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Facilitating Emotional Regulation in Adults with Developmental Disabilities through Person-
Centered Play Therapy

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Abstract

Adults with developmental disabilities may employ maladaptive behaviors that stem from limited opportunities to interact with their community and non-nurturing interactions within their environment. This literature review explores the effects of play on maladaptive behaviors and provides a rationale that supports the use of PCPT to improve this population's emotional regulation skills. More specifically, the sources indicate that activities containing exercise and games, improves the emotional regulation skills of this population. Based on the presented information, created cost effective activities will potentially improve these skills amongst adults with developmental disabilities. These activities that adhere to PCPT are basketball, water basketball, football, water football, and walking while playing catch. There is a need for research that will assess the activities' effectiveness and more research to provide further knowledge on the effectiveness of PCPT. Implications to occupational therapy practice include: a nurturing environment to practice social skills, increased use of occupational therapy services within this population, and more research opportunities.

Keywords: Adults, developmental disabilities, Child-Centered Play Therapy, Person-Centered Play Therapy, emotional regulation, occupational therapy, exercise

Introduction

Following the establishment of a therapeutic relationship and implementation of simulated sport activities, anecdotal observations at Western Michigan University's Center for Disability Services (CDS) identified improved emotional regulation skills. Group sessions containing the activities inadvertently adhered to Virginia Axline's eight basic principles and displayed congruence, acceptance, and empathy by CDS staff. The eight principles govern therapists' actions as they support children on their journey through Child-Centered Play Therapy (CCPT). The journey is a gradual process towards self-growth (Guerney, 2001). Axline's (1969) eight basic principles are:

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
4. The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behavior.
5. The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. *The child leads the way*; the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.

8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of responsibility in the relationship (p. 73).

Based on the observations of the author, adults at the Center for Disability Services improved emotional regulation skills through supportive staff that facilitated space for self-growth. Within the Occupational Therapy Practice Framework (OTPF) (AOTA, 2014), emotional regulation classifies as a social interaction skill. In facilitating the psychological growth needed for the improvement of social interaction skills, the therapist must have personal qualities of congruence, acceptance, and empathy (Robinson, 2011); “Congruence means that the therapist is genuine and sincere about believing in the client’s innate potential to self-direct and achieve insight into their own problems” (Robinson, 2010, p. 210). To show acceptance, the therapist should receive the child in a comforting manner, so that the child loses their natural defensiveness (Robinson, 2011). Last, Robinson (2011) describes the empathic therapist, as one that steps into the client’s shoes to emotionally understand their world. Improvements in emotional regulation were evident through decreased maladaptive behaviors such as screaming, hitting others, self-stimulation (hand flapping, gazing, body rocking, head nodding, and object tapping), tantrums, self-injurious behavior (SIB), and running to avoid participation in group activities. Other than the inadvertent use of Axline’s eight basic principles, a plausible reason for the phenomenon described is that CDS’ consumers had staff and other peers to serve as role models. Pan (2010) mentions that children with autism spectrum disorder benefit from the positive social interactions displayed by others and draws a connection between this benefit and decreased antisocial behavioral problems. In his study, a swimming exercise program provided appropriate examples of social interactions (examples made by instructors and peers) for children

with ASD, resulting in a reduction of antisocial behavior problems such as body rocking. The antisocial behavioral problems described by Pan could classify as maladaptive behaviors displayed by clients at CDS. Additionally, a plausible reason for the improvement of emotional regulation skills, as seen in the decreased occurrences of maladaptive behaviors, is that CDS' consumers chose to engage in enjoyable or reinforcing activities. The enjoyment they received from these activities, provided motivation to continue to engage in the therapeutic process. Powers, Thibadeau, and Rose (1992) explained that roller skating was reinforcing to the participant of their study; the enjoyment that he received from roller skating was evident in his smile and many laughs during activity performance. The authors of this study believe that this joy contributed to the decreased use of self-stimulating behaviors by the participant, to adapt in his environment. These self-stimulating behaviors are what the author of this literature review classifies as maladaptive behaviors because of their negative impact on social interactions. Later, additional articles also connect self-stimulating and maladaptive behaviors. Based on the presented information, there is merit to the idea that CDS consumers should continue to engage in group activities where instructors and peers model appropriate social interaction skills. The groups should also consist of reinforcing play activities and adhere to Axline's eight basic principles that guide Child-Centered Play Therapy. Purposeful use of these principles provides reason to believe that play sessions at CDS would have a stronger impact on emotional regulation skills. This literature review provides evidence for cost-effective activities grounded in CCPT. These activities may potentially the improve emotional regulation skills amongst adults with developmental disabilities at the Center for Disabilities Services and other facilities alike.

Introduction to Child-Centered/ Person Centered-Play Therapy

The mental ages of adults with developmental disabilities allows this population to embark on this journey because it places them in the developmental stages of a child. A study conducted by Stephen P. Demanchick, Nancy, H. Cochran, and Jeff L. Cochran titled, “Person-Centered Play Therapy for Adults with Developmental Disabilities;” explains that, Child-Centered Play Therapy shapes Person-Centered Play Therapy (PCPT) for adults. The rationale is that differences in functioning occur among adults with developmental disabilities, based on their chronological and mental age (Demanchick, Cochran, & Cochran, 2003). In fact, most adults with developmental disabilities “function cognitively, emotionally, and socially between the ages of three and thirteen years” (Demanchick, Cochran, & Cochran, 2003, p. 50); this information provides a logical explanation for the use of CCPT with this population. Child-Centered Play Therapy is a non-directive approach that has not fundamentally changed in over fifty years (Guerney, 2001); based on Roger’s (1951) belief that individuals have the power within themselves to grow and mature in a nurturing context. Rogers thought that this belief was a part of normal development and recognized that it can induce healing during the therapeutic process (Guerney, 2001). According to Rogers (1951) and Axline (1969), everyone’s main life goal is to achieve self-actualization. On the quest to achieving self-actualization in a non-nurturing environment, “inappropriate behaviors can be acquired in an effort to cope that distort the self-concept and lead to maladjustment” (Guerney, 2001). Distortion occurs because of the person’s perceptual field, which is their reality (Rogers, 1951). The idea here is that non-nurturing environments can cause inappropriate behaviors for persons who are yearning for self-actualization. Maladjustment in a toxic environment, can lead to maladaptive behaviors that others in a nurturing environment, do not utilize. An adult diagnosed with autism

institutionalized in a virulent environment, could develop additional maladaptive behaviors unlike an adult with autism raised in a loving and caring environment. The developed maladaptive behaviors, are based on the person's reality or perceptual field. Therapists that practice CCPT, must accept this reality instead of challenging it (Guerney, 2001).

Five Core Beliefs of Child-Centered Play Therapy

To practice CCPT, all therapists are to adhere to five core beliefs. The beliefs are as follows: 1) the child directs the content of therapy, 2) the approach is not symptom specific or problem oriented, 3) the internal frame of reference, or perceptions of reality of the child is accepted by the therapist without challenge, 4) CCPT is a system that must be followed in its totality, and 5) the therapist must whole-heartedly believe in CCPT (Guerney, 2001). The first tenet says that the client is responsible for their behavior; the therapist cannot set limitations outside those that protect the child's safety (Guerney, 2001). The author also explains the importance of separating the therapeutic process from real world issues, unless the child chooses to explore those areas. The author explains that the second tenet focuses on the child's inner self that part that may not show in their behaviors. The inner self is the self-concept, which holds all inappropriate behavior stemming from psychological impairments (Guerney, 2001). Guerney (2001) believes that addressing maladjustments improves the self-concept, which will subsequently increase appropriate behaviors without addressing external issues. The third tenet says that all forms of communication related to the child's perceptions of reality, "should not be interpreted, nor are explanations about them sought from the child" (Guerney, 2001, p.18). It is the therapist's duty to build a strong relationship and create a safe environment where the child feels comfortable disclosing their inner world (Guerney, 2001). The fourth tenet describes CCPT as a system that cannot introduce any new strategies or techniques that goes against what

is currently in place (Guernsey, 2001). The ability of the therapist to adhere to the system, affects their clients' self-growth (Axline, 1969). The fifth tenet says that there must be an understanding "that the child is the best one to map out his or her road to healing, and that the child has the internal strength to take the necessary steps, with the full therapeutic support of the therapist" (Guernsey, 2001, p. 19). Therapists are to follow Axline's eight basic principles to properly facilitate growth during the therapeutic session.

The Effectiveness of CCPT

Research has suggested that CCPT is an effective intervention approach. However, the results of these studies are hard to generalize due to small sample sizes (Ray, Bratton, Rhine, & Jones, 2001). In research, large sample sizes heavily contribute to quality; therefore, meta-analytic reviews triumph over many study designs (Bratton, Ray, Edwards, and Landreth, 2009). Bratton, Ray, Rhine, and Jones (2005) conducted one of the largest meta-analyses on play therapy. Their study included 93 articles and the overall effect size calculated at .80 standard deviations which interpreted as a large treatment effect. This indicates that children receiving play therapy interventions performed significantly better than children who did not receive play therapy (as cited in Bratton et al., 2009, p. 269-270). Furthermore, child-centered and nondirective play therapy were in the large effect category while nonhumanistic interventions had a moderate effect on children (as cited in Bratton et al., 2009). According to Bratton et al., (2009) research on filial or Child-Parent-Relationship therapy, has provided evidence supporting the use of CCPT. The authors state that independent studies and review of meta-analytic research suggests that child-centered play therapy is a statistically supported treatment intervention. The information presented supports the use of CCPT as an effective intervention amongst children with a wide variety of diagnoses. Guernsey (2001) stated that children with

nearly every type of diagnosis or problem have benefited from CCPT. Only those with active schizophrenia or severe autism are likely to respond negatively to the intervention. The investigators of this literature review believe that the use of CCPT amongst adults with developmental disabilities would yield related results based on the chronological vs. mental age rationale provided earlier.

Relationship between Play and Emotional Regulation

In occupational therapy, it is well known that play improves social interaction skills (Robins, Dautenhahn, & Dickerson, 2009). The following articles present a relationship between play and emotional regulation however, there is lacking evidence supporting the use of Person-Centered Play Therapy amongst adults with developmental disabilities to improve emotional regulation skills. Demanchick et al. (2003) conducted the lone study that captures the phenomenon in its entirety. The authors stated that the participants in their study experienced greater self-control (emotional regulation) by utilizing child-centered play therapy. These authors concluded that child-centered play therapy caused each participant to experience greater self-control, by using a self-developed five-point Likert Scale (See Assessment) that tracked participants' maladaptive behaviors. The maladaptive behaviors emphasized areas such as an appropriate expression of needs, a reduction of self-injurious behaviors resulting from frustration, smooth transitioning, and other evidences of improved independence and emotional well-being (Demanchick et al., 2003). As previously stated, anecdotal observations at CDS found a relationship between maladaptive behaviors such as self-stimulation and emotional regulation. Often, consumers at CDS engaged in behaviors such as hand flapping, gazing, body rocking, head nodding, and object tapping, to emotionally regulate. Three studies found that exercise decreases self-stimulation in children and adolescents, suggesting the discovery of

appropriate coping strategies amongst the studies' participants (Powers, Thibadeau, & Rose, 1992; Pan, 2010; Rosenthal-Malek & Mitchell, 1997). Locating studies that draws a connection between exercise and children/adolescents, was a necessity based on anecdotal experience that functionally places adults with DD amongst this population. Demanchick, Cochran, & Cochran, (2003) share the same experience on adults with developmental disabilities: authors experience has shown that most of these individuals function cognitively, emotionally, and socially between the ages of 3 and 13 years". According to Merriam-Webster, exercise in its true definition: "a regular or repeated use of a faculty or bodily organ" (2018), is not play, but is play if it provides "enjoyment, entertainment, amusement, or diversion" (Parham & Fazio, 1997, p. 252; as cited in AOTA, 2014). In Powers, Thibadeau, & Rose (1992) and Pan (2010), the authors noted that the participants enjoyed exercising. Gary Kielhofner (1981) describes the progression of a group of men who struggled to manage their anger at the beginning of a game program. Kielhofner (1981) stated, "mild teasing from a peer might escalate quickly into a fist fight" (p. 380). As the group of men progressed through the program, they learned acceptable ways to express their emotions (Kielhofner, 1981). Gallup and Serianni (2017) stated that after engaging in a video game, participants better managed their emotions (emotional regulation).

Evidence Based Practice Intervention

Based on this literature review, activities (See activities) provided to the Center for Disability Services as a cost-effective tool, will potentially improve the emotional regulation skills of adults with developmental disabilities. Provided education may facilitate such results. The author hopes that staff will create many activities that use PCPT to improve the emotional regulation skills of this population. Additionally, a five-point Likert Scale provided to CDS to measure for changes in emotional regulation and information gathered on its effectiveness, will

be valuable in a future study. The Likert Scale is from Stephen P. Demanchick, Nancy, H. Cochran, and Jeff L. Cochran's study titled, "Person-Centered Play Therapy for Adults with Developmental Disabilities." Staff at CDS may improve the instrument's sensitivity to change, by increasing the scale by five points (one to ten instead of one to five). The maladaptive behaviors will match those displayed by the appropriate client. With a lack of these studies, there is a need to better understand the experience of adults with developmental disabilities and factors that facilitate improved social interactions. The investigators of this literature review connected studies regarding the phenomenon, so professionals who work with this population may better understand the experiences and needs of adults with developmental disabilities.

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Appendices

Appendix A: Five-Point Likert Scale

Target Behavior Ratings (Demanchick, 2003)

1. The individual makes eye contact with staff and peers.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

2. The individual initiates or chooses an activity independently.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

3. The individual is frustrated in new situations or around inexperienced staff.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

4. The individual engages in a new behavior when a limit is set (redirects when prompted).

1	2	3	4	5
Almost Never		Sometimes		Almost Always

5. The individual engages staff or peers or includes them in activities.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

6. The individual verbally communicates thoughts and feelings when frustrated.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

7. The individual engages in appropriate activities when faced with change.

1	2	3	4	5
Almost Never		Sometimes		Almost Always

Note: The instrument's sensitivity to changes in behavior is better by increasing the scale (one to ten instead of one to five). Author suggests changing maladaptive behaviors within the Likert Scale to match the behaviors displayed by the client.

Appendix B: Basketball

Purpose: The activity's purpose is to improve emotional regulation through a non-directive approach that allows the participant to explore the activity in their own way. It is important to remember that it derives from a PCPT approach which provides strict guidelines to follow during the therapeutic process. Refer to the Principles/Tenets section of binder for principles and tenets that govern PCPT. When implementing the activity, it is important to not rush the therapeutic process, the participant will move at their own pace and the therapist should follow. Basketball will only facilitate the therapeutic process if it is of interest to the participant.

Materials:

- Basketballs or other small to medium sized balls such as nerf and tennis balls
- Basketball rims, baskets, bins, hula hoops, or other objects with an opening and space to hold a ball
- Basketballs and rims are not necessary, use what is available to simulate the activity however; all simulated objects must be deemed safe for use with the population.
 - To determine whether an object is safe, staff must consider everyone's mental and physical strengths/weaknesses and make an approval in the organization's usual fashion

Instructions:

- Set up the environment so the basketballs and basketball rims/objects that simulate these items, are visually and physically accessible to the consumer
- Allow the consumers to choose the activity's direction, there are no specific rules on how to play (Ex. If the client establishes rules to the game, then adds rules as the game develops, allow it to happen)
- Set rules with the consumer that protect their safety
- Refer to the literature review for all questions regarding PCPT

Duration: The activity's length is up to staff however, consumers may move on to something else at any time

Frequency: The activity's frequency is up to staff however, consumers may choose to terminate the activity at any time

Appendix C: Water Basketball

Purpose: The activity's purpose is to improve emotional regulation through a non-directive approach that allows the participant to explore the activity in their own way. It is important to remember that it derives from a PCPT approach which provides strict guidelines to follow during the therapeutic process. Refer to the Principles/Tenets section of binder for principles and tenets that govern PCPT. When implementing the activity, it is important to not rush the therapeutic process, the participant will move at their own pace and the therapist should follow. Water basketball will only facilitate the therapeutic process if it is of interest to the participant.

Materials/Resources

- Swimming pool
- Basketballs or other small to medium sized balls such as nerf and tennis balls
- Basketball rims, baskets, bins, hula hoops, or other objects with an opening and space to hold a ball
- Basketball and rims are not necessary, use what is available to simulate the activity however; all simulated objects must be deemed safe for use with the population.
 - To determine whether an object is safe, staff must consider everyone's mental and physical strengths/weaknesses and make an approval in the organization's usual fashion

Instructions:

- Set up the environment so the basketballs and basketball rims/objects that simulate these items, are visually and physically accessible to the consumer
- Allow the consumers to choose the activity's direction, there are no specific rules on how to play (Ex. If the client establishes rules to the game, then adds rules as the game develops, allow it to happen)
- Set rules with the consumer that protect their safety
- Refer to the literature review for all questions regarding PCPT

Duration: The activity's length is up to staff however, consumers may move on to something else at any time

Frequency: The activity's frequency is up to staff however, consumers may choose to terminate the activity at any time

Appendix D: Football

Purpose: Purpose: The activity's purpose is to improve emotional regulation through a non-directive approach that allows the participant to explore the activity in their own way. It is important to remember that it derives from a PCPT approach which provides strict guidelines to follow during the therapeutic process. Refer to the Principles/Tenets section of binder for principles and tenets that govern PCPT. When implementing the activity, it is important to not rush the therapeutic process, the participant will move at their own pace and the therapist should follow. Football will only facilitate the therapeutic process if it is of interest to the participant.

Materials:

- Footballs or other small to medium sized balls such as nerf and tennis balls
- Footballs are not necessary, use what is available to simulate the activity however; all simulated objects must be deemed safe for use with the population.
 - To determine whether an object is safe, staff must consider everyone's mental and physical strengths/weaknesses and make an approval in the organization's usual fashion

Instructions:

- Set up the environment so the footballs/objects that simulate this item, are visually and physically accessible to the consumer
- Allow the consumers to choose the activity's direction, there are no specific rules on how to play (Ex. If the client establishes rules to the game, then adds rules as the game develops, allow it to happen)
- Set rules with the consumer that protect their safety
- Refer to the literature review for all questions regarding PCPT

Duration: The activity's length is up to staff however, consumers may move on to something else at any time

Frequency: The activity's frequency is up to staff however, consumers may choose to terminate the activity at any time

Appendix E: Water Football

Purpose: The activity's purpose is to improve emotional regulation through a non-directive approach that allows the participant to explore the activity in their own way. It is important to remember that it derives from a PCPT approach which provides strict guidelines to follow during the therapeutic process. Refer to the Principles/Tenets section of binder for principles and tenets that govern PCPT. When implementing the activity, it is important to not rush the therapeutic process, the participant will move at their own pace and the therapist should follow. Water football will only facilitate the therapeutic process if it is of interest to the participant.

Materials/Resources:

- Swimming pool
- Footballs or other small to medium sized balls
- Footballs are not necessary, use what is available to simulate the activity however; all simulated objects must be deemed safe for use with the population.
 - To determine whether an object is safe, staff must consider everyone's mental and physical strengths/weaknesses and make an approval in the organization's usual fashion

Instructions:

- Set up the environment so the footballs/objects that simulate this item, are visually and physically accessible to the consumer
- Allow the consumers to choose the activity's direction, there are no specific rules on how to play (Ex. If the client establishes rules to the game, then adds rules as the game develops, allow it to happen)
- Set rules with the consumer that protect their safety
- Refer to the literature review for all questions regarding PCPT

Duration: The activity's length is up to staff however, consumers may move on to something else at any time

Frequency: The activity's frequency is up to staff however, consumers may choose to terminate the activity at any time

Appendix F: Walking and catch

Purpose: The activity's purpose is to improve emotional regulation through a non-directive approach that allows the participant to explore the activity in their own way. It is important to remember that it derives from a PCPT approach which provides strict guidelines to follow during the therapeutic process. Refer to the Principles/Tenets section of binder for principles and tenets that govern PCPT. When implementing the activity, it is important to not rush the therapeutic process, the participant will move at their own pace and the therapist should follow. Walking while playing catch will only facilitate the therapeutic process if it is of interest to the participant.

Materials/Resources:

- Safe space for walking
- Small to medium sized ball such as a nerf and tennis ball
- Use what is available to simulate the activity however; all simulated objects must be deemed safe for use with the population.
 - To determine whether an object is safe, staff must consider everyone's mental and physical strengths/weaknesses and make an approval in the organization's usual fashion

Instructions:

- Set up the environment so that the small to medium sized ball/object that simulates this item, is visually and physically accessible to the consumer
- Allow the consumers to choose the activity's direction, there are no specific rules on how to play (Ex. If the client establishes rules to the game, then adds rules as the game develops, allow it to happen)
- Set rules with the consumer that protect their safety
- Refer to the literature review for all questions regarding PCPT

Duration: The activity's length is up to staff however, consumers may move on to something else at any time

Frequency: The activity's frequency is up to staff however, consumers may choose to terminate the activity at any time