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The effect of play and creative arts therapy on the emotional wellbeing and behaviour of a boy with Attention-Deficit/Hyperactivity Disorder: a case study

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ABSTRACT

Play and creative arts therapy offers a safe space for children to express themselves, to enable them to reach their potential. There is little evidence in the U.K. on whether this type of therapy is beneficial for ADHD. This single-case study examines the effect of play and creative arts therapy on the emotional wellbeing and behaviour of an 8-year-old boy with ADHD. The boy was referred because of difficulties to manage his anger and frustration at school and home. Twenty-three individual sessions of therapeutic play were delivered at school. The Strengths and Difficulties Questionnaire was used to assess hyperactivity, peer, conduct and emotional problems, pre-therapy, mid-therapy and post-therapy. In addition, data from parent and teacher interviews alongside clinical observations of sessions were analysed pre-therapy, mid-therapy and post-therapy. Data from the SDQ, interviews and clinical observations were triangulated via supervision. Themes from the clinical sessions were in line with child-centred play therapy principles and indicated therapeutic growth. Results showed a 50% reduction in hyperactivity and a steep decrease in emotional problems post-therapy at school but not at home. Further work in supporting parents at home may be beneficial alongside individual therapy at school. Implications for theory and clinical practice are discussed.

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Introduction

Attention-Deficit/Hyperactivity Disorder (ADHD) is the most common neurodevelopmental condition of childhood, characterised by developmentally inappropriate levels of inattention, impulsivity, and hyperactivity (Posner et al., 2020). ADHD is divided into three subtypes: primarily inattentive, primarily hyperactive-impulsive and combined type with combined type being the most common in children (American Psychiatric Association, 2013). Hyperactive/impulsive symptoms include running around or

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talking excessively. Inattentive symptoms include being easily distracted or losing things. Children of ADHD combined type present symptoms of both hyperactivity-impulsivity and inattention (APA, 2000). At least 5% of school-aged children present symptoms of ADHD in the U.K. (Sayal et al., 2017). Boys are three times more likely than girls to be diagnosed with ADHD (Reuben & Elgaddal, 2024). In addition, boys are more likely to show externalising symptoms (e.g. running around, hyperactivity) whereas girls are more likely to show internalising symptoms (e.g. daydreaming, inattention). Girls with ADHD might also use different coping strategies (e.g. masking), and greater compliance in social situations (Quinn & Madhoo, 2014). As a result, it is often harder for parents and teachers to identify ADHD in girls. Although ADHD is often diagnosed around the age of 8 (APA, 2000), early onset preschool hyperactivity can be a precursor to ADHD (Sonuga-Barke et al., 2005). Inattention symptoms tend to remain stable over time, whereas hyperactivity and impulsivity tend to decline with age (Eng et al., 2023). ADHD diagnosed in children often persists into adulthood (Agnew-Blais et al., 2016).

Children with ADHD often present high levels of anxiety (Duchesne et al., 2010) and depression (Jensen et al., 2001). In addition, inattention and hyperactivity in children often co-occur with conduct problems, which consist of a range of oppositional and aggressive behaviours (Fairchild et al., 2019). These oppositional behaviours (e.g. anger, irritability) are observed in up to 60% of individuals with ADHD (Connor & Doerfler, 2008). Interestingly, ADHD may emerge in ways that are problematic due to the social context where ADHD is observed (e.g. school classrooms which are outcomes-focussed). Both genetic and environmental risk factors are implicated in ADHD. For instance, ADHD has a strong genetic component, with heritability estimates ranging from 70% to 80% (Faraone & Larsson, 2019). Environmental risk factors for ADHD include parental mental illness and alcohol, and drug use during pregnancy (Chen et al., 2024; Pagnin et al., 2019; Robinson et al., 2024). Research has also shown that children who have experienced Adverse Childhood Experiences (ACEs) such as abuse, neglect and household dysfunction, are more likely to have an ADHD diagnosis compared to children without ACEs (Boswell et al., 2024).

Recent models have challenged ADHD as a categorical entity by highlighting the dimensional and multi-axial nature of the condition (Sonuga-Barke, 2020). These consider both cognitive and motivational factors. For instance, some children with ADHD present difficulties with processing positive (e.g. reward; Chronaki et al., 2017) or aversive (e.g. delay; Chronaki et al., 2019) stimuli as well as emotional stimuli (Chronaki et al., 2015). Emotion dysregulation, including difficulties to recognise and regulate emotions such as anger, has been increasingly considered an important clinical feature of ADHD (Shaw et al., 2014). Anger, often considered a signal of social punishment, may act as a trigger for negative emotional outbursts in children with ADHD and contribute to coercive cycles of parent–child interactions (Johnston & Jassy, 2007). Recent research has shown that higher levels of emotion dysregulation at age 3 and 5 longitudinally predicted the levels of hyperactivity, conduct problems and emotional problems at age 7 (Murray et al., 2025). In summary, wellbeing and emotional factors are important to consider in the aetiology of ADHD.

Existing treatments for ADHD, such as Cognitive-Behaviour Therapy (CBT), focus on symptoms, and impairment (Battagliese et al., 2015). This approach offers a descriptive

account of change post therapy rather than an in-depth understanding of broader mechanisms such as emotional regulation. In addition, existing treatment approaches focus on 'deficits' without considering the positive outcomes of ADHD on the child. This hinders a personalised treatment approach where the child is 'seen' as a whole person rather than for the 'problems' it has, and where the child's strengths and creative potential are recognised. For instance, research investigating creative abilities in individuals with ADHD, has found evidence for increased divergent thinking in children with traits of ADHD (Hoogman et al., 2020). These findings call for more personalised, and strengths-based treatment approaches in childhood ADHD. Instead of merely focusing on 'deficits', treatments for ADHD need to consider a facilitative environment allowing the child the opportunity to explore his/her strengths and creative potential (Sonuga-Barke, 2020). When a child feels free to express him/herself in any way he/she chooses, the child learns to develop trust in helping him/herself. A safe therapeutic relationship can act as the vehicle for change as it offers a facilitative context for the child to learn to self-regulate.

Play and creative arts therapy is a type of therapy using play and creative media to help children express themselves freely, especially if they struggle to understand and verbalise how they are feeling (Levine, 2014). Play is the child's natural medium of self-expression, where 'toys are viewed as the child's words and play as the child's language' (Landreth, 2012). Play and creative arts therapy utilises creative media such as therapeutic storytelling, drama, music, creative visualisation, and sand play. It is important to distinguish play work from play therapy. Children's play is a multifaceted activity; it is both about communication and an activity engaged in for its own sake. These aspects of play are interconnected and not mutually exclusive. For instance, children play not only to express themselves but also because they enjoy playing (e.g. play is driven by intrinsic motivation). Playwork is a child-led approach to working with children, where children determine the content and intent of their play, rather than being led or directed (Brown, 2003). Playwork can be described as the art of working with playing children, whereas play therapy has a therapeutic objective and is based on a therapeutic alliance. The purpose of play work is to facilitate play as a valuable activity in its own right, whereas the purpose of play therapy is to help children express emotions and resolve emotional or behavioural issues (Landreth, 2012).

Child-centred play therapy consists of play work built on principles of person-centred theory. Person-centred theory, developed by Rogers (1951), emphasises the therapeutic relationship as a catalyst for change. Axline (1969), who was Rogers' student, proposed non-directive play therapy principles, where the child leads, and the therapist follows the child's lead. As the therapist emphatically listens, and recognises the child's needs, a therapeutic space is created where the child begins to feel free to express his/her feelings (Axline, 1964; Landreth, 2012). This relationship aims to offer acceptance of the child, allowing, in turn, the child to accept him/herself. A child who can express his/her feelings without being judged, develops a sense of self as a valued individual in his own right. This allows the child to regulate his feelings more effectively. The co-regulation of emotion within a safe therapeutic relationship represents an important mechanism enabling the child to self-regulate (Ray, 2011).

Non-directive play therapy approaches are supported by research as school-based interventions which can be effective in reducing childhood behaviour problems (Bratton et al., 2005). A meta-analysis of 93 studies has examined the efficacy of this

approach across settings and conditions and has found a strong mean effect size of 0.8 (Bratton et al., 2005). Similarly, a meta-analysis of 94 studies has examined the clinical effectiveness of person-centred play therapy for a range of childhood issues including externalising behaviours. Results revealed a large effect size across outcomes, including childhood hyperactivity, inattention and conduct problems (Ray et al., 2001). A recent meta-analysis found a medium effect size of child-centred play therapy for reducing externalising behaviours (e.g. conduct problems, hyperactivity) compared to alternative treatments and wait list controls (Parker et al., 2021). Evidence on the effectiveness of non-directive play therapy in the U.K. is more limited. Data from 3702 children classified as 'at risk' for emotional and behaviour problems in the U.K., who have undergone play therapy following the Play Therapy UK (PTUK) model, have shown that 74–83% of children displayed a positive change after play therapy (Thomas, 2011). Research in non-directive play therapy tailored for children with ADHD in the U.K. is lacking.

This study examined how play and creative arts therapy impacts the emotional wellbeing and behaviour of a child with ADHD. Existing play therapy research has not systematically examined the role of emotion regulation, wellbeing and behaviour problems in childhood ADHD. As the priority concerns for this child were around managing anger and frustration, the intervention aimed to improve wellbeing and behaviour across home and school settings. We hypothesised that therapeutic play would help reduce hyperactivity, emotional and conduct problems at home and at school. By utilising a case study design we aimed to address the question of 'why' and 'how' therapeutic play worked (Yin, 2018), as opposed to merely describing if therapeutic play worked or not, with the goal to establish a connection between therapeutic play and a mechanism of change.

Case introduction

Oliver (pseudonym) is an 8-year-old boy referred for one-to-one therapeutic play by the school Special Educational Needs Co-ordinator (SENCo). He lived at home with his mum, and younger brother. The primary reason for the referral revolved around difficulties to manage his anger and frustration at school and home. The desired outcomes from the SENCo and mother from therapy included learning coping strategies to manage his anger. In the initial parent interview, his mum described Oliver as a caring, and energetic boy. Oliver never met his dad as he left his mum when she was pregnant. His mum reported that Oliver has always been an active baby. She noted that Oliver met all developmental milestones but added he had speech and language therapy in the past. Oliver's mum mentioned that her main concern was that Oliver becomes easily angry, frustrated, and tends to overreact especially when teased by his brother and during transitions (e.g. from playtime to bedtime). His mum noted that Oliver's anger and frustration started during lockdown and worsened when he was bullied at school. His teacher's main concerns revolved around Oliver managing his anger at school. Oliver had been referred to the GP for an assessment of ADHD when we started play therapy and received a diagnosis of ADHD at the end of therapy, a year later. Oliver was under no medication or other intervention during play therapy. Child and Adolescent Mental Health Services (CAMHS) became involved during the period Oliver received a clinical diagnosis of ADHD, a year after the therapeutic play intervention began. In the absence of a clinical

diagnosis, during Oliver's therapeutic play intervention the focus was on anger and frustration as those were the main reasons for Oliver's referral. As anger, frustration and symptoms of ADHD have been linked with traumatic experiences during childhood (Boodoo et al., 2022), we considered Olivers' family environment and attachment with his mother. Oliver had experienced separation from his father and grew up with his mother who was a single mother and described the family life as 'chaotic'. It is possible that the home environment has not allowed a facilitative context for Oliver to learn to self-regulate. Oliver's mother mentioned that she had avoided to talk to Oliver about his father. It is possible that Oliver had internalised feelings of confusion, sadness, rejection about his absent father. Oliver's mother remarked that Oliver had his paternal uncle as a male role model in his life. The teacher did not raise concerns regarding Oliver's peer relationships at school and added that Oliver was no longer bullied by other children.

Therapy model

Therapy followed a non-directive play therapy approach (known as child-centred play therapy). All sessions and equipment followed a holistic approach underpinned by Axline principles (1969). This approach draws on guidelines of child-centred play therapy proposed by Landreth (2012), and further developed by Ray (2011) into a protocol for a therapeutic intervention. This is based on the idea that the child innately knows what he/she needs to facilitate his/her own healing. The therapist acts as a container available to 'hold the space' for the child. This approach aimed to empower the child and help the child develop self-awareness and self-direction (Ray, 2011). Oliver was free to choose the media in the room and explore themes relevant to him. A play theme is defined as a coherent metaphor from which the child communicates the meaning he or she attributes to experience (Ray, 2011). Themes can help the therapist understand the subjective experience of a child. The therapist strived to be fully present with Oliver and 'see' his world, show respect for his uniqueness and sensitively attune to his needs. The goal was to offer Oliver a sense of freedom and permit a relationship where Oliver could be himself without judgement from others (Axline, 1964).

Initially, 15 weekly sessions of child-centred one-to-one therapeutic play at school were agreed. Each session lasted 45 min. An additional 8 sessions were offered after the parent and teacher interviews after week 10, bringing the sessions to 23. The therapist (first author) is a qualified professional counsellor and a Certified and PTUK Registered Practitioner of Therapeutic Play. The first author was clinically supervised by the second author who is a Certified Play and Creative Arts Therapist (PTUK), and Clinical Supervisor in Play and Creative Arts Therapies.

Research design and measures

A case study design was adopted as it allows the investigation of multiple sources of evidence (e.g. observation, questionnaires) in real-world settings. A pretest-posttest design was adopted whereby behaviour problems were assessed pre-therapy, mid-therapy and post-therapy. A follow up assessment was not possible because this work was part of a clinical placement. The first and second author reviewed clinical notes from sessions

and discussed in clinical supervision in order to identify themes based on child-centred play therapy principles. Examples of responses that help facilitate growth in the child included tracking responses the therapist made verbally on non-verbally (e.g. reflecting content or feeling), facilitating decision making and returning responsibility to the child, and encouraging the child (Landreth, 2012; Ray, 2011). To further understand the underlying mechanisms of change, in-depth interviews were conducted with the parent, teacher, and child pre-therapy, mid-therapy and post-therapy. Audio-recording of the interviews was not possible due to ethical and practical constrains of the clinical placement. However, detailed notes were taken during the interviews. Interview data (clinical notes) was triangulated alongside data from clinical observations, as convergent evidence (Yin, 2018). The first and second author independently assessed and discussed all interview data.

Both parent, and teacher completed the hyperactivity, conduct, emotional and peer problems, as well as prosocial subscales of the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997). The SDQ is a validated measure for 6–11-year-olds (Goodman, 1997) with high reliability (Cronbach's alpha = .85). Each item is scored on a scale from 0 (not true) to 2 (certainly true). The five items for each sub-scale generate a score of 0–10. Three categories indicate the level of concern based on cut-of scores: Normal = low concern, Borderline = moderate concern and Cause for Concern = High level of concern (Goodman, 1997). Oliver met the criteria for therapeutic intervention as he displayed difficulties indicating cause for concern, with high hyperactivity scores at home and at school (see quantitative analysis).

Typical interactions in the sessions and initial strategy

On our first encounter, Oliver gave me the impression of a confident child. Oliver showed curiosity. He occasionally asked thoughtful questions and showed an interest to understand how things worked in the playroom. When he saw the shopping till, he took out the pretend money and started making calculations quickly and accurately. Oliver's play was spontaneous, and impulsive. As he moved quickly from playing with Lego, sand, and talking, I felt carried away with the chaotic nature of his play. In parallel, his action-oriented play resonated with my own energy. This made me feel attuned to Oliver. Oliver seemed keen to put his fingers, toys and people figures in the sand, while talking quickly and impulsively. He used Play-Doh to make people-like figures who sounded angry and were killed while fighting with dinosaurs. This triggered thoughts in me about injury, anger, and death. I felt uncertain as to whether I understood the meaning in his play but tried to keep calm and reflect his thoughts back to him following Axline principles (1969). My clinical supervisor (second author) helped me process my own countertransference towards Oliver as his chaotic play challenged my personal inclination for order, and structure, but also my avoidance of ideas related to injury and death. 'What if through chaos we find order', I thought. These reflections helped me realise that through not accepting parts of myself, such as my negative feelings towards chaos, I was unconsciously pushing away the chaotic components of Oliver's play. This realisation paved the way for a more accepting attitude of Oliver, and an exploration of the purpose 'chaos' served for him. In the initial sessions, a theme that was emerging from his play was that of chaos/instability. It was as if he was saying 'I don't know how to bring order in my world. This is out of my control'.

Therapeutic journey

Oliver's favourite medium in the playroom continued to be physical play. Across sessions, he chose characters who were fighting angrily and got injured or killed. The repetitive nature of his aggressive play behaviour demonstrated that Oliver was determined to express his internal struggles. Oliver's aggressive play was of high energy, focus, and emotional response. He often verbalised loudly and screamed. Angry characters tended to dominate in his play. I wondered whether a theme emerging from our sessions was possibly that of power/control. It was as if he was saying 'I must have power over you and others to feel worthy'.

As sessions progressed, I continued to follow his lead and offer Oliver the opportunity to express his anger in a non-judgemental context. For example, in one of our sessions, I observed Oliver grabbing a dog-shaped cushion from the floor. '*He is a kidnapper!*' he cried. '*I will kill him!*'. He forcefully hit the dog-shaped cushion with his fist and then kicked it. He seemed angry and frustrated. His hand movements were impulsive, and successive. To show acceptance, applying Axline (1969) principles, I moved my hands mirroring the energy in his hands. The co-regulation of affective arousal between therapist and child represents an important mechanism enabling the child's ability to self-regulate (Landreth, 2012).

Gradually, Oliver started to involve me more in his play by giving me a role to play in a fighting game. I felt surprised the first time this happened. Child behaviours which occur for the first time may signal an emotional change within the child in the context of the therapeutic relationship, such as the child feeling safe enough to approach the therapist (Landreth, 2012). It seemed as if through his chaotic play, Oliver had somehow started to co-construct with me some sort of 'structure' or 'meaning'. A 'relationship' theme was emerging from his play. I interpreted his interactive play as Oliver saying to me 'I want to connect with you'. Norton and Norton (2002) propose that the first 'Exploratory Stage' of play therapy involves the establishment of trust where the therapist begins to build a relationship with the child. This is followed by a 'Testing for Protection' stage characterised by the expression of the child's needs and the therapist's acceptance of the child's feelings and a 'Dependency Stage' involving greater expression of needs with trust growing as progress continues. The 'relationship' theme was helpful for me to understand the internal meaning making process within Oliver. This theme was also reflected in his sand tray play. Oliver would often hide objects in the sand and ask me to find them. Hide-and-seek games during sand play may reflect a longing for connection (Carey, 1998). These games are characterised by disappearance and appearance, separation and reunion, and they are likely to activate the attachment system (Israelievitch, 2008). Hide-and-seek games allow children to experience loss and learn how to manage separation and reunion in close relationships. Hide-and-seek can be seen as a symbol of the universal human desire to be found, seen and heard. Mahler et al. (1975) proposed that a major developmental task is achieving emotional and object constancy. Emotional constancy refers to managing emotions during change or in response to anger, and frustration. It can also refer to having a stable sense of self while connecting with others. Repetitive hide-and-seek may suggest the child may have experienced an inability to master the developmental task of emotional (object) constancy (e.g. a weak or ruptured attachment bond) and offer the child the opportunity to work through these issues.

As our sessions progressed, Oliver's play became more relational and purposeful. We played hide-and-seek games several times across sessions. I noticed that Oliver engaged more in interactive role play and dramatic play as sessions progressed. One day, while he was hiding under the table, and I was searching he said: '*Pretend I am the prisoner hiding in the dungeon and you come to look for me*'. I played out the role he gave me. When I found him, he turned to me and said: *'Pretend I have escaped while you were having a nap, and you are angry because you were the guard*'. I felt surprised by the imaginative nature of his play. I felt lost as to what to do next. I followed the role he gave me by trying to be angry. '*I am angry, my prisoner has escaped*' I shouted whilst waving my hands in an arrhythmic, rising and sinking manner. I kept thinking I could do a better job of pretending to be angry. Lost in my thoughts, I noticed that the angrier I pretended to be the more Oliver was smiling. I noticed a shift from negative (anger) to positive affect (laughter) in his play. He jumped out and said: '*Now you need to bring the keys of the dungeon, unlock the door and get me out'*. I then heard him shouting '*I have escaped!'*. Based on Laban's framework, his impulsive movements seemed to reflect his energetic character (Laban & Ullman, 1950). When it was my turn to hide, I kept wondering what the 'dungeon' may represent for him while I was trying to hide awkwardly under the little table with half of my leg sticking out. It is difficult to know with certainty what play means to a child. In Oliver's play the 'escape from the prison' may have signified his desire for freedom, control, or a way to overcome uncomfortable feelings. An alternative interpretation to the idea of power/control might be that of loss or abandonment. For example, escaping from the prison may have related to how Oliver had felt discovering his dad had left (e.g. angry, sad) and his efforts to escape from challenging feelings. In any case, any interpretations regarding a child's play need to be made with caution. Across sessions Oliver would often make a toy dinosaur fight with a man in the sand tray until the dinosaur got defeated and sank in the sand. He often said: '*The girl came to help the man escape from the dinosaur'*. My analysis was that the man represented himself, the dinosaur represented the struggles Oliver was facing, and the girl represented the therapist (myself) who tried to help him. The aim of this interpretation was to understand his deep feelings of power/control or loss which had emerged as a theme. Another possibility may be that dinosaurs are extinct now and so this could be interpreted as a potential representation of something challenging from the past. I also noticed Oliver often chose to 'rescue' his character from the dinosaur in the sand tray. The theme of 'rescuing' and 'protection' was starting to emerge in his play with 'the good' prevailing over 'the bad'. As an important element of thematic work is context, I hoped that acquiring some background information from Oliver's mother would help me explore these themes further.

In a consultation with Oliver's mum, after 10 sessions of therapeutic play, I discussed some of the themes I had observed in the sessions with Oliver while respecting confidentiality. I shared with his mum that Oliver's themes seem to convey a need for power/control but also a longing for connection with others. Oliver's mum was struggling with anger issues and poor mental health herself. She said that she shouts at Oliver sometimes but tries to apologise afterwards. She described the family life as 'chaotic' as she tried to raise two children as a single mother. I asked her if she had thought Oliver was trying to gain a sense of control by acting out and engaging in aggressive behaviours at home. Oliver's mum seemed tearful. She nodded and seemed surprised. '*I didn't*

imagine he might feel that way' she muttered. I hoped that sharing this theme with his mum would help his mum see Oliver's perspective. We discussed how his mum could offer an environment at home (e.g. by sensitively attuning to his needs) that helps Oliver develop self-regulation. Sensitive caregiving can promote more effective emotional regulation in the child, while exposure to maternal negative emotion may disrupt learning related to emotional regulation (Boldt et al., 2020).

Oliver's mum provided feedback that Oliver had started to become more aware of his emotions in the last few weeks and tried to calm himself down when frustrated. His mum reported that although Oliver would still get angry, he tried to find outlets for his anger (e.g. hit a cushion). In the mid-therapy interview, his teacher reported that Oliver now seemed able to control his anger better, and rarely became frustrated in class. She added that Oliver's concentration in class had improved. This was corroborated with a steep decrease in teacher-rated hyperactivity, emotional, and conduct problems on the SDQ. Despite the positive feedback, it seemed that Oliver would benefit from further sessions, so we extended the number of sessions at this stage. This was decided following discussions in clinical supervision based on the interim SDQ scores, and based on feedback from the teacher and parent. The eight additional sessions would further and continually provide Oliver a safe space where he was allowed to process his angry feelings and expect resolution themes.

Turning point in therapy

A turning point in our work was observed when Oliver gradually moved away from the themes of power/control as sessions progressed. As themes represent a dimension of change in play therapy, themes can offer insight into change in the emotional dynamics of the child's subjective world (Ryan & Edge, 2012). When a theme is no longer evident, this can be a marker of emotional growth and therapeutic movement (Landreth, 2012). I noticed that Oliver had gradually started to replace fighting games with relationship building games like the 'tag' game where we would chase each other or throw cuddly toys to make each other lose points. Although occasionally he referred to cuddly toys were 'weapons' used to kill each other, these games were primarily centred around losing points and not physical aggression. I also noticed that his individualistic play of characters fighting with each other had now turned into relational, turn-taking play**.** This could possibly suggest that Oliver felt a sense of safety to reveal his inner world and reach out to connect with me. Themes suggesting relationship/connection versus power/control or loss may be a sign of a child moving towards a deeper, more satisfying relationship with himself and others (Ray, 2011).

Safe ending

To prepare for a safe ending, each week I reminded Oliver of how many sessions were left. In our last session, I noticed Oliver had ice over his eye. *'Someone kicked me in the head'* he said as he walked in the playroom. Then he said: '*The doctor said I have ADHD'*. When we entered the room, I asked him how he had experienced his therapeutic journey and if the sessions had helped him. *'Now I can control my anger and I can calm myself down more'* he replied. I reminded him he had been working hard on himself. I

shared with him the positive feedback from his mum and teacher. I shared I was feeling sad it was our last session. He said he was sad too. I reminded Oliver that our last session was a 'celebration' for his progress and accomplishments during his therapeutic journey. The last session is important for helping the child process the end of therapy and internalise their progress. The termination phase offers closure and promotes the child feeling empowered with new skills (Ray, 2011). I asked Oliver how he wanted to celebrate in our last session together. He responded he wanted to play the game where he was the prisoner, and I was the guard. While we were hiding under the table (the 'prison'), he said I was his friend. Oliver invited me in the prison, and we escaped from the prison together. We then played the 'tag' game where he 'rescued' a little teddy bear because 'he was good'. There was a noticeable shift in his play from 'fighting' to 'rescuing' and from 'the bad' to 'the good'. When a child develops a narrative about 'rescuing', this may reflect a process of making meaning of protection and healing (Sarah et al., 2021).

In the post-therapy interview, his mum reported that Oliver was now able to be more aware of his anger and calm himself down more by going to another room. She mentioned that Oliver was now seen in CAMHS. Oliver's mum explained that the reason CAMHS were involved was because she found it difficult to cope with Oliver's behaviour at home and she needed further support at home. She added that although Oliver still gets angry sometimes, his anger is now less explosive. She remarked that on some days when he is in low mood, he is name-calling, but this happens rarely. His mum, agitated, mentioned that she gets upset when he is calling her names, she shouts and worries about what others may think of Oliver. We discussed about possible options for individual therapy for his mum. His mum added Oliver sometimes worries about what others may think of him. In the post-therapy interview, his teacher remarked that Oliver could now concentrate better in class and that she has seen improvement in Oliver's ability to manage his anger at school. The teacher's observations were corroborated by the SDQ scores showing a decrease in teacher-rated hyperactivity, emotional, and conduct problems.

Quantitative analysis

This analysis examined the degree of treatment effect associated with therapy. The total scores for hyperactivity, conduct, emotional and peer problems as well as prosocial scores from the SDQ were calculated pre-therapy, mid-therapy and post-therapy (see Tables 1 and 2). The Percentage of Nonoverlapping Data (PND) was used to evaluate overlap and treatment effect. This metric has been applied to single-subject research in the area of conduct problems (Scruggs et al., 1986) and hyperactivity (Robinson et al., 2017). We calculated the PND using the steps described by Scruggs et al. (1987). PND scores higher

Table 1. Total teacher-rated SDQ scores per sub-scale pre-therapy, mid-therapy, and post-therapy.

	Pre-therapy	Category	Mid-therapy	Category	Post-therapy	Category
Emotional	6	Cause for Concern	2	Normal	2	Normal
Conduct	3	Borderline	1	Normal	2	Normal
Hyperactivity	9	Cause for concern	8	Cause for Concern	4	Normal
Peer	3	Normal	0	Normal	0	Normal
Prosocial	7	Normal	9	Normal	6	Normal
Total Difficulties	21	Cause for concern	11	Normal	8	Normal

Table 2. Total parent-rated SDQ scores per sub-scale pre-therapy, mid-therapy, and post-therapy.

	Pre-therapy	Category	Mid-therapy	Category	Post-therapy	Category
Emotional	2	Normal	2	Normal	3	Normal
Conduct	3	Borderline	4	Borderline	4	Borderline
Hyperactivity	10	Cause for concern	10	Cause for concern	10	Cause for concern
Peer	2	Normal	2	Normal	1	Normal
Prosocial	9	Normal	10	Normal	9	Normal
Total Difficulties	17	Cause for concern	18	Cause for concern	18	Cause for concern

than 90% indicate the treatment is highly effective, scores between 70–90% indicate the treatment is moderately effective and scores between 50–70% indicate that treatment effects are questionable.

The PND statistic for each sub-scale – teacher-rated hyperactivity, conduct, and emotional problems – was 100% indicating that Oliver displayed these behaviours below the baseline score mid-therapy and post-therapy, suggesting high treatment effectiveness. Teacher-rated scores decreased dramatically (see Figure 1), with a 50% reduction in hyperactivity scores at school (see Figure 2), suggesting Oliver was less hyperactive, and better able to concentrate, and manage his emotions at school. Hyperactivity declined from pre-therapy to mid-therapy and continued to decline from mid-therapy to post-therapy. Emotional problems declined from pre-therapy to mid-therapy and remained stable from mid-therapy to post-therapy. Conduct problems showed a steep decline from pre-therapy to mid-therapy, and despite slightly increasing from mid-therapy to post-therapy, remained below the baseline level. Teacher-rated prosocial behaviour increased from pre-therapy to mid-therapy and slightly decreased from mid-therapy to post-therapy. Teacher-rated peer problems decreased from pre-therapy to mid-therapy and post-therapy.

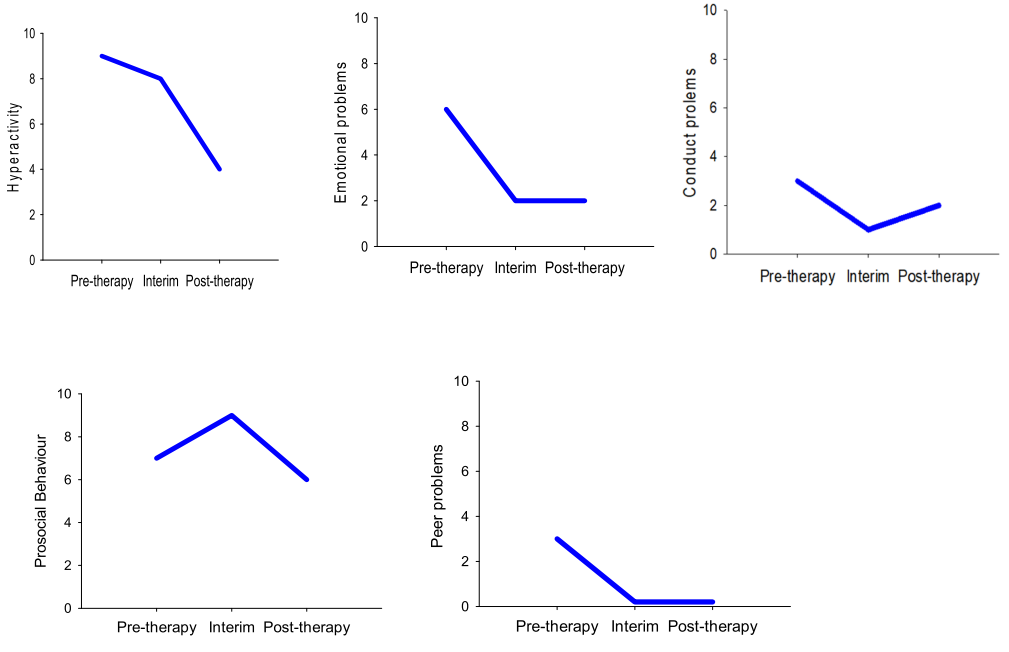

Figure 1. Teacher-rated behaviour problems and prosocial behaviour at pre-therapy, mid-therapy and post-therapy.

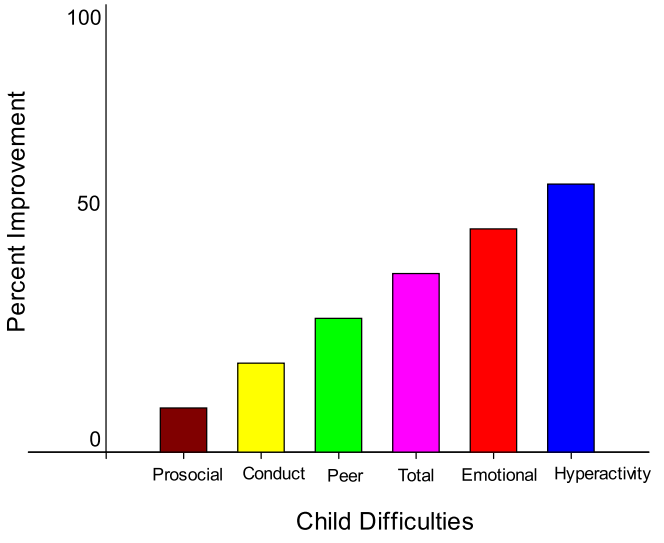

Figure 2. Percent improvement (reduction of scores) from pre-therapy to post-therapy for the teacher-rated hyperactivity, emotional, peer, conduct problems, and total difficulties. Improvement for prosocial behaviour represents increase in prosocial behaviour.

Although Oliver showed marked improvement based on teacher scores, the scores from his mother indicated there was still cause for concern in relation to total difficulties. The PND statistic for each sub-scale score- parent-rated hyperactivity, conduct, peer and emotional problems- was 0 indicating no treatment effectiveness (see Figure 3). There was no change in parent-rated hyperactivity from pre-therapy to mid-therapy and

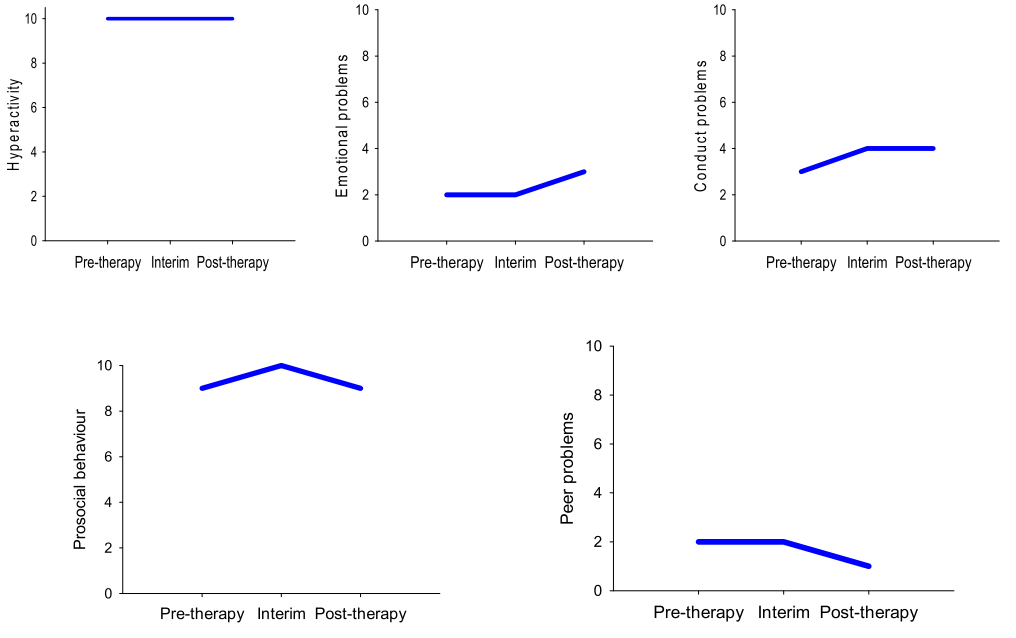

Figure 3. Parent-rated behaviour problems and prosocial behaviour at pre-therapy, mid-therapy and post-therapy.

post-therapy. Parent-rated emotional problems were stable from pre-therapy to mid-therapy and slightly increased from mid-therapy to post-therapy. There was a slight increase in parent-rated conduct problems from pre-therapy to mid-therapy and stability from mid-therapy to post-therapy. Parent-rated prosocial behaviour increased from pre-therapy to mid-therapy and slightly decreased from mid-therapy to post-therapy. Parent-rated peer problems remained stable from pre-therapy to mid-therapy and slightly decreased from mid-therapy to post-therapy.

Discussion

This case study investigated the impact of play therapy on the wellbeing and behaviour of a child with ADHD. Oliver has shown significantly lower hyperactivity and emotional problems at school as indicated in the SDQ scores post-therapy compared to pre-therapy. Parent-rated behaviour problems did not change post-therapy. Results provide evidence to support the idea that play therapy is an effective intervention for improving wellbeing and behaviour in childhood ADHD at school.

Overview of findings and theoretical implications

Oliver engaged in physical play at the beginning of therapy and transitioned into interactive dramatic play as therapy progressed. Jennings (2005), founder of neurodramatic play, argued that children play physically and messily before they can create a form. Although a child's play may seem chaotic, it eventually leads to order. Dramatic play can help 'reinvent' ourselves by transforming the inner narrative about how we function in the world (Van der Kolk, 2014). The sensory experience offered by physical play allowed Oliver to re-script his inner experience. The therapeutic relationship allowed Oliver to project his inner reality by 'acting out' his feelings of anger during role play. In person-centred theory, an individual has an inherent drive towards growth (Rogers, 1951). A supportive environment may help the child to trust his organismic valuing process and develop autonomy. An angry child may act out and build up walls to defend himself. Research supports that the brain of boys with ADHD can be hyper-sensitive to signals of hostility by others such as angry voices (Chronaki et al., 2015). When Oliver was approached with acceptance, he learnt to accept himself. The therapeutic play intervention offered Oliver a sense of freedom through a therapeutic relationship where he could be himself. As the opposite of defensiveness is the discovery of self in experience (Rogers, 1961), through his therapeutic journey, Oliver was able to express his anger without being judged and began to develop a sense of self as a valued individual in his own right. This allowed him to regulate his anger more effectively. When Oliver found his own voice, he did not need to shout to be heard.

Based on child-centred play therapy principles (Ray, 2011), the power to change resides within the child. The therapeutic play intervention helped Oliver develop self-directed change. By the end of therapy, Oliver was able to express his needs for connection more, be more self-accepting and develop a positive self-concept (Kottman & Meany-Walen, 2018). He also learnt to accept responsibility for his actions and shift from negative (anger) to positive (laughter) affect, all of which indicate a process of growth. One way to understand how this was achieved is to examine themes in

Oliver's play. Themes are dynamic processes, in the context of a therapeutic relationship, which can offer a glimpse into a child's inner world (Sarah et al., 2021). We can tentatively identify several themes in Oliver's play. A first theme may be that of power/control or loss. For example, power/control was reflected in Oliver's play through mistrust and hurting others (e.g. physically via fighting or emotionally via trickery), destruction, death, and chaos. Through his therapeutic journey, Oliver learnt to balance power/control, autonomy and connection within the therapeutic relationship. Second, a 'relationship' theme seemed to gradually emerge. For example, connection and trust were reflected in Oliver's play with symbols such as 'the guard' offering protection. Interestingly Oliver saw the 'guard' in the face of the therapist. He wanted the therapist to bring the '*keys to unlock the dungeon and get him out*'. In our last session the therapist ('guard') and Oliver ('prisoner') were friends and escaped together. Similarly, a girl attempted to 'rescue' the man from the dinosaur. Oliver also attempted to 'rescue' a cuddly toy in his 'tag' games. In parallel, he engaged in games of 'hide-and-seek' which often reflect the seeking of attunement and connection (Prat, 2001). Fantasy play offered Oliver the opportunity to 'play out' his thoughts around 'rescuing', which often reflects nurturing, resilience and ultimately healing in play therapy (Sarah et al., 2021). Play has a therapeutic role when it helps children to develop confidence, and trust in helping themselves as compared to needing someone to 'fix' their problems (Russ, 2004). When Oliver developed a narrative about 'rescuing' others, this helped him make meaning of ways to 'protect' and 'nurture' and became able to integrate that process in his self-concept. This way, he developed trust in helping himself.

Moustakas (1997) has argued that aggressive children typically begin play therapy with undifferentiated and negative emotions, such as anger expressed towards toys or persons. As these expressions are accepted, feelings of anger become less intense and affect the child less. At a later stage, the child fluctuates between aggression and more positive forms of expression (e.g. laughter). In the end, positive feelings in the child are separated from negative feelings. Oliver was progressing in his theme from feeling out of control to feeling more in control and attempted to find ways to protect himself. Oliver used his play behaviours to work through his theme of control/power or loss. While repeated behaviour (e.g. aggression) may show emotional issues the child is playing out, when a theme ceases to be evident, this may suggest that the child has reached a resolution (Landreth, 2012). As the theme of control/power became less evident, the theme of 'relationship' started to emerge. Mills and Allan (1992) argued that as the child engages in more interaction with the therapist, the aggressive behaviours decline. In the end, Oliver moved from aggressive behaviours to socially accepted behaviours.

This change coincided with less aggressive behaviour at home and school. Findings from the themes analysis were in line with the post-therapy interview where Oliver's mother indicated that angry outbursts were less common at home. Similarly, in the post-therapy interview, the teacher indicated that Oliver was less angry in class and that his angry outbursts were limited to outdoor play. His teacher reported that Oliver was able to concentrate better in class. This was corroborated by the SDQ scores showing that teacher-rated hyperactivity, and emotional problems, decreased dramatically post-therapy, suggesting that Oliver was better able to concentrate, and manage his emotions at school.

Contrary to expectation, parent-rated behaviour, based on the SDQ, did not change post-therapy. Here we discuss possible explanations for this finding. First, it is possible that teachers rate higher impacts of play therapy on child outcomes compared to parents. This finding is consistent with previous research showing that teachers but not parents reported a significant decrease of aggressive behaviour in children following child-centred play therapy (Ray et al., 2009). A second possibility is that some children may get worse before they get better and longer therapy duration is needed for positive change to emerge. For example, meta-analyses have shown that the maximum effect of child-centred play therapy occurred between 35 and 40 sessions (Bratton et al., 2005), while Oliver had 23 sessions. Third, the environment at home may not have facilitated growth in Oliver in the same way the school setting did. This is plausible especially as Oliver's mum was struggling with anger issues and poor mental health herself. As the target of therapy in this study was the child rather than the parent and the school rather than the home setting, it is possible that the benefits of play therapy were limited in the absence of parental involvement. Research has indeed supported that significant treatment outcomes are produced by play therapy that involves parents (Bratton et al., 2005). Filial therapy is a type of play therapy where parents are trained by a therapist to conduct special play sessions with their children, focusing on strengthening the parent–child relationship (Van Fleet, 2005). Alongside traditional filial therapy, other relationship-based approaches have emerged that also emphasise parent involvement in special play. For example, the Child–Parent Relationship Therapy (CPRT) is an evidence-based 10-session filial therapy model developed by Bratton and Landreth (2006). In addition, the Parent–Child Attachment Play (PCAP) model integrates attachment theory and non-directive play techniques to promote emotional attunement and secure attachment (Maskell-Graham, 2017). Similarly, the Filial Play Coaching model by Play Therapy UK (PTUK) provides a structured framework for supporting parents to develop non-directive play skills tailored to their child's emotional needs. Given the range of approaches available, clinical guidelines would help therapists determine which model to use, when to begin with parent-involved approaches versus individual play therapy, when to transition from one to the other, and whether combining the two is optimal. This approach should consider a number of factors such as family dynamics, parental mental health, ACEs, but also barriers to parental involvement (e.g. time constraints, cultural norms). Interviews with parents about the 'fit' of therapy approach could be combined with quantitative tools (e.g. filial therapy readiness scales) to evaluate the parents' preparedness for filial therapy.

Clinical implications

Our findings have a number of implications for clinical practice. First, it is important to adopt an accepting and non-threatening tone in therapeutic play with children with ADHD. A child feels free to change only when he/she experiences a relationship in which his/her inner world is understood and accepted (Landreth, 2012). Second, when conceptualising child psychological difficulties, the perceptual world of the child needs to be considered. Based on a child-centred framework, a child is accepted for his/her uniqueness as an individual and is offered an environment which can facilitate his/her talents and growth. This approach shifts the focus of therapy from the idea of

'impairment' to that of an 'environment', which aims to meet the child's needs. Our results highlight the importance of focusing on the person of the child rather than the problem. Third, play and creative approaches (e.g. dramatic play) can be added to the delivery of therapeutic interventions in a child-led way. Fourth, it is important to understand not only whether play therapy works but also how it works. This can help illuminate the therapeutic process of growth. Our results highlight the importance of understanding broader mechanisms of change such as emotional regulation. The co-regulation of emotion between therapist and child represents an important mechanism enabling the child to self-regulate. By trusting the therapeutic process, the child learns to develop trust in helping him/herself.

Finally, the delivery of therapeutic play at school should consider the resources available to parents and maximise the benefits of play therapy by involving parents in therapy. In addition, it is important to consider factors in the school context which are conducive to supporting play therapy interventions. For instance, play therapy interventions should be integrated with the school's support systems by involving pupils, staff, parents, and the wider community collaboratively. The finding that change occurred at school but not at home in this study underscores the unique role of schools in children's emotional well-being especially for vulnerable children. The school setting can serve as a buffer or counterbalance the effects of a chaotic home environment. Children whose parents have difficulty accessing or engaging with school-based interventions may be at higher risk for emotional and behavioural problems. Policies should reduce structural barriers to therapy access and offer targeted support for children who navigate disparities between the school and home environments. Finally, in the present study, clinical services became involved with Oliver's case a year after therapeutic play intervention began, due to a long waiting list. School-based play therapy can offer a valuable avenue to reach more children and prevent emotional and behavioural difficulties, before they escalate to more serious problems, potentially reducing the pressure on clinical services.

Limitations and directions for future research

Future research should address limitations of the current study. Future studies should video-record and analyse the sessions content to identify themes and assess adherence to the person-centred principles (Ryan & Edge, 2012), alongside reviewing notes from clinical sessions to identify themes. Second, future research should audio record interviews which was not possible in this study due to practical and ethical limitations. Third, future research should include a follow-up assessment, to examine whether change was sustained for a period of time. Finally, although we followed recommended statistical procedures for a Single Case Research Design (Park et al., 1990), by examining the PND recommended when only one baseline score is obtained, a strongest design would include a multiple baseline design across participants (Kratochwill & Levin, 2010). In addition, a case study design can help researchers identify patterns and form initial hypotheses to be tested in larger studies (Yin, 2018). However, a case study focuses on a single individual and it is challenging to generalise findings to other children. Future research should prioritise Randomised Controlled Trials (RCTs) of child-centred play therapy tailored to children with ADHD to generate rigorous evidence

regarding the effectiveness of this intervention in the U.K. Similarly, future RCTs should systematically examine the cost-effectiveness of child-centred play therapy for ADHD to support decisions about play therapy service delivery and investment in U.K. primary schools. Despite the afore mentioned limitations, this therapeutic play intervention was provided in accordance with the Academy of Play and Psychotherapy (APAC) training, meeting the professional body (PTUK) standards and ethical framework.

Conclusion

In summary, this study applied principles of child-centred theory to a case from clinical practice to demonstrate that through play a child can learn to find his inner voice within the context of a genuine, accepting therapeutic relationship. Anger, which is often frowned upon in society and individuals alike, when accepted and understood can be a vehicle in a journey to self-acceptance and self-discovery. Results support play and creative arts therapy as a beneficial treatment at school to help improve wellbeing in childhood ADHD.

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Appendix

Ethical issues were carefully considered in this case study. The parent gave written informed consent that (i) Oliver can attend sessions, (ii) the information from the sessions can be used for monitoring and review purposes, and as part of supervision, (iii) data would not identify the child in any way and may be used for research purposes and case studies. Participants were informed that the therapist would abide by the Play Therapy UK (PTUK) Ethical Framework.

After parental consent, Oliver was offered information about therapy and child assent was taken. The child and parent agreed that only themes of sessions could be shared in interviews with parents and teachers. The content of the sessions could not be shared with parents and teachers, unless the child requested it or gave consent for this. Limitations of confidentiality (e.g. safeguarding) were also discussed with the parent and child before therapy.