman (Eds.), *Play therapy theory and practice. A comparative presentation.* (pp.123-162). New York, NY: Wiley & Sons.

Lanius, R., Vermetten, E., & Pain, C. (2010). *The impact of early life trauma on health and disease. The Hidden Epidemic.* New York, NY: Cambridge University Press.

Leblanc, M. & Ritchie, M. (2001). A meta-analysis of play therapy outcomes. *Counseling Psychology Quarterly,* 14(2), 149-163. doi:10.1080/09515070110059142

Lebo, D. (1952). The development of play as a form of therapy: From Rosseau to Rogers. *American Journal of Psychiatry*. 112(6), 418-422.

Leckman, J. & Leventhal, B. Editorial. A global perspective on child and adolescent mental health. *The Journal of child psychology and psychiatry.* 49(3), 221-225. doi:10.1111/j.1469-7610.2008.01884.x

Lee, A. (2009). Psychoanalytic play therapy. In K. O'Conner, & L. Braverman. (2009). *Play therapy, theory and practice. Comparing theories and techniques* (pp. 25-82). Hoboken, NJ: Wiley & Sons.

Leenarts, L., Diehle, J., Doreleijers, T., Jansma, E., & Lindauer, R. (2013). Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: A systematic review. *European Child & Adolescent Psychiatry*. 22:269–283. doi:10.1007/s00787-012-0367-5

LeFrançois, B. (2006). They will find us and infect our bodies: The views of adolescent inpatients taking psychiatric medication. *Radical Psychology*. *A Journal of Psychology, Politics and Radacili*. 5:3

LeFrançois, B. (2007). Children's participation rights: Voicing opinions in inpatient care. *Child and Adolescent Mental Heath*. 12 (2), 94-97. doi:10.1111/j.1475-3588.2007.00439.x

LeFrançois, B. (2008). It's like mental torture: Participation and mental health services. *International Journal of Children's Rights.* 16: 211–227. doi:10.1163/157181808X301809

LeFrançois, B., & Coppock, V. (2014). Psychiatrized children and their rights: Starting the conversation. *Children & Society*. 28: 165-171. doi:10.1111/chso.12082

Levenson, J., & Grady, M. (2016). Childhood Adversity, Substance Abuse, and Violence: Implications for Trauma-Informed Social Work Practice. *Journal of Social Work Practice in the Addictions.* 16. 24–45.

Levine, P., & Klein, M., (2007). *Trauma through a child's eyes. Awakening the ordinary miracle of healing*. Berkeley, CA: North Atlantic Books.

Levy, D. (1976). Release therapy. In Schaefer (Ed.), *Therapeutic use of child's play.* (pp. 173-186). New York, NY: Jason Aronson.

Liberman, A., Chu, A., Van Horn, P. & Harris, W. (2011). Trauma in early childhood: Empirical evidence and clinical implications. *Development & Psychopathology*. 23. 397-410. doi:10.1017/S0954579411000137.

Liberman, F. (1982). *Clinical social workers as psychotherapists*. New York, NY: Gardner Press.

Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

Lipsitz, J., & Marcowitz, J. (2013). Mechanisms of change in interpersonal therapy (IPT). *Clinical Psychology Review*. 33: 1134-1147. Retrieved from http://dx.doi.org/10.1016/j.cpr.2013.09.002

Livesley, J., Dimaggio, G., & Clarkin, J. (Eds). (2016). *Integrated Treatment for Personality Disorder: A Modular Approach*. New York. Guilford Press.

Longhofer, J., & Floersch, J. (2012). The coming crisis in social work: Some thoughts on social work and science. *Research on Social Work Practice* 22, 499–519.

Lowenfeld, M. (1991). *Play in childhood.* London, NW: Mac Keith Press.

MacLean, G. (1986). A brief story about Dr. Hermine Hug-Hellmuth. *Canadian Journal of Psychiatry*. 31(6): 586-589.

Main, M., & Weston, D. (1981). The quality of the toddler's relationship to mother and to father: Related to conflict behavior and the readiness to establish new relationships. *Child Development*, 52(3), 932-940.

Majer, M., Nater, U., Lin, J., Capuron, L., & Reeves, C. (2010). Association of childhood trauma with cognitive function in healthy adults: a pilot study. *MMC Neurology* 10 (61), 1-10. doi:10.1186/1471-2377-10-61

Malchiodi, C. (Ed.) (2014). *Creative interventions with traumatized children*. New York, NY: Gilford.

Mander, J., Wittorf, A., Schlarb, A., Hautzinger, M., Zipfel, S., & Sammet, I. (2013). Change mechanisms in psychotherapy: Multiperspective assessment and relation to outcome. *Psychotherapy Research*, 23(1), 105-116. doi:10.1080/10503307.2012.744111

Manpreet, K. & Chang, K. (2012). The neural effects of psychotropic medications in children and adolescents. *Child Adolescent Psychiatric Clinics of North America.* 21(4): 753–771. doi:10.1016/j.chc.2012.07.010

Mannarino, A. & Cohen, J. (2011). Traumatic loss in children and adolescents. *Journal of Child and Adolescent Trauma.* 4(1): 22-23. doi:10.1080/19361521.2011.545048

Marmor, J. (1987). The psychotherapeutic process: Common denominators in diverse approaches. In J. Zeig, (Ed.), *The evolution of psychotherapy* (pp. 266-282). New York, NY: Brunner/Mazel.

Maslow, A. (1954). *Motivation and personality*. New York, NY: Longman.

Masson, J. (1984). *The assault on truth. Freud's suppression of the seduction theory*. New York, NY: Pocket Books.

Mathinsen, E. (2011). Social work practice and social science history. *Social Work and Social Sciences Review,* 15(1), 5-27. doi:http://dx.doi.org/10.1921/095352211X604291

May, K. (1996). Naturalistic inquiry and counseling: Contemplating commonalities. *Counseling and Values,* 40(3), 219-226.

MacLeod, C., Tonmyr, L., Thorton, T. (2004). What is child maltreatment? *Health Policy Research Bulletin*, Issue 9: 6-8. Retrieved from www.hc-sc.gc.ca

McCuaig, D. (1982). James Naismith: Inventor of basketball. Reprinted in: *YMCA world famous figures in YMCA history*, (2010). Retrieved from http://www.ymca.int/uploads/media/YWorld_-_December_2010_-_FINAL__web_.pdf

McLeod, J. (1990). The practitioner's experience of counselling and psychotherapy: A review of the research literature. In D. Mearns & W. Dryden (Eds.), *Experiences of counselling in action* (pp. 66–79). Thousand Oaks, CA: Sage.

McLeod, S. (2007). *Bowlby's attachment theory.* Retrieved from http://www.simplypsychology.org/bowlby.html

McMahon, L. (2009). *The handbook of play therapy and Therapeutic play*. (2nd ed.). New York, NY: Routledge.

Mental Health Gap Action Program & World Health Organization. (2010). *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: version 1.0*. Geneva: World Health Organization.

Meyers, J. (Ed.). (2011). *The Apsac handbook on child maltreatment*, (3rd ed.). Thousand Oaks, CA: Sage.

Mikulincer, M. & Shaver, P. (2016). Attachment in adulthood: Structure, dynamics and change. (2nd ed.). New York, NY: Guilford.

Millar, S. (1972). *The psychology of play.* Harmondsworth, Middlesex: Penguin Books.

Miller, A. (1983). *For your own good. Hidden cruelty in child-rearing and the roots of violence*. Toronto, Ont.: McGraw-Hill Ryerson Ltd. Retrieved from http://www.nospank.net/fyog.htm

Mills, C. (2014). Psychotropic childhoods: Global mental health and pharmaceutical children. *Children & Society*. 28, 194-204. doi:10.1111/chso.12062

Minuchin, S. (1985). My many voices. In Zeig, J. (Ed.), *The evolution of psychotherapy* (pp.5-16). New York, NY: Brunner/Mazel, Publishers.

Miriam-Webster's New collegiate dictionary (1989). (9th ed.). Massachusetts: Miriam-Webster.

Myrick, A. & Green, E. (2014). Establishing safety and stabilization in traumatized youth: Clinical implications for play therapists. *International Journal of Play Therapy***.** 23(2), 100-113. doi:10.1037/a0036397

NASW Foundation (2014). (Homepage) NASW Pioneers. Charlotte Towle (1896-1966). Retrieved from http://www.naswfoundation.org/pioneers/t/towle.htm

Newman, T. (2000). Workers and helpers: Perspectives on children's labour 1899-1999. *British Journal of Social Work*. 30(3), 323- 338.

Newton, P. (1995). *Freud: From youthful dream to mid-life crisis.* New York, NY: Guildford.

Norton, B., Ferriegel, M., & Norton, C. (2011). Somatic expressions of trauma in experiential play therapy. *International Journal of Play Therapy*. 20(3), 138-152. doi:10.1037/a0024349

Norton, C. (2011*). Innovative interventions in child and adolescent mental health*. New York, NY: Routledge.

Oaklander, V. (1978). *Windows to our children. A gestalt therapy approach to children and adolescents*. Maine, NE: Gestalt Journal Press.

O'Conner, K. & Braverman, L. (2009). *Play therapy theory and practice. Comparing theories and techniques.* Hoboken, NJ: Wiley & Sons.

O'Conner, K. (2009). Ecosystemic play therapy. In K. O'Connor & L. Braverman (Eds.), *Play therapy theory and practice*, (pp. 367-450). Hoboken, NJ: Wiley & Sons.

Ogawa, Y. (2004). Childhood trauma and play therapy intervention for traumatized children. *Journal of Professional Counseling: Practice, Theory, & Research*. 32(1), 19-29.

Olson-Morrison, D. (2017). Integrative Play Therapy With Adults With Complex Trauma: A Developmentally-Informed Approach. *International Journal of Play Therapy.* Advance online publication. http://dx.doi.org/10.1037/pla0000036

Oxford English Dictionary (2005). Online version. (3rd ed.). (June, 2005). Retrieved from http://www.oed.com/view/Entry/137329?redirectedFrom=paradigm#eid

Page, T. (2011). Attachment theory and social work treatment. In F. Turner (Ed.), *Social work treatment,* (pp. 30-47). New York, NY: Oxford.

Palmstierna, V., & Werbart, A. (2013). Successful psychotherapies with young adults: an explorative study of the participants' view. *Psychoanalytic Psychotherapy*. 27(1), 21-40. doi:10.1080/02668734.2012.760477

Parad, H., & Parad, L. (1990). *Crisis intervention, book 2: The practitioner's sourcebook for brief therapy*. Milwaukee, WI: Family Service America.

Payne, M., (2016). *Modern Social Work Theory*, (4th ed.). New York. Oxford University Press.

Perlman, H. (1957). *Social casework. A problem-solving process*. Chicago, IL: University of Chicago Press.

Pehrsson, D., & Aguilera, M. (2007). *Play therapy: Overview and implications for counselors* (ACAPCD-12). Alexandria, VA: American Counseling Association.

Pepler, E., & Bryant, M. (2011). *A call for change to the system for delivering child & youth mental health services in South Western Ontario*. School of Business. London, Ontario: University of Western Ontario.

Perry, B. (2009). Examining child maltreatment through a neurodevelopmental lens: Clinical applications of the neurosequential model of therapeutics. *Journal of Loss and Trauma.* 14(4), 240-255. doi:10.1080/15325020903004350

Phillips, R. (1985). Whistling in the dark? A review of play therapy research. *Psychotherapy*. 22(4), 752-760.

Piaget, J., Gattegno, C., & Hodgoon, F. (1962). *Play, dreams and imitation in childhood.* New York, NY: Norton.

Pieper, M. (1994). Science, not scientism: The robustness of naturalistic inquiry. In E. Sherman & W. Reid (Eds.), *Qualitative research in social work* (pp.71-85). New York, NY: Columbia University Press.

Pieper, M., & Tyson, K. (1999). Response to Padgett's "does the glove really fit". *Social Work*. 44(3), 278-279.

Pine, D., Costello, J., & Masten, A. (2005). Trauma, proximity, and developmental psychopathology: The effects of war and terrorism on children. *Neuropsychopharmacology*. 30(10), 1781–1792. doi:10.1038/sj.npp.1300814

Poulter, J. (2005). Integrating theory and practice: A new heuristic paradigm for social work practice. *Australian Social Work*. 58(2).

Public Health Agency of Canada. (2010). *Canadian Incidence Study of Reported Child Abuse and Neglect – 2008. Major Findings*. Ottawa. Retrieved from http://www.phac-aspc.gc.ca/ncfv-cnivf/index-eng.php

Publication manual of the American Psychological Association (6th ed.). (2010). Washington, DC: American Psychological Association

Putnam, F. (2006). The impact of trauma on child development. *Juvenile and Family Court Journal*. 57(1), 1-11. doi:10.1111/j.1755-6988.2006.tb00110.x

Pynoos, R., Steinberg, A., & Piacentini, J. (1999). A developmental psychopathology model of childhood traumatic stress and intersection with anxiety disorders. *Biological Psychiatry*, 46(11), 1542–1554. doi:10.1016/S0006-3223(99)00262-0

Rabaia, Y., Saleh, M., & Giacaman., R. (2014). Sick or sad? Supporting Palestinian children living in conditions of chronic political violence. In *Children & Society*. 28(3), 172 – 181. doi:10.1111/chso.12061

Racco, A., & Vis, J. (2015). Evidence based trauma treatment for children and youth. *Child and Adolescent Social Work Journal.* 32(2): 121-129. doi:10.1007/s10560-014-0347-3

Ray, D. (2006). Evidence-based play therapy. In C. Schaefer and H. Kaduson (Eds.), *Contemporary play therapy: Theory, research, and practice.* (pp. 136-161). New York, NY: Gilford.

Ray, D., Bratton, S., Rhine, T., & Jones, L. (2001). The effectiveness of play therapy: Responding to the critics. *International Journal of Play Therapy*, 10(1), 85-108.

Reid, W. (1994). Reframing the epistemological debate. In E. Sherman, & W. Reid, (Eds.) *Qualitative research in social work*. (pp.464-481). New York, NY: Columbia University Press.

Reisman, J., & Ribordy, S. (1993). *Principles of psychotherapy with children* (2nd ed.). New York, NY: Lexington Books.

Reyes, C., & Asbrand, J. (2005). A longitudinal study assessing trauma symptoms in sexually abused children engaged in play therapy. *International Journal of Play Therapy*. 14(2), 25-47.

Richmond, M. (1917). *Social diagnosis.* New York, NY: Russell Sage Foundation.

Riedel Bowers, N. (2001). A Journey within a journey: A naturalistic study of the early relationship development process in non-directive play therapy. (Unpublished doctoral dissertation). Wilfred Laurier University, Faculty of Social Work, 2001. *Thesis and Dissertations (Comprehensive)*. Paper 228.

Riedel Bowers, N. (2009). A naturalistic study of the early relationship development process of nondirective play therapy. *International Journal of Play Therapy.* 18(3), 176-189.

Riedel Bowers, N. (2013). *Play therapy with families. A collaborative approach to healing*. Lanham, Maryland: Jason Aronson.

Riedel Bowers, N., Pac Wan, W., and Bowers, A. (2016). The curative powers of play. The voices of therapists around the world. *Psychology Research*, 6(9), 496-508. doi:10.17265/2159-5542/2016.09.002

Riggs, S. (2010). Childhood emotional abuse and the attachment system across the life cycle: What theory and research tell us. *Journal of Aggression, Maltreatment and Trauma*. 19(1): 5-51. doi:10.1080/10926770903475968

Rind, B., Tromovitch, P., & Bauserman, R. (1998). A meta-analytic examination of assumed properties of child sexual abuse using college samples. *Psychological Bulletin*. 124(1), 22-53.

Roberts, A. (2005). *Crisis intervention handbook: Assessment, treatment and research.* (3rd ed.). New York, NY: Oxford University Press.

Robinson, H. & Kaplan, C. (2011). Psychosocial theory and social work. In F. Turner (Ed.), *Social work treatment.* (pp. 387- 400). New York, NY: Oxford Press.

Robson, M. (2010). Therapeutic work with children; A contextual overview. *British Journal of Guidance and Counseling.* 38(3), 247-261. doi:10.1080/03069885.2010.491850

Robinson, V. (1934). *A changing psychology in social case work*. Chapel Hill, NC: University of North Carolina Press.

Roche, A., Fortin, G., Labbe, J., Brown, J., & Chadwick, D. (2005). The work of Ambroise Tardieu: The first definitive description of child abuse. *Child Abuse & Neglect.* 29(4). 325-334. doi:10.1016/j.chiabu.2004.04.007

Rodwell, M. (1987). Naturalistic inquiry: An alternative model for social work assessment. *Social Service Review. 61*(2), 231-246.

Roemer, M. (2011). Health care expenditures for the five most common children's health conditions, 2008: Estimates for U.S. civilian noninstitutionalized children, ages 10-17. *Statistical brief #349.* Medical expenditure panel survey; Agency for healthcare research and quality. Retrieved from http://meps.ahrq.gov/mepsweb/data_files/publications/st349/stat349.pdf

Rogers, C. (1942). *Counseling and psychotherapy*. Cambridge, MA: The Riverside Press

Rogers, C. (1951). *Client-centered therapy: Its current practice, implications and theory.* Boston, MA: Houghton Mifflin.

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*. 21(2), 95-103.

Rothchild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment*. New York, NY: Norton.

Rush, F. (1980). *The best kept secret. Sexual abuse of children*. New Jersey: Prentice-Hall, Inc.

Ryan, G. & Bernard, H. (2003). Techniques to identify themes. *Field Methods.* 15(1), 85-109. doi:10.1177/1525822X02239569.

Sarina, K., Landreth, G., & Maria, M. (1998). Intensive child-centered play therapy with child witnesses of domestic violence. *International Journal of Play Therapy,* 7(2), 17-36. doi.org/10.1037/h0089421

Satir, V. (1987). Going behind the obvious. In K. Zeig (Ed.), *The evolution of psychotherapy* (pp.58-70). New York, NY: Brunner/Mazel.

Saldana, J. (2009). *The coding manual for qualitative researchers*. Los Angeles, CA: Sage

Sandelowski, M. & Barroso, J. (2002). Reading qualitative studies. *International Journal of Qualitative Methods,* 1(1), Article 5.

Schaefer, C. (1993). *The therapeutic powers of play*. Northvale, NJ: Jason Aronson.

Schaefer, C. (Ed.). (1976). *Therapeutic use of child's play*. New York, NY: Aronson.

Schaefer, C. (2011). History speaks. Schaefer interview. Assn4PlayTherapy. Retrieved from http://www.youtube.com/watch?v=uWSUkUsWeZI

Schaffer, H., & Emerson, P. (1964). The development of social attachments in infancy. *Monographs of the Society for Research in Child Development*. 29(3). Lafayette, Ind.: Child Development Publications of the Society for Research in Child Development.

Schaefer, C. & O'Connor, K. (Eds.) (1983). *Handbook of play therapy*. Hoboken, NJ: Wiley & Sons.

Schore, J., & Schore, A. (2008). Modern attachment theory: the central role of affect regulation in development and treatment. *Clinical Social Work Journal*: 36(1), 9-20. doi:10.1007/s10615-007-0111-7

Schwean, V. & Rodger, S. (2013). Children first: It's time to change! Mental health promotion, prevention, and treatment informed by public health, and resiliency approaches. *Canadian Journal of School Psychology*, 28(136), 136 -166. doi:10.1177/0829573513475773

Shapiro, V. (2009). Reflections on the work of Professor Selma Fraiberg. A pioneer in the field of social work and infant mental health. *Clinical Social Work Journal*. 37(1), 45-55. doi:10.1007/s10615-007-0120-6

Sherman, E. & Reid, W. (1994). *Qualitative research in social work.* New York, NY: Columbia University Press.

Shulman, L. (2015a). *The skills of helping individuals, families, groups and communities.* (8th ed.). Belmont, CA: Cengage.

Shulman, L. (2015b). *Social Work Practice in Child Welfare. The Interactional Model.* National Association of Social Workers. NASW Press

Siegel, D. (2009). *Mindsight*, New York, NY: Random House.

Silberg, J. (2013a). Dissociative disorders in children and adolescents. In M. Lewis & K. Rudolph (Eds.), *Handbook of developmental psychopathology.* (pp.761-765). New York, NY: Springer.

Silberg, J. (2013b). *The child survivor: Healing developmental trauma and dissociation.* New York, NY: Routledge.

Silva, R. (Ed.). (2004). *Posttraumatic stress disorders in children and adolescents*. New York, NY: Norton Medical Publications.

Sinason, V. (2011). *Attachment, trauma and multiplicity. Working with dissociative identity disorder*. New York, NY: Routledge.

Singh, M. & Chang, K. (2012). The neural effects of psychotropic medications in children and adolescents. *Child Adolescent Psychiatric Clinics of North America.* 21(4), 753–771. doi:10.1016/j.chc.2012.07.010

Smith, E., & Grawe, K. (2003). What makes psychotherapy sessions productive. A new approach to bridging the gap between process research and practice. *Clinical Psychology and Psychotherapy*. 10, 275-285. doi:10.1002/cpp.377

Solanto, J. (2014, June 12). *Allies in Healing: Supporting Recovery from trauma and addictions.* Presented by the Trauma and Addictions Mobile Trauma Team. Grand Falls Windsor, Newfoundland, Ca.

Solomon, J. (1954). Therapeutic play techniques. Play technique and the integrative process. *American Journal of Orthopsychiatry*. 25(3), 591–600.

Spandler, H., & Warner, S. (2007). *Beyond fear and control. Working with young people who self-harm.* Herefordshire, EN: Ross-on-Wye.

Spataro, J., Mullen, P., Burgess, P., Wells, D., & Moss. S. (2004). Impact of child sexual abuse on mental health: Prospective study in males and females. *The British Journal of Psychiatry.* 184: 416-421.

Sprenkle, D., Davis, S., Lebow, J., (Eds.). (2009). *Common factors in couple and family therapy: The overlooked foundation for effective practice.* New York, NY: Guilford.

Steele, W. & Malchiodi, C. (2012). *Trauma-informed practices with children and adolescents.* New York, NY: Routledge.

Stein, A. (2007). *Prologue to violence. Child abuse, dissociation, and crime*. Mahwah, NJ: The Analytic Press.

Steven, J. & Murphy, D. (2014). Trauma, a unifying concept for social work. *British Journal of Social Work*. 44(5), 1094-1109. doi:10.1093/bjsw/bcs207

Strachey, J. (1965) *New introductory lectures on psychoanalysis. Sigmund Freud*. New York, NY: Norton.

Straussner, S., & Fewell, C. (2011). *Children of substance-abusing parents: Dynamics and treatment.* (Eds.). New York, NY: Springer Publishing.

Struik, A. (2014). *Treating chronically traumatized children. Don't let sleeping dogs lie*. New York, NY: Routledge.

Tasca, G., Sylvestre, J., Balfour, L., Chyurlia, L., Evans, J., Fortin-Langelier, B. … Wilson, B., (2014). What clinicians want: Findings from a psychotherapy practice research network survey. *Psychotherapy*. American Psychological Association. 52(1), 1–11. doi:10.1037/a0038252

Taylor, M. (2013). *Not in isolation: The importance of relationships and healing in childhood trauma.* Report for the Creswick foundation. Downloaded from http://www.berrystreet.org.au/Assets/2707/1/NotinIsolation_10_11_14.pdf

Teicher, M., & Samson, J. (2013). Childhood maltreatment and psychopathology: A case for ecophenotypic variants as clinically and neurobiologically distinct subtypes. *American Journal of Psychiatry.* 170 (10), 1114-1133.

Terr, L. (1990). *Too scared to cry*. New York, NY: Basic Books.

Terr, L. (2008). *Magical moments of change.* New York, NY: Norton.

Terr, L. (2010). (Forward). In E. Gil, (2010). *Working with children to heal interpersonal trauma*. New York, NY: Gilford.

The Cambridge Dictionary (online edition). Retrieved from http://dictionary.cambridge.org/us/

Thomas, J. (2011). An effective way of alleviating children's emotional, behavior and mental health problems. The latest research. *Play Therapy UK*. Retrieved from http://www.playtherapy.org.uk

Thomlison, B., & Bagley, C., (1991). *Child sexual abuse: Expanding the research base on program and treatment outcomes.* Calgary, Alberta. University of Calgary Press.

Tishelman, A., & Geffner, R. (2011). Child and adolescent trauma across the spectrum of experience: Research and clinical interventions. *Journal of Child & Adolescent Trauma*, 4(1), 1–7. doi:org/10.1080/19361521.2011.545982

Tomlinson, P. (2008). Assessing the needs of traumatized children to improve outcomes. *Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community.* 22(3), 359-373. doi:10.1080/02650530802396684

Towle, C. (1957). *Common human needs*. National Association of Social Workers. The University of Michigan.

Turner, F. (2011). Theory and social work treatment. In Turner. F (Ed.), *Social work treatment. Interlocking theoretical approaches*. (5th ed.). New York: Oxford University Press.

Turner, F. (Ed). (2017). *Social work treatment. Intersecting theories,* (6th ed.). Toronto. Oxford University.

Tyson, K. (1995). *New foundations for scientific social and behavioral research. The heuristic paradeigm*. Boston: Allyn & Bacon.

Uehara, E., Coulton, C., Manderscheid, R., Flynn, M., Davis, K., Padilla, Y., (2013). Grand challenges for social work. *Journal of the Society for Social Work and Research*. 4(3), 165-170.

Ungar, M. (2013). Resilience after maltreatment: The importance of social services as facilitators of positive adaptation. *Child Abuse and Neglect, 37, 110-115.* doi:org/10.1016/j.chiabu.2012.08.004

Urwin, C. & Hood-Williams, J. (Eds.). (1988). *Selected papers of Margaret Lowenfeld*. Brighton: Sussex Academic Papers.

van der Kolk, B. (2005). Developmental trauma disorder. *Psychiatric Annals.* 35(5), 401- 408.

van der Kolk, B., & Courtois, C. (2005). Editorial comments: Complex developmental trauma. *Journal of Traumatic Stress*. 18(5), 385–388.

van der Kolk, B., Pynoos, R., Cicchetti, D., Cloitre, M., D'Andrea, W., Ford, J., … Teicher, M. (2009). *Proposal to include a developmental trauma disorder diagnosis for children and adolescents in DSM-V*. Unpublished manuscript. Retrieved from http://www.traumacenter.org/announcements/DTD_papers_Oct_09.pdf .

VanFleet, R. (2009). Filial therapy. In K. O'Conner, & L. Braverman, (2009). *Play therapy theory and practice. Comparing theories and techniques* (pp. 163- 202). New Jersey: John Wiley & Sons, Inc.

VanFleet, R. (2014). *Filial therapy. Strengthening parent-child relationships through play*. (3rd ed.). Fl: Professional Resources Press.

Vicario, M., Tucker, C., Adcock, S., Hudgins-Mitchell, C., (2013). Relational-cultural play therapy: Reestablishing healthy connections with children exposed to trauma in relationships. *International Journal of Play Therapy.* 22(2), 103-117.

von Greiff, N., & Skogens, L. (2013). The mechanisms of treatment – client and treatment staff perspectives on change during treatment for alcohol problems, *Nordic Social Work Research*. 4920, 129-143.

Vygotsky, L. (1978). The Role of play in development. *In mind in society.* (Trans. M. Cole), 92-104. Cambridge, MA: Harvard University Press.

Wakefield, J. (2013). DSM-5: An overview of changes and controversies. *Clinical Social Work Journal*. 41(2), 139-154.

Wampold, B. & Budge, S. (2012). The 2011 Lenora Taylor award address : The relationship – and its relationship to the common and specific factors of psychotherapy. *The Counseling Psychologist.* 40(4), 601-623.

Wang, I., Murray, M., Camilleri-Novak, D. & Stephens, P. (2004). Increased prescribing trends of pediatric psychotropic medications. *Archives of Disease in Childhood* 89(12), 1131-1132.

Weersing, V., & Weisz, J. (2002). Mechanisms of action in youth psychotherapy. *Journal of Child Psychology and Psychiatry*. 43(1), 3 -29.

Welbourne, P., & Dixon, J. (Eds.). (2013). *Child protection and child welfare: A global appraisal of cultures, policy and practice* . London: Jessica Kingsley Press.

Whitaker R. (2012). Weighing the evidence: what science has to say about prescribing atypical antipsychotics to children. In S. Olfman & B. Robbins (Eds.). *Drugging our children. How profiteers are pushing antipsychotics on our youngest and what we can do to stop it.* (pp. 3-16). Santa Barbara, CA: Praeger.

White, J., & Allers, C. (1994). Play therapy with abused children: A review of the literature. *Journal of Counseling & Development.* 72(4), 390-394.

White, M. (2007). *Maps of narrative practice.* New York, NY: Norton.

White, M. (2006). Working with children who have experienced significant trauma. In M. White & A. Morgan (Eds.). *Narrative therapy with children and their families* (pp. 85-97). Adelaide: Dulwich Centre Publications.

Winnicott, C. (1945). Children who cannot play. In J. Kanter (Ed.), (2004*). Face To face with children. The life and work of Clare Winnicott*. London, Karnac.

Winter Commission Report (1990). *The report of the Archdiocesan Commission of Enquiry into the Sexual Abuse of Children by Members of the Clergy.* Catholic Church. Archdiocese of St. John's. Special commission of enquiry into sexual abuse of children by members of the clergy. St. John's, Nfld: Archdiocese of St. John's.

World Health Organization, (2005). *Child and adolescent mental health resources global concerns - Implications for the future.* Geneva; Herndon: World Health Organization Stylus Pub. LLC [distributor]. Retrieved from http://site.ebrary.com/id/10104334

World Health Organization. (2012). *Adolescent mental health. Mapping actions of nongovernmental organizations and other international development organizations*. Retrieved from http://apps.who.int/iris/handle/10665/44875

Xenakis, S. (2014). *Posttraumatic stress disorder: Beyond best practice. Psychoanalytic Psychology*. 31(2), 236-244.

Yeun, A. (2007). Discovering children's responses to trauma: a response based narrative practice. *The International Journal of Narrative Therapy and Community Work.* 4. 3-18.

Zeig, J., (Ed.). (1985). *The evolution of psychotherapy*. New York, NY: Brunner/Mazel.

List of Appendices

School of Social Work
P.O. Box 4200, St. John's, NL A1C 5S7
Tel: (709) 864-8165 Fax: (709) 864-2408
http://www.mun.ca/socwrk

Appendix A

Initial Design Statement

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research, such as the way you have been treated or your rights as a participant, you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at 709-864-2861.

Proposal

Problem Statement

Context & Theoretical Framework

Purpose

Objectives & Research question(s)

1. Determining a focus of the inquiry.
2. Determining fit of paradigm to focus area.
3. Determining fit of the inquiry paradigm to the substantive theory selected to guide the inquiry.
4. Determining where and from whom the data will be collected.

    Providing for identification of initial elements.

    Planning for purposive sample selection.

    Providing for orderly emergence of the sample

Provide for continuous refinement or focusing

Providing for termination

5. Determining successive phases of the inquiry.
6. Using human instrumentation.
7. Collecting and recording data

    Planning for data collection, and data analysis

8. Data analysis procedures.
9. Planning the logistics

    Prior logistical considerations for the project as a whole

    The logistics of field excursions while in the field

    The logistics of activities following field excursions

    The logistics of activities following field excursions

10. Planning for trustworthiness

    Final Steps

    Developing a case report

    Process

    Data analysis

    Theoretical implications

Subjecting case report to a comprehensive member check

Commissioning and facilitating an external audit

Dissemination

School of Social Work
P.O. Box 4200, St. John's, NL A1C 5S7
Tel: (709) 864-8165 Fax: (709) 864-2408
http://www.mun.ca/socwrk

Appendix B

Letter of Introduction and Explanation

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research, such as the way you have been treated or your rights as a participant, you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at 709-864-2861.

date

52 Gardner Street,
Grand Falls Windsor, NL
A2A 2S5
ruthmparsons@nf.sympatico.ca

Dear _____,

This letter is a follow-up to my initial telephone contact with you dated _____.

You are invited to participate in my dissertation research study, which seeks to explore the conceptualizations and practices of play therapists in their interventions with children who have experienced complex trauma. The title of my research is 'Identifying therapeutic change processes in the treatment of complex trauma'. The aim of this research is to inform the clinical interventions of social workers who work on an ongoing basis with this vulnerable population.

Your name was provided to me through snowball sampling technique whereby a play therapy colleague has recommended you as a participant in this research based on

their knowledge of your work.

Your participation in this research is totally voluntary. Please be advised that you can withdraw at any time during the study however there are limits to the withdrawal of any data you will have provided up to the point that you no longer wish to participate. In the naturalistic inquiry, recorded interviews are transcribed immediately following the interview process, so as to inform the next interview. As interviews proceed, data from each interview becomes aggregated (anonymously) with that of previous interviews to inform future interviews, and therefore information from individual interviews cannot be removed following aggregation, even if the participant decides to withdraw from the study. This is stipulated in the 'Letter of Informed Consent', which is attached. You are required to read this consent form before participating in this study. It will be reviewed and endorsed immediately prior to proceeding with data collection.

I am a PhD candidate at Memorial University of Newfoundland, through the School of Social Work. I am in the dissertation phase of my program. My research is being conducted in partial fulfillment of dissertation requirements. I have also been a student of play therapy in the past. From 2006 to 2009, I attended three summer institutes through the Canadian Association of Child and Play Therapy, at Kings College, University of Western Ontario.

In my work, I practice as a clinical social worker with a health authority in Central Newfoundland, and as a private practitioner in Newfoundland and Labrador. In both of these capacities I work with children and youth who have experienced trauma and complex trauma. Based on my study in play therapy, I often utilize therapeutic play in my work with child clients.

I am looking forward to meeting with you and interviewing you for my research. As an expression of my appreciation for your time, and for sharing your expertise, I would like to request that you identify a Canadian children's charity, of your choice, to be entered into a draw. A draw will be made at the end of my study, at which time the charity's name drawn will receive a monetary donation of $200.00 on behalf of this study's participants. I will notify participants when the donation is made, and identify the receiving charity at that time.

Sincerely,

Ruth Parsons, MSW, RSW, PhD Candidate
Principal Investigator

Note: copy to participant, and copy to file

School of Social Work
P.O. Box 4200, St. John's, NL A1C 5S7
Tel: (709) 864-8165 Fax: (709) 864-2408
http://www.mun.ca/socwrk

Appendix C

Letter of Informed Consent

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research, such as the way you have been treated or your rights as a participant, you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at 709-864-2861.

Title:	Identifying therapeutic change processes in the treatment of complex trauma
Researcher(s):	Ruth Parsons, School of Social Work, Memorial University of Newfoundland. ruthmparsons@gmail.com Tel: 709 486 2860 Mailing address: 52 Gardner Street, Grand Falls, Windsor, NL. A2A 2S5
Supervisor(s):	Dr. Dennis Kimberley, Professor at School of Social Work, Memorial University of NL. denniskimberle@gmail.com Tel: (709) 864-4859 (Phone)

You are invited to take part in a research project entitled *"Identifying therapeutic change processes in the treatment of complex trauma"*.

This form is part of the process of informed consent. It gives you the basic idea of what the research is about and what your participation will involve. It also describes your right to withdraw from the study. In order to decide whether you wish to participate in this research study, you should understand enough about its risks and benefits to be able to make an informed decision. This is the informed consent process. Please take time to read this letter carefully and to understand the information given to you. You can contact the researcher, Ruth Parsons, if you have any questions about the study or would like more information before you consent.

Participation in this research project is totally voluntary. If you choose not to take part in this research or if you decide to withdraw from the research after it has started, your choice to do so will be fully respected, and there will be no negative consequences for you, now or in the future.

Introduction:

I am a doctoral student in the School of Social Work, at Memorial University of NL. I am in the dissertation phase of my program. As part of my dissertation I am conducting research under the supervision of Dr. Dennis Kimberley, Professor at School of Social Work, at Memorial University of NL.

Purpose of study:

This research seeks to explore the conceptualizations and practices of certified play therapists in their interventions with children who have experienced complex trauma. Complex trauma is defined as "both children's exposure to multiple traumatic events usually of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure" (National Child Traumatic Stress Network, 2007, p.34). Although there are in excess of 550 types of therapies in use with children, little is known about how and why they work. Within every form of therapy lie processes of therapeutic change, and these are rarely studied in child and adolescent therapy. Furthermore, very few studies focus on the experiences of experts in the field of children's therapy. This study serves to do both. It seeks to understand the processes of therapeutic change in children's therapy, by studying the experiences of professional play therapists who work with children exposed to complex trauma.

If we were to understand the processes of therapeutic change, we would be better positioned to utilize these processes to develop specific interventions to optimize therapeutic outcome. This would serve to maximize treatment outcomes specifically for one of the most vulnerable groups of children presenting for therapy, those exposed to complex trauma.

What you will do in this study:

Participants in this study will be required to participate in an in-person interview, which will be at a location of their choice. This is an unstructured interview, which will

begin with the following grand tour question: 'What do you consider to be the therapeutic change processes within your treatment of children who have experienced complex trauma?' The interview will be audio recorded. Participants will be required to complete of 10-item demographic questionnaire, prior to the interview. At the completion of the interview, you will be invited to recommend a potential participant known to you who has experience in the subject area, for possible participation in this study. You can choose to forego this invitation, or to proceed. If you decide to make a recommendation, you will be asked to contact this person to advise them that you are recommending them for this study. If they do not wish to partake, no contact by this researcher will be made. If they are agreeable, this researcher will then contact that individual directly using email contact information provided by all registered play therapists on their professional association's (CACPT) website, or using contact information provided to you by the potential participant.

Your interview will be scheduled for 1-1.5 hours. Additionally member checks, which are a testing of the data, will be conducted with all participants. The purpose of member checks is to have the researcher learn from the interviewee's as to how well the researcher's interpretations reflect the interviewee's meanings, in terms of the analysis and resulting themes. Member checks will be carried out with each participant, at two separate points during the study. The first check will be conducted following the analysis of individual participant interviews, which is the point whereby provisional insights and hypotheses are formed. The analysis will be forwarded to participants (via email) for their review. This member check provides opportunity for correction of factual errors, feedback, and possibly the addition of more information. Following this member check, the analysis will be refined based on information provided. It will then be aggregated with analyses' of previous interview analyses' and thus it will not be possible to remove your individual data following this process. The resulting product will inform future interviews, as is the case in the naturalistic inquiry's emergent design. *The time required for this process will be specific to the individual, however the time frame is estimated to be up to 7 days inclusive following your interview.* The second member check will be carried out upon completion of the initial draft of the aggregated data of all participants, at the end of the study's data collection process. This is the final opportunity to test for factual and interpretive accuracy. Each participant will be forwarded this analysis (via email) in which aggregated data will be reported anonymously, therefore not identifiable to any single participant. The researcher is bound to accept any comment's, concerns and/or criticisms submitted by participants and weigh their meaningfulness, making adjustments to the analysis where appropriate. The time frame for this process fully depends on the time frame of the overall project, which may be 3 – 6 months from its beginning.

Compensation

To thank you for your participation in this study, a children's charity of your choice will be entered into a draw for a financial donation of $200.00, donated by this researcher in the name of this study's participants as an anonymous group. Study

participants will be notified of the winning charity by the researcher with verification that the donation has been received.

Withdrawal from the study:

You may withdraw from participation in this study by advising this researcher either verbally or in writing of your intent to do so. There will be no consequences to participants who choose to withdraw. Withdrawal remains a participant's option at any point from the request to participate to the analysis of the data. However, given that in naturalistic inquiry, data analysis is completed immediately following individual interviews, participants are advised of the following.

If withdrawal is decided upon following data collection but before the completion of data analysis phase, then all recorded data collected will be erased, and any written notes will be destroyed. However, in naturalistic inquiry, recorded interviews are transcribed immediately following the interview, so as to inform the next interview. As interviews proceed, data becomes aggregated, and therefore information from individual interviews cannot be removed following aggregation, even if the participant decides to withdraw from the study. As such, information gathered from a participant's interview and its subsequent data analysis which has already been utilized to shape the next interview, cannot be withdrawn after it has been utilized. However all data will be utilized anonymously.

Given the specialized work of the population being interviewed, it is possible that information from data analysis of previous interviews may unavoidably identify previous participants to new participants. This may be a result of participants' recognition within their field of practice. If so, this will be neither confirmed nor denied, and participants will be reminded of the confidentiality of all participants.

Possible benefits:

The study of change processes, specifically in services to children, has been identified as a priority for study by both clinicians and researchers across multiple disciplines, including the fields of play therapy and social work. Because there are so few studies on processes of therapeutic change in therapies specifically with children, your contributions are important to moving this concept forward. Knowledge of change processes would add to a newly developing body of literature that seeks to identify how and why therapy works, specifically with children who have experienced complex trauma, who are presenting in ever increasing numbers in both public and private mental health clinics. Such knowledge would support the ongoing development of therapeutic services specific to children's presenting issues.

Possible risks:

You will be asked to consider past experiences as a play therapist in working with children who have experienced complex trauma. As such, you may recall difficult cases you have worked on while discussing and identify conceptualizations and practices you have utilized in the treatment and amelioration of long-term sequelae of children exposed to complex trauma. Reflecting on past experiences has the potential to trigger troublesome memories, and thereby cause you upset. To prepare for this possibility, all

participants will be asked to identify a support person and their contact number prior to beginning the interview, and contact will be made with that person if required.
There are no foreseeable physical, social, or financial risks to participants of this study.

Confidentiality:

The ethical duty of confidentiality includes safeguarding participants' identities, their personal information, and protection of their data from unauthorized access, use, or disclosure.

As this study is being undertaken as a dissertation study, participants are advised that data may be reviewed by this writer's dissertation committee member(s) as part of their role in supervision. However, all data and documentation reviewed will be coded and therefore will not have any identifying information.

All information you provide to me during this research will remain confidential. However, b*ecause the participants for this research project have been selected from a small group of people, all of whom may be known to each other, it is possible that you may be identifiable to other participants on the basis of analysis of your interview*, which may be used in subsequent interviews.

Procedures for ensuring relative confidentiality (relative as some play therapists may recognize the theories and/or relative positions of others) will be implemented to prevent raw data from being linked with any specific participant. These will include: no identifying information will be utilized; no confirmation or denial of references to you or your work will be made; no reference will be made to the identities of any other participants or locations of interviews or participants; *if I report direct quotations from your interview, a pseudonym will be utilized to protect your identity;* and *all identifying information will be removed from my dissertation (case report).*

The data from this research project may be published and presented at conferences; if so, the above procedures will be implemented as well.

Anonymity:

Anonymity refers to protecting participants' identifying characteristics, such as name or description of physical appearance. Every reasonable effort will be made to ensure your anonymity, both in your participation and in the data you provide.
Data from this research project may be published and presented at conferences, however it will be reported in aggregate form, so that it will not be possible to identify individual participants.

As a further measure to ensure anonymity, consent forms will be stored separately from the data analysis documentation, so that it will not be possible to associate a name with any given set of responses.

Other than this consent form, please do not put your name or other identifying information on any documentation, specifically Appendix F, titled 'Demographics and Practice Information'.

Participants who prefer not to be anonymous may choose this option only if it does not negatively affect and/or identify other participants who do wish to remain anonymous.

Prior to interviewing, all participating play therapists will be reminded not to disclose any third party information, as a means of protecting their clients. If they inadvertently do so, an additional level of protection will be implemented in the analysis phase of this study, by irrevocably stripping the data of direct identifiers. Stripping data means it will be deleted without any type of coding thus preventing the possibility of the risk of re-identification of individuals from the remaining indirect identifiers. Any such de-identification will immediately follow recorded interviews.

Recording of Data:

All interviews will be audio recorded. A back-up recorder will also be used in cases of technical difficulties. In the event of continued technical difficulties with audio recording that cannot be resolved, consent will be requested to take written notes for the duration of the interview.

Storage of Data:

Electronic data will be stored on this researchers personal laptop computer, password protected. Data will be copied to USB flash drives(s) for the purpose of back up, and therefore will negate the possibility of losing data. USB flash drive(s) will also be password protected. All audiotapes, back up tapes, typed transcripts, and any related documentation related to this study will be stored in a locked filing cabinet, in this workers home office. Keys to this filing cabinet are safeguarded such that the researcher is the only person with access. Consent forms will be stored separately from the data, in a separate locked filing cabinet, in the same location. Keys to this filing cabinet are safeguarded such that this researched is the only person with access. You and your information, including transcripts, will be protected by the assignment of a code number that will identify any reference to information provided by you. Only my dissertation committee, which consists of three members, (Dr. Dennis Kimberley (chair); Dr. Brenda LeFrançois; Dr. Nancy Riedel Bowers) will have authority to access audio-tapes to ensure research integrity/quality. My Peer Advisor, who has signed‘Consent to Participate & Agreement to Maintain Confidentiality’, will see only the anonymity protected numbered transcripts. Audio-tapes, data, data analysis documents, and all other research information will be kept for a minimum of five years, as required by Memorial University’s policy on Integrity in Scholarly Research. At the end of this five-year period, all data will be destroyed via shredding, by this researcher.

Reporting of Results:

Results from this research study will be reported in the researcher’s doctoral dissertation, two copies of which will be retained in the Memorial University of Newfoundland QEII library, in addition to any personal copies printed by this researcher. Results will be reported only in aggregate and summary form, and any quotations obtained from the interviews will only be used anonymously and in accordance with your consent at the end of this document. Future use of this information may result in scholarly

publications or presentations about complex trauma and/or the processes of therapeutic change, which would be utilized under the same terms of anonymity proposed for this study.

Sharing of Results with Participants:

All participants will have the opportunity to voluntarily provide a mailing or e-mail address to which results of this study will be sent at the completion of the study. At the end of the interview, you will be asked if you wish to receive a copy of the study results. Depending on whether you provide a mailing address or e-mail address will determine the format in which you receive a copy of the results. If you wish to receive copies of any published journal articles that may arise from the study, you can request so from the researcher directly at any time.

Conflict of Interest:

This researcher does not have any individual financial interest in this research, nor am I affiliated with any funding bodies. Although I may be aware of the names of potential participants through my past attendance at play therapy summer institutes, I have no relationship, personal or professional with potential participants of this study, nor with any interest groups.

Questions:

You are invited to ask any questions you may have prior to signing this Informed Consent Form. Additionally, you are welcome to ask questions at any time before, during, or after your participation in this research.
If you would like more information about this study, please contact:

Researcher: Ruth Parsons, Tel: 709 486-2860 Email: ruthmparsons@gmail.com
and/or

Supervisor: Dr. Dennis Kimberley, Memorial University of NL, Tel. (709) 864-4859
denniskimberle@gmail.com

ICEHR Approval Statement

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research, such as the way you have been treated or your rights as a participant, you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at 709-864-2861.

Consent:

Your signature on this form means that:

- You have read the information about the research.
- You have been able to ask questions about this study.
- You are satisfied with the answers to all your questions.
- You understand what the study is about and what you will be doing.

- You understand that you are free to withdraw your participation in the study without having to give a reason, and that doing so will not affect you now or in the future.
- You understand that if you choose to end participation during data collection, any data collected from you up to that point will be destroyed. However, if you choose to withdraw after the data has been aggregated into the study, your data cannot be withdrawn.

I agree to be audio-recorded.	☐ Yes ☐ No
I agree to the use of direct quotations.	☐ Yes ☐ No
I agree to the use of the researchers note taking during the interview process.	☐ Yes ☐ No
I agree to the use of this study's data in future research	☐ Yes ☐ No
I agree to contact by this researcher for member checks	☐ Yes ☐ No

By signing this form, you do not give up your legal rights and do not release the researcher from professional responsibilities.

Your signature confirms:

☐ I have read what this study is about and understand the risks and benefits. I have had adequate time to think about this and had the opportunity to ask questions and my questions have been answered.

☐ I agree to participate in the research project understanding the risks and contributions of my participation, that my participation is voluntary, and that I may end my participation at any time.

☐ A copy of this Informed Consent Form has been given to me for my records.

_____ _____

Signature of participant Date

Researcher's Signature:

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

Ruth M Parsons, PhD Candidate Principal Investigator	Date

School of Social Work
P.O. Box 4200, St. John's, NL A1C 5S7
Tel: (709) 864-8165 Fax: (709) 864-2408
http://www.mun.ca/socwrk

Appendix D

Peer Advisor Agreement

Consent to Participate & Agreement to Maintain Confidentiality

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research, such as the way you have been treated or your rights as a participant, you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at 709-864-2861.

I, _____ consent to participate as a Peer Advisor in a research project by Ruth Parsons PhD candidate, titled 'Identifying therapeutic change processes in the treatment of complex trauma'. Ms. Parson's research will explore play therapists conceptualizations and practices with children exposed to complex trauma. The aim of this study is to inform the clinical interventions of social workers who work on a daily basis with this vulnerable population.

I understand that my role as peer advisor is as a non-involved professional, to provide unbiased inquiry, ongoing support, methodological exploration, and debriefing to the researcher and the project, keeping records for later consultation. As a peer advisor, I will oversee and advise Ms. Parsons with respect to such areas as: providing her with advice on relevant issues that may arise through data collection; provide support with review and interpretation of transcripts; and provide her with a peer support throughout her project.

I understand the nature and the purpose of this project being conducted by Ms. Parsons is as a doctoral dissertation at Memorial University of Newfoundland, through the School of Social Work. I also understand that the purpose of this study is to expand on the existing practice intervention knowledge of social workers who provide therapeutic

services to children who have experienced trauma.

I am aware that Ms. Parsons will code all transcripts and the information contained therein. I am also aware that Ms. Parsons guarantees that participant's information will be kept confidential and participants themselves will remain anonymous. Identities will not appear on any documentation or materials originating from the study

I understand that my participation is voluntary and that I may withdraw at anytime. I am aware that all transcript-related written materials are to be returned to Ms. Parsons at the end of each meeting we have. I am also aware that I will be asked for my written notes, memos, or other written texts that I may have made during these meetings, which will become part of the research audit trail. As such, Ms. Parsons will provide notebooks for the purpose of note taking in an effort to contain all notes in a coherent format, and to increase the cohesiveness of the audit trail. I understand that these materials will be preserved and stored in a secure manner as part of the audit trail. Also I am aware that all research related notes and materials will be destroyed five years after successful completion of Ms. Parson's research.

I understand that participant names will not be disclosed to me, and that protecting the confidentiality and anonymity of participants is critical. I agree that I will not share in any way information associated with participants, or any of the interview information shared with me as part of my advisory role, with anyone other than privately with Ms. Parsons, or members of her Advisory Committee, which consists of Dr. Dennis Kimberley (Chair), Dr. Brenda LeFrançois, and Dr. Nancy Riedel Bowers.

I also understand that the proposal for this research has been approved by the Interdisciplinary Committee on Ethics in Human Research (ICEHR) at Memorial University. If I have any ethical concerns about the research (such as the way I have been treated or participants' rights), then I may contact the Chairperson of the ICEHR at _____or by telephone at _____ .

I acknowledge that I have read and fully understand this consent form. My signature indicates my agreement to voluntary participate in this research. A copy of this consent has been given to me.

_____	_____
Participant Signature	Researcher
_____	_____
Date:	Date:

School of Social Work
P.O. Box 4200, St. John's, NL A1C 5S7
Tel: (709) 864-8165 Fax: (709) 864-2408
http://www.mun.ca/socwrk

Appendix E

Demographics and Practice Information

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research, such as the way you have been treated or your rights as a participant, you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at 709-864-2861.

1. What is your professional designation?

_____

2. When did you complete your certification in play therapy?

_____ (year)

3. From what association did you receive your certification?

_____

4. Where do you presently practice play therapy?

_____

5. How long have you been practicing as a certified play therapy?

0-5 yrs 6-10 yrs 11-15 yrs 16-20 yrs 20+ yrs.

6. Are you employed: publically (_____) or privately (_____), or both (_____).

7. Are you: Male _____ Female _____ Other _____

8. Have you completed any formal training in trauma work?

_____ yes (where) _____

_____no

9. In providing play therapy services, which of the following do you use?

_____ Non-directive play therapy _____ Directive play therapy

_____ Combination of the two

10. Is there a specific modality of play therapy that you prefer to use in your work with children who have experienced complex trauma?

_____

_____

Thank-You

School of Social Work
P.O. Box 4200, St. John's, NL A1C 5S7
Tel: (709) 864-8165 Fax: (709) 864-2408
http://www.mun.ca/socwrk

Appendix F

Oral Telephone Recruitment Script

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research, such as the way you have been treated or your rights as a participant, you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at 709-864-2861.

Hello, my name is Ruth Parsons, and I would like to speak with _____.
Can you conform that you are _____?

If yes, proceed. (If no, the call will respectfully end.)

I am a student in the School of Social Work PhD Program, at Memorial University of Newfoundland and Labrador. I am conducting a research project on identifying therapeutic change processes, applying play therapy, in the treatment of complex trauma in children and youth, to fulfill dissertation requirements within this program.

(To the initial participant…)
I obtained your name from Ms. Theresa Fraser, who has undertaken the role as gatekeeper for my project. Within that role Ms. Fraser has kept a listing of play therapists who recently responded to my letter to the CACPT web blast, seeking expressions of interest from play therapists interested in possible participation in my dissertation study.

(To all other participants…)
I obtained your name from a play therapy colleague of yours who recommended you as a participant for this project based on your work in both play therapy and trauma. That individual made contact with you and advised that you were open to my contact with you.

I would like to invite you to participate in my project, which is a qualitative study using naturalistic inquiry. It will require an in-person interview, for duration of 1 – 1.5 hours. If you agree, I will forward a copy of the study's 'Letter of Introduction and Explanation' via email. This form outlines the details of my study and what participation will entail.

Based on this information, are you interested in proceeding?

If yes, proceed. (If no, the call will respectfully end, thanking the person for their time and consideration.)

I have obtained your email address from the CACPT membership website. I can forward a 'Letter of Introduction and Explanation' to you for your review?

If yes, proceed. (If no, discuss alternative ways to forward this information to potential participant.)

If you are interested in proceeding after you review this letter, and you confirm this interest to me via email, I will then forward a copy of the 'Letter of Informed Consent'. This letter outlines all key aspects of my study, and what is being asked of participants. I will bring a copy of this consent form to the interview for us both to sign before the interview begins.

Your participation is confidential and your contact information will not be shared with anyone. Information on confidentiality is outlined in the 'Letter of Informed Consent'.

After you have had opportunity to review the 'Letter of Informed Consent', I would like to connect with you by email or telephone to discuss setting up a date, place, and time for us to meet. Is this agreeable to you?

If yes, proceed. (If no, discuss alternate ways of follow-up.)

Do you have any questions?
If yes, answer appropriately. (If no, proceed)

If you think of any questions please do not hesitate to contact me by phone, at 709-486-2860, or by email at ruthmparsons@nf.sympatico.ca.

Thank you for your time.

School of Social Work
P.O. Box 4200, St. John's, NL A1C 5S7
Tel: (709) 864-8165 Fax: (709) 864-2408
http://www.mun.ca/socwrk

Appendix G

E-blast to all Certified Play Therapists listed on CACPT Website in the province of Ontario

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research, such as the way you have been treated or your rights as a participant, you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at 709-864-2861.

NOTICE TO ALL PLAY THERAPISTS IN ONTARIO

A PhD Student from Memorial University, St. John's Newfoundland is preparing to undertake a qualitative study entitled:

'Identifying therapeutic change processes in the treatment of complex trauma'.

She is seeking participants for her study who are certified play therapists who have training and/or experience in the provision of therapeutic services to children who have been exposed to complex trauma.

If you are interested in possibly participating in this study, please forward an expression of interest via email to theresafraser@rogers.com

This study is anticipated to begin: July/August, 2015.

School of Social Work
P.O. Box 4200, St. John's, NL A1C 5S7
Tel: (709) 864-8165 Fax: (709) 864-2408
http://www.mun.ca/socwrk

Appendix H

Thank-you Letter

October 15, 2015

I recently sent out an e-blast to Certified Play Therapists, in Ontario, Canada, seeking expressions of interest from play therapists who may be interested in take participating in my research study, entitled:

'Identifying therapeutic change processes in the treatment of complex trauma'.

The response to this e-blast was very encouraging. I would like to say thank-you to you for responding, for your willingness to participate, and also your interest in this study. Because you responded I am taking this opportunity to advise you that I have now completed interviews for my data collection. Participants were chosen based on a combination of snowball sampling and self-identification through the e-blast. As per my model of inquiry, interviews stopped when the information being sough became saturated.

Again, please accept my sincere thank-you for your willingness to participate

Ruth Parsons, MSW, RSW, PhD(C)

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research, such as the way you have been treated or your rights as a participant, you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at 709-864-2861.

MEMORIAL UNIVERSITY
School of Social Work
P.O. Box 4200, St. John's, NL A1C 5S7
Tel: (709) 864-8165 Fax: (709) 864-2408
http://www.mun.ca/socwrk

Appendix I

Inclusion Criteria

Potential participants, as identified through e-blast were contacted by email a week before the interview process began. Participant criteria were reviewed.

Inclusion criterion:

1. Residing in Ontario
2. Is a certified play therapist
3. Has training and/or experience in trauma counseling
4. Provides services to children who have been exposed to complex trauma

Participants' interest was confirmed as was their willingness to participate (if contacted).

Availability during the interview dates of July 21 to August 4/2015 was assessed.

Appendix J-1

ICEHR Approval Letter

MEMORIAL UNIVERSITY

Interdisciplinary Committee on Ethics in Human Research (ICEHR)

St. John's, NL Canada A1C 5S7
Tel: 709 864-2561 icehr@mun.ca
www.mun.ca/research/ethics/humans/icehr

ICEHR Number:	**20152102-SW**
Approval Period:	May 4, 2015 – May 31, 2016
Funding Source:	N/A
Responsible Faculty:	Dr. Dennis Kimberley School of Social Work
Title of Project:	*Identifying therapeutic change processes in the treatment of complex trauma*

May 4, 2015

Ms. Ruth Parsons
School of Social Work
Memorial University of Newfoundland

Dear Ms. Parsons:

Thank you for your email correspondence of April 29, 2015 addressing the issues raised by the Interdisciplinary Committee on Ethics in Human Research (ICEHR) concerning the above-named research project.

The ICEHR has re-examined the proposal with the clarification and revisions submitted, and is satisfied that the concerns raised by the Committee have been adequately addressed. In accordance with the *Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans (TCPS2)*, the project has been granted *full ethics clearance* to May 31, 2016. ICEHR approval applies to the ethical acceptability of the research, as per Article 6.3 of the *TCPS2*. Researchers are responsible for adherence to any other relevant University policies and/or funded or non-funded agreements that may be associated with the project.

If you need to make changes during the course of the project, which may raise ethical concerns, please forward an amendment request form with a description of these changes to icehr@mun.ca for the Committee's consideration.

The *TCPS2* requires that you submit an annual update form to the ICEHR before May 31, 2016. If you plan to continue the project, you need to request renewal of your ethics clearance, and include a brief summary on the progress of your research. When the project no longer requires contact with human participants, is completed and/or terminated, you need to provide the annual update form with a final brief summary, and your file will be closed.

The annual update form and amendment request form are on the ICEHR website at http://www.mun.ca/research/ethics/humans/icehr/applications/.

We wish you success with your research.

Yours sincerely,

Gail Wideman

Gail Wideman, Ph.D.
Vice-Chair, Interdisciplinary Committee on

Appendix J-2

ICEHR Extension Letter

Interdisciplinary Committee on
Ethics in Human Research (ICEHR)

ICEHR Approval #:	20152102-SW
Researcher Portal File #:	20152102
Project Title:	*Identifying therapeutic change processes in the treatment of complex trauma*
Principal Investigator:	Ms. Ruth Parsons School of Graduate Studies
Supervisor: (if applicable)	Dr. Dennis Kimberley
Clearance expiry date:	**May 31, 2017**

Dear Ms. Parsons:
Thank you for your response to our request for an annual update advising that your project will continue without any changes that would affect ethical relations with human participants. On behalf of the Chair of ICEHR, I wish to advise that the ethics clearance for this project has been extended to May 31, 2017. The *Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans* (TCPS2) requires that you submit another annual update to ICEHR on your project prior to this date. We wish you well with the continuation of your research.

Sincerely,
Debby Gulliver
Secretary, ICEHR

Appendix K

Participant Demographics

Participant	Professional Designation	# of Years Practice	Practice Public/ Private	Trauma training Formal/Informal	Preferred Modalities of Treatment
1	Play Therapist M.A., R.S.W	4	Both	Trauma Institute Safeguards CACPT	Trauma Focused CBT, Narrative therapy, CBT
2	Play Therapist Masters in Counseling Psychology	12	Public	National Institute for Trauma/Loss in Children (TLC)	Non-directive play therapy
*3	Play Therapist Registered Psychotherapist PhD (C), Social Work Certified in EMDR	20	Both	Trauma Learning Institute Sexual Assault Center Training Adoption Council of Ontario EMDR Institute Training with trauma specialist's - Bruce Perry - Geraldine Crisci	EMDR, Sandtray World Play, non-directive play, theraplay, narrative
4	Play Therapist Sociology Degree (Child & Family) Diploma in Social Work Trauma & Loss Clinical Specialist	9	Public	National Institute of Trauma/Loss in Children (TLC)	Collective, primarily parent/child focused theraplay
5	Play Therapist Counselling Psychology Child/Youth Trauma & Loss Clinical Specialist	9	Privately	National Institute for Trauma & Loss Sandtray Worldplay, CACPT Training with Trauma specialist: - Geraldine Crisci	Combination of modalities
6	Play Therapist Certified Child Psychotherapist Master of Arts	7	Privately	Informally, through clinical Supervision	Theraplay, non-directive
7	Play Therapist Clinical Psychologist	20+	Privately	Training by Trauma specialist's Trainer with CACPT - Bessel Van der Klok - Bruce Perry - Dr. Dan Hughes - Ilianna Gil - Dr. Dan Siegel	Theraplay

8	Play Therapist Master of Science in Mental Health Counselling: Specialization in Play Therapy Degree in Art Therapy	4	Publically	Canadian Center for Threat Assessment & Trauma response. Living Works – Suicide Prevention	Non-Directive, and Directive
9	Play Therapist Social Work, PhD Clinical	17	Privately	Certified EMDR therapist & consultant (trauma training)	Sandtray, EMDR, Symbolic Play through sandtray miniatures; Puppetry Theraplay (integrated with EMDR); storytelling (narrative)

NOTE: All participants are certified with CACPT.
All are female.
All practice a combination of Directive & Non-Directive.

Appendix L

Final Member Checking Document (#2)

This is the second of two member checking processes with participants of my study which seeks to understand the therapeutic change processes in the treatment of children who experience complex trauma. The goal of my study is to understand what it is that play therapists do in their therapy with children that can affect a positive outcome, and the opening question for each interview was the same, and that is: what do you consider to be the therapeutic change processes within your treatment of children who have experienced complex trauma?

A total of nine interviews were completed. Following each interview, a narrative summary of the interview was sent to individual participants, as a member checking process, to seek feedback. Participants were advised that upon completion of the interview and analysis process, a second member checking process would be undertaken. This present document, based on analysis of all interviews, was developed for member checking process #2. It is a report on the analysis of interviews, both individually and cumulatively.

By following the process of thematic analysis, I completed steps 1 – 3 (out of 6 steps) along my journey to understand the therapeutic change processes within the treatment of complex trauma. Step 4 is the development of a thematic map, which is a visual representation of the themes, and Step 5 is the naming of each theme and clearly defining same, and finally Step 6 – is the final analysis of the selected extracts, relating this back to the research question, and production of the case report.

At the present step, step 3, themes have emerged from the data, which I am forwarding to each participant, as a second member checking process, to seek feedback, as to these themes representing an overall view of therapeutic change processes within participants work with children who experienced complex trauma. The goal of this second member checking process is to ensure adequate representation of the reality of participants as to my reconstruction of information provided – in a cumulative form. Member checking is crucial for establishing credibility. A review of each step is outlined so as to provide an understanding of the process to date.

Step I of thematic analysis - Immersion in data.

Following the completion of all 9 interviews (final one in September/15) I began the process of dictation. This was a timely process, but very worthwhile in that I became familiar with not only details and intricacies of individual interviews, but also with the cumulated data, so I was able to identify repeated patterns, unique details, and core concepts. This was very helpful in moving to step 2.

Step 2 of thematic analysis – Coding

Following the dictation process, I reviewed each interview in great detail. The following codes emerged to organize the data within each interview:

1. Practices – Used to identify all the various forms/types of interventions utilized by participants

2. Resources – Used to identify the individual and combined resources referred to, utilized, and recommended by participants. This was a very rich array of materials that have all been reviewed in detail.
3. Assessment – This code was used to capture details of the assessment process, in the beginning phase of treatment
4. Relationship Building – This is a key feature that was referred to often as a key feature of trauma work. There was much discussion about this, and a consensus that with a strong therapeutic relationship, good work can be accomplished
5. Play Process – This code captured the many references to the type of work taking place through play, under the guidance of experienced therapists.
6. Time – This code was used to capture the many references made to the concept of allowing a child to progress at their own pace, and matching that pace with that of the therapeutic process. It was a consensus that time, patience, and processing were key to a traumatized child moving forward in the treatment process. Many risks were identified where time was not utilized to the benefit of the therapeutic process. Also there was consensus that preparation work should continue until assessment determines a child is prepared to move into processing.
7. Change Agents – This is the code used to capture what play therapists identified as to what happens within the therapeutic process …. following development and implementation of the above components (1-6).
8. Processing the trauma – This code was used to identify how trauma is processed; what methods, resources, and therapeutic components are used to help the traumatized child work through the processing of their trauma.

9. Therapists – This code was utilized to capture the many qualifications, skills, experience, and expertise of participants.
10. Findings – This code was used to identify any component within the data that was of importance to the overall study.

Step 3 of thematic analysis – Identifying Themes

Upon completion of this coding process I chose to undertake a re-coding process. Recoding is highly recommended for new researchers, as by re-coding a researcher gets to have a second look at the data through more experienced eyes. This was a very worthwhile process. Through undertaking this process, the middle phase of treatment was found to have sequencing within it specific to complex trauma, and it is within this sequencing that therapeutic change processes were able to be identified. Analysis of each of the 3 steps in the sequencing identified therapeutic change processes and therapeutic change agents. Furthermore, therapist's skill development was identified as a key feature of working with complex trauma, and the utilization of trauma specific interventions was evident throughout. Each of these are further discussed as follows:

This sequencing of steps followed the relationship building phase of treatment and are:

1. pre-processing (stabilization) - teaching skill development, creating opportunities for success, enhancing attachment,
2. processing- trauma processing, mastery, and resolution, and,
3. post-processing (integration) – transferring gains made and moving on.

The following is an explanation of each of these steps as they emerged from the data:

Step 1 – Pre-processing (stabilization)

Teaching skill development – This is key to the beginning work required for trauma processing. The therapist teaches children skills required for processing, inclusive of: coping skills, down-regulation skills, and communication skills. Repetition of newly acquired skills, which is a major component of a child's learning, is utilized in order for children to gain mastery, and begin to overcome their well-established defense mechanisms – prior to starting the processing of their trauma. Skill development includes: deep breathing exercises (such as square breathing, bubble breathing, belly breathing blowing out the candles, etc); relaxation exercises, sensory exercises; grounding; emotional regulation; behavioral regulation; self-efficacy & self-perception (especially with teens).

Creating opportunities for success – This has emerged as a very important aspect of trauma work, as it is aimed at identifying children's strengths, instilling confidence in those strengths and building upon them towards enhancing positive mental health growth, promoting resiliency, and focusing on celebration of successes. Opportunities are initiated through matching a child's strengths and interests with activities that set them up for success, using support, encouragement, praise, and excitement. This can include activities inside the therapy room (art, clay work, projects) or outside such as restarting a past fun

activity or starting a new one. Physical activity was noted to be encouraged often, with focus on expressive body activities (yoga, dance, music activities, etc.); and on finding purpose and meaning.

Enhancing attachment – This is a very important prerequisite to trauma processing and resolution. Attachment work is aimed at rebuilding trust and thus instills 'hope' that things can get better, which has emerged as a key change agent. Attachment work takes place between children and their supporting caregiver, child and therapist, and between the therapist and the caregiver as a form of modeling. It was consensus by all participants that positive attachment work is necessary for working with complex trauma.

Step 2 - Processing

Trauma processing and resolution – This is a very skilled piece of work in which the therapist parallels child work and the work with the parent, so that each is in receipt of individual work that is aimed at supporting the work of the other. By doing this parallel work, the therapist can pair various components (attachment, trauma education, education on developmental ages/stages), so as to enable the parent to provide support beyond the clinical setting. Also, as a child is processing their trauma, the parent is learning; attunement, reading cues, learning how to down-regulate, learning to understand trauma behavior, and learning about the effects of trauma on a child's brain. Meanwhile, a child's own therapy (in which they take the lead) involves the following; narrating their trauma, re-storying for new possibilities into the future, change of cognitive distortions,

gaining mastery over the trauma, moving from victim to relinquishing blame, receiving validation, becoming empowered, and enhancing competencies. These are paired with psychoeducation on trauma, trauma brain, and trauma behavior ….all within a child's developmental ability to understand the information and apply it to their own situation. By processing their trauma experience(s) children begin moving towards adaptive resolution. The goal of pairing children's work with caregiver work is to support the transference of the gains made in therapy beyond the play room to a child's life at home, at school, with their peers, and in other areas of their lives that are key to their continued positive development. The processing phase ends when children experience mastery, which has been referred to as 'ah-ha moments', however work continues into transference, referred to here as post-processing.

Step 3 – Post-processing (integration) - This step reinforces gains made in processing phase, and serves to promote and follow-up on the transfer of gains made in therapy into day today lives, at home, at school, with peers, and in social environments. It provides opportunity for review, repair, and correction of prior learning, and repeating if necessary. In this step, self-reports and reports from parents and teachers serve to determine if transference is successful.

Within the codes identified, those of #7 (change agents), and #8 (processing the trauma), were further studied. The therapeutic work described by participants was broken down into categories of work by children, the parent, and the therapist.

Each grouping is interwoven with the others. It became increasingly obvious that work with a child and their parent/caregiver has to be undertaken together; in other words it is a parallel process to enable both to be ready for processing, and for the a child to be able to successfully process the trauma to resolution. Within this, the following **therapeutic change processes** were identified:

- A renewed ability to attach
- A positive relationship building experience
- Renewed ability to trust
- Hope; the therapist's faith in children renews their strength
- Time and pacing as can be tolerated by chldren
- Therapist facing children's trauma & fears with them so they don't have to do it alone
- Believing in children enables them to belief in themselves
- Mental health growth & resiliency

These therapeutic change processes require agents to support their development.

The following change agents were identified:

- Utilization of trauma specific interventions (see below)
- Age/stage appropriate play materials
- Therapist's skills (see below)
- Respect for children and their individual story
- Secure enough attachment to enable work to proceed
- Ability to engage in a therapeutic dance

In addition to the above, the following key features were identified:

Therapist's skill development – This theme captures the many skills required by therapists to provide trauma intervention work with children inclusive of: attunement, mirroring, pacing, teaching, advocacy, modeling (relationship development, trusting relationship), developmentally appropriate intervention skills, creative solutions, connection, experience, openness, and transparency. Additionally therapists have to be well versed in complex trauma – its presentations – its effects on children and their caregivers – and its effects on all areas of children's lives. As complex trauma presents differently in every child, the therapist has to be very skilled in recognizing the effects in each individual child and determining their role as therapist both inside and outside the therapy room (advocacy, collaboration), with both being equally important. A key finding in this area has been the requirement for the therapist to be able to work with all client systems; individuals, caregivers, couples, families, schools, CAS, foster care system, community systems, and any other system their client may be involved in (case management)– therefore highlighting the diverse skill set required to work in the area of complex trauma.

Utilization of trauma-specific interventions – this theme captures the many types of interventions and pairings of interventions utilized by play therapists, in treatment of complex trauma, and knowing how/when to use same. This includes: TF-CBT, CBT, Circle of Security, EMDR, Sandtray, Erica Method, Theraplay,

directive play therapy, non-directive play therapy, EFT, art therapy, filial therapy, narrative therapy, life story work, use of therapy dogs, and an integration of approaches. Many of these interventions require advanced training, over and above the requirements of becoming a play therapist and trained trauma therapist.

Sent to all participants via email on Jan. 7/16

Appendix M

Coding Scheme – Thematic analysis

Initial coding process (October, 2015)

Dictation of all interviews completed

Initial read through of all written interviews, without making notes

Second reading: made margin notes on each transcript

Transferred margin notes to blank document. Located each in naturally occurring groups.

Themed each group.

Created a thematic map for each interview.

After completing this process for each of the nine interviews, grouped them all together, into overall themes. Within each theme, began coding.

Completed a full recoding process, as recommended for new researchers. (January 2016)

1. Placed the research questions visually in front of me, as I began the process anew.
2. Utilized my learning from initial coding process to organize more coherently.
3. Utilized margin notes, using color-coding for each transcript
4 Highlighted important concepts
5. Categorizing
6. Noted new findings
7. Notes to self (good point, question, etc.)
8. Use of arrows to connect findings
9. Circling key words.

Upon completion of all transcripts, transferred the information to a 'code book'.
Column 1 identified Findings: column 2 identified Codes

Upon completion of this process, codes were transferred to a 'code sheet' identified by the file from which it was retrieved. Patterns were identified and grouped together into themes, identified by a color-coding process.

The resulting themes were then matched to the research questions.

Appendix N

CHECKLIST FOR STUDY'S PARTICIPANTS

CODED ID _____

☐ TELEPHONE SCRIPT Date _____

☐ LETTER OF INTRODUCTION & DEDCRIPTION SENT

Date _____

☐ CONSENT FORM SENT Date _____

☐ INTERVIEW DATE/TIME _____

☐ LOCATION _____

☐ CONSENT FORM ENDORSED

☐ PARTICIPANT IS REQUESTED TO IDENTIFY A PERSON OF SUPPORT AND THEIR CONTACT INFORMATION

☐ DEMOGRAPHICS FORM COMPLETED

☐ Begin each interview with the same grand tour question, specifically, 'What do you consider to be the therapeutic change processes within your treatment of children who have experienced complex trauma?'

Leading into the three questions that will guide my research. These are:

☐ 1. What practices have play therapists found to be effective in assessment

and treatment of children exposed to complex trauma?

☐ 2. What practices have play therapists found to be effective in reducing the long-term impact of complex trauma?

☐ 3. What are play therapists' understandings of change processes in which they have confidence?

☐ Discuss member-checking process & arrange same with participant.

- ☐ Initial member checking
- ☐ Final member checking

☐ INTERVIEW COMPLETED

Length of time for interview

_____

☐ DOCUMENTS REVIEWED (incl. informational material on programs)

_____

_____

_____

☐ CHILDRENS CHARITY IDENTIFIED

Name:

_____

☐ NEXT PARTICIPANT IDENTIFIED

- ☐ Has contact been made to determine interest

☐ Document my own observations.

☐ Transcribed

☐ Analyzed

☐ Peer Debriefing Date

_____