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Communicating With Play: Helping Adults Recognize Separation Anxiety Disorder and Social Anxiety Disorder In Preschool Children

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Table of Contents

Abstract

Despite well-founded and agreed upon evidence showing preschool-aged children experience anxiety (CDC, 2020), children ages 2-6 are continuously understudied, underdiagnosed, and undertreated for these disorders (NIMH, 2019). Researchers attribute this to the primarily cognitive, as opposed to behavioral symptoms of anxiety, communication deficits during the preschool years, and the nature of childhood amplifying already existing barriers to a diagnosis of anxiety. Because diagnosis is the first step to gaining access to mental health resources and early intervention mitigates symptoms and impaired functioning (Barstead et al., 2018), as well as preventing long-term negative outcomes (Hammen et al., 2008; Ramsawh et al., 2011), it is necessary to lift children's voices to ensure every child receives the treatment they need. To successfully understand and help children experiencing anxiety, adults can use play, the language of childhood to communicate with children. Make-believe play has been shown to be the child's version of talk therapy, transcribing internal thoughts and feelings of children into visible and verbal action (Segal, 1973). The history and development of play therapy literature suggest playing with children bridges the gap between the direct expression of adults and the indirect expression of children (Pehrsson, 2007). This analytical review will therefore include literature suggesting ways children with anxiety play differently than children without anxiety. Finally, based on this review, a tool will be developed specifically for parents and teachers to recognize separation anxiety disorder and social anxiety disorder through play behaviors and play themes at home and at school.

**Communicating With Play: Helping Adults Recognize Separation Anxiety
Disorder and Social Anxiety Disorder In Preschool Children**

Introduction

'I made some blue and green spots, which are cold colors, and then yellow and red that are warmer, to express the change in the home environment, from more serious to getting along better and communicating better' EN, VIG01 (Mateos et al., 2020, p. 5).

The above quote is from a collection of interviews of children (ages 6-12) who underwent the 'Learning Together, Growing as a Family' parental education program in 2016 and 2017 in Spain. This program aimed to enhance communication between parents and children (Amorós-Martí et al., 2016). A follow-up study interviewing the children who attended this program asked them to create a drawing depicting what they liked most about the course and their favorite change at home after the program. Examples of these drawings can be seen in Figure 1. Many children, like the one above, express that their favorite change was the improved ability of their parents to listen and communicate with them, making them feel more valued, loved, and heard.

'My parents now give me much more love'. EN, MAL03

Figure 1.
Drawing made from kids in the "Learning Together, Growing as a Family" parental education programing.

Note: Drawings made from kids in the 'Learning Together, Growing as a Family' parental education programing. These depict how their families transformed for the better. Reprinted from What do parents perceive are the barriers and facilitators to accessing psychological treatment for mental health problems in children and adolescents? A systematic review of qualitative and quantitative studies by Reardon and colleagues (2017).

Efforts made by training programs such as the 'Learning Together, Growing as a Family' parental education program show how increased parent-child communication contributes to the well-being of children. Adult ability to understand, interpret, and communicate is especially important for preschool-aged children (2-6 years) because, at this age, children do not possess the same language ability as adults. They have smaller vocabularies and utilize different styles making it difficult for children to verbalize their internal states (Gable, 2003.; Law et al., 2017). Additionally, symptoms of separation anxiety disorder (SEP) and social anxiety disorder (SOC) — two internalizing anxiety disorders widely known to be prevalent in preschool-aged children — can be mitigated and perhaps eliminated long-term if recognized at this early age (Barstead et al., 2018; Hammen et al., 2008; Ramsawh et al., 2011). Therefore, communication between adults and children is paramount to noticing disorders that manifest internally within a child. How can we increase communication between adults and children when they seemingly don't speak the same language?

Ultimately, the goal of the following literature review is to provide evidence that play is the language of childhood, and therefore, the use of play (at home and in schools) can be used as a means of increasing communication between adults and children and as a way to recognize preschool children at risk for developing SEP and SOC. An analysis of the literature on play, play therapy, childhood communication, and preschool anxiety will provide examples of the ways children with anxiety play differently than children without anxiety. Based on these findings, a tool for parents and teachers will be developed.

The goal of developing a tool for adults to recognize anxiety through play tendencies is two-fold. First, the increased ability for adults to communicate and interpret when children are

experiencing anxiety will hopefully decrease the number of children who go without necessary diagnosis or treatment. Second, because adults are communicating and understanding their children better, the number of children who develop anxiety in preschool will hopefully decrease.

To express the urgent need for a tool for adult recognition of anxiety in preschool-aged children, I will provide an overview of the relevant literature on factors contributing to the problem. First, I will discuss what it means to have preschool anxiety when you are between the ages 2 and 6. By showing how these disorders function differently in this age group than they do in adults or even slightly older children and how these disorders follow children into adolescents and adulthood, it will become clear that targeting anxiety in preschool children is necessary. Second, a summary of the literature on the difficulties of recognizing anxiety in children, diagnosis methods, and underdiagnosis will show the need for available tools to help parents, teachers, and other gatekeepers recognize anxiety in children. Finally, I will dedicate a section to the environments where adults can observe children play the most naturally: at home and school. I argue that at home, parents have a unique opportunity to witness children with SOC engage in make-believe play in a way teacher's can not because children with SOC tend not to play with peers at school (Gazelle et al., 2010; APA, 2013). Additionally, I will use literature showing why the early education system would be especially effective at recognizing both SOC and SEP in children. In response, I will develop a tool specialized for observing anxious play themes and play behaviors at home and in the classroom.

Play therapists take advantage of the therapeutic benefits of play and understand that play can tell them more about a child. However, at the moment this knowledge is reserved for professionals and parents and teachers don't understand how to use play to recognize anxiety in children or that they even can. There are online tools parents and teachers can utilize to test if

they should bring their child to a professional but there are none that utilize play behaviors and play themes. Therefore, following this literature review, I will provide a tool of play themes and play behaviors that mark anxiety for parents and teachers to use to identify when play might represent symptoms of SOC and SEP.

Overview of Anxiety

First, I will give an overview of what anxiety is and how it manifests in children younger than 6. This section will provide a detailed description of the DSM-5 definition of SEP and SOC, the prevalence of each in children ages 2-6, and associated symptoms while emphasizing what makes children with these disorders different from adults with these disorders and their peers without anxiety.

Anxiety comes in many forms, the DSM-5 names separation anxiety disorder (SEP), specific phobia, social anxiety disorder (SOC), selective mutism, panic disorder (PD), agoraphobia, and generalized anxiety disorder (GAD). Anxiety disorders are one of the most common mental health problems in children ages 3-17 years. The Center for Disease Control reports the prevalence rate in this age group to be 7.1% (CDC, 2020). The American Psychological Association defines anxiety as an emotion characterized by feelings of tension, worried thoughts, and physical changes. Anxiety is a common emotion, often appropriate and beneficial in certain situations. For example, anxiety can motivate a child to put in extra effort and time studying for an exam, or read over an assignment they completed before handing it in, ultimately improving their grades and academic experience. The motivation to complete these tasks can come from normal fears, worries, and rituals that are appropriate and necessary for

development and success (Rosen & Schulkin, 1998). However, anxiety transforms from a common emotion into a disorder when a child's fears and worries become excessive, developmentally inappropriate, and cause impairment of function in both social and academic areas (Mash & Wolfe (2019).

Mash & Wolfe (2019) provide an overview of the symptoms and response systems of anxiety disorders that can be characterized into physical, cognitive, and behavioral domains. Each set of symptoms have specific immediate responses to perceived danger (fight or flight response). Physical symptoms of anxiety include increased heart rate, nausea, sweating, dizziness, stomach upset, vomiting, etc. These symptoms physically activate the entire metabolism, literally preparing the body for the fight or flight response. Chemical, cardiovascular, respiratory, sweat glands, and other physical effects combine to mobilize the body into action if necessary. Cognitive symptoms of anxiety include thoughts of being scared or hurt, incompetent, foolish, or being overly self-critical. In response to these thoughts, the fight or flight system automatically looks for a threat or explanation for a person's fear, and when they don't find what they are looking for, they invent reasons or blame themselves. Behavioral systems of anxiety include avoidance, crying, nail-biting, trembling voice, fidgeting, etc. The immediate behavioral fight or flight reaction to anxiety is aggression (fight) or a desire to escape (flight). The different anxieties children face and the fight or flight response to those anxieties help define how individual children experience anxiety.

The focus here will be separation anxiety disorder (SEP) and social anxiety disorder (SOC). They are among the most common anxiety disorders children between the ages 2-6 experience, the others being specific phobia, and general anxiety disorder (GAD) (CDC, 2020;

Polanczyk et al., 2015). I have chosen to focus on SEP and SOC because they each offer a unique opportunity to observe how play tendencies can highlight when children are experiencing SEP and SOC at home and in school.

Separation Anxiety Disorder (SEP)

Although the age of onset for SEP is normally reported to be around 7-8 years old , it is also reported to be experienced by 4-9% of children younger than 7. In fact, separation anxiety disorder (SEP) is known to be the most prevalent anxiety disorder in preschool children (Franz et al., 2013; Paulus et al., 2015; Silove et al., 2015). Essentially, someone with SEP experiences excessive fear or anxiety regarding the separation from home or attachment figures " (American Psychiatric Association [APA], 2013; DSM-5). Before exploring how children specifically experience SEP, let's look at how the Diagnostic and Statistical Manual of Mental Disorders, 5th edition defines this disorder generally:

A. Developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached, as evidenced by at least three of the following:

1. Recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures.

2. Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters, or death.

3. Persistent and excessive worry about experiencing an untoward event (e.g., getting lost, being kidnapped, having an accident, becoming ill) that causes separation from a major attachment figure.

4. Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation.

5. Persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings.

6. Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure.

7. Repeated nightmares involving the theme of separation.

8. Repeated complaints of physical symptoms (e.g., headaches, stomachaches, nausea, vomiting) when separation from major attachment figures occurs or is anticipated.

B. The fear, anxiety, or avoidance is persistent, lasting at least 4 weeks in children and adolescents and typically 6 months or more in adults.

C. The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.

D. The disturbance is not better explained by another mental disorder, such as refusing to leave home because of excessive resistance to change in autism spectrum disorder; delusions or hallucinations concerning separation in psychotic disorders; refusal to go outside without a trusted companion in agoraphobia; " in generalized anxiety disorder; or concerns about having an illness anxiety disorder.

(APA, 2013, p. 191).

SEP presents in children similarly to how it does in adults, however, children have specific contexts in which SEP is triggered. Bedtime tends to be a particularly difficult time for children with SEP. This is because often bedtime is when children are expected to sleep in their own beds, away from their parents. As a result, children insist someone stay with them until they fall asleep, or climb into bed with an attachment figure. Additionally, two typical features of bedtime are being alone at night and in the dark. These circumstances have generated instances where children with SEP have experienced unusual perceptual experiences (i.e., seeing a figure in the closet) (APA, 2013).

Situations, where a child is expected to leave home, can cause significant bouts of fear and worry. Behaviorally, this can be seen as a reluctance or refusal to leave the house for extended amounts of time like attending camp or going to a friend's house. Even going on short trips like running errands with a parent can cause worry for a child with SEP. They may fear losing their parents in the store, or being kidnapped, or killed while they are out (APA, 2013; Mash & Wolfe, 2019). One major disruptive circumstance universal to almost every child is when they begin attending school. When a child starts going to school, not only are they expected to leave their parents for an extended period but also the introduction of a new routine can be a major stressor in a child's life — the onset of SEP often occurs after major life stress (Figueroa et al., 2012). A child with SEP might be reluctant or even refuse to go to school at all, as a result, they may struggle academically and face social isolation (APA, 2013). Yet, children with SEP are not reported to have any social skill impairments, in fact, they actually get along well with others (Mashe & Wolfe, 2019). However, despite having the social skills, they will

withdraw themselves socially, become apathetic, sad, and have difficulty focusing on work and play (APA, 2013; Lewinsohn et al., 2008).

Social Anxiety Disorder

Although recent evidence shows children younger than 7 can experience SOC (CDC, 2020), an official diagnosis of the disorder is not usually given to children until they are around 13 (de Lijster et al., 2017). This may reflect how SOC develops overtime, existing quietly in children until it becomes harder to manage during the transition from childhood to adolescence (Knappe et al., 2010). Studies showing preschool behavioral inhibition predicts social anxiety in middle school children (Hirshfeld-Becker et al., 2007) support this theory. Although there is no conclusive evidence of SOC in children younger than 7, likely they experience symptoms that will eventually develop into SOC if left untreated. The DSM-5 defines SOC as follows:

A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech).

   Note: In children, the anxiety must occur in peer settings and not just during interactions with adults.

B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing: will lead to rejection or offend others).

C. The social situations almost always provoke fear or anxiety.

Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.

D. The social situations are avoided or endured with intense fear or anxiety.

E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the socio-cultural context.

F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmoφhic disorder, or autism spectrum disorder.

J.   If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from bums or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.

Specify if*:*

Performance only: If the fear is restricted to speaking or performing in public.

(APA, 2013, p. 202).

Children younger than 7 do not necessarily present with all mandatory DSM-5 criteria for the disorder but do present with symptoms (i.e., behavioral inhibition and shyness) that highly predict SOC later in life (APA, 2013). It is important to recognize these symptoms in children because getting treatment would halt symptoms before they persist into adolescents. Because children with SOC are more shy and withdrawn, emotional and sad, and exhibit anxious and ineffective social responses, their peers tend to perceive them as less likable and less socially desirable (Scharfstein & Beidel, 2015). Unfortunately, cognitive symptoms of SOC include fear of being judged as unlikeable and being rejected (APA, 2013), so when their fear of being rejected makes them withdrawn from their peers, their peers reject them, making their fears come true. In response to their fears or anxieties, a person with SOC will experience any number of the following physical symptoms: blushing, trembling, staring, sweating, rapid heartbeat, dizziness, etc. (*Social Anxiety Disorder (Social Phobia) - Symptoms and Causes*, n.d.) For children, physical symptoms may be paired with behavioral symptoms such as crying, freezing, clinging and tantrums (APA, 2013). Physical symptoms of SOC perpetuate fears and anxieties because a person with SOC fears that they will act or appear in a way that showcases their anxiety (physical symptoms). Therefore, if a person with SOC begins experiencing cognitive symptoms, likely physical symptoms will follow, amplifying their cognitive symptoms, creating a positive feedback loop. Periodically, people experiencing SOC will respond to their symptoms with bouts of anger and aggression (Cassiello-Robbins & Barlow, 2016).

Fears and anxieties of SOC occur in situations where a person may be perceived. Most often these fears manifest themselves at work, in school, or in settings where they are expected to present in public (APA, 2013). Settings where people are expected to meet new people, socialize,

and participate in activities, can be difficult for individuals with SOC. School, parties, or social gatherings are all events and places adults and children alike will be reluctant to attend (Mashe & Wolfe, 2019).

Importance of diagnosis

Diagnosis is the first step to gaining access to mental health resources. Therefore, it is essential to combat any factors contributing to the increased likelihood of missing a diagnosis in childhood. The *National Alliance on Mental Illness* (NAMI) explains that a diagnosis allows increased communication between medical professionals and specialists. A pediatrician and therapist can use a diagnosis to suggest treatment options and inform parents of the trajectory of the disorder. For example, a mental health professional might tell a parent of a child with anxiety that it is typical for a child with anxiety to have difficulty performing in school, socializing, and that anxiety at an early age predicts other mental disorders in the future (Kessler et al., 1985; Swan & Kendall, 2016). Additionally, a diagnosis tells health insurance companies that a child does have a condition requiring medical care. In receiving a diagnosis, a child goes from having little to no mental health resources to having their pediatrician's expertise, referrals to other specialists, and the support from insurance companies to fund it. A diagnosis is also useful for parents because it gives them direction to do their own research on what to expect for their child's experience with the disorder (Reardon et al., 2017).

The purpose of a diagnosis is to help determine the best treatment for someone living with a specific mental health disorder. Longitudinal studies have shown that for preschool children, early treatment for anxiety and depression can be the difference between experiencing these disorders long-term or reducing the likelihood they will persist into adolescence and

adulthood (Rapee, 2002). Additionally, early cognitive-behavioral interventions, psychoeducation, Parent-Child Interaction Therapy (PCIT), and Social Skills Facilitated Play (SSFP) have shown to be effective at mitigating the symptoms (i.e., behavioral inhibition) and impaired functioning that comes with anxiety in early childhood settings (Barstead et al., 2018; Luby et al., 2012; Stein, 2007). Without early intervention for anxiety, preschool-aged children experience poorer outcomes and less manageable symptoms than their peers who receive mental health support (Hammen et al., 2008; Ramsawh et al., 2011).

Targeting anxiety in early childhood is effective because preschool children are more plastic than later primary and middle school children. Preventing long-term outcomes is successful when you treat anxiety and depression early because children younger than 7, are more open to growth and reorganization in terms of brain development (Hirshfeld-Becker & Biederman, 2002; Luby et al., 2012). Research on older children (ages 6-16) has shown that anxiety in childhood impairs neural plasticity (Liu et al., 2017). Also, Tsujimoto (2008) describes how around the age of 8, synaptic pruning and cerebral cortex lateralization make the brain less malleable, resembling adult levels of energy consumption (synaptic connections) and that in comparison, between the ages 2 and 7, the prefrontal cortex undergoes rapid myelination and formation, and has an abundance of synaptic connections. Additionally, because lateralization — the process of committing brain functions to specific areas of the brain — of the cerebral cortex does not occur between the ages of 2-6 (Berk, 2012), the preschool brain has a high capacity for learning because cognitive functions are not localized in distinct neural systems, making preschool brains more flexible (Tsujimoto, 2008).

Neuroplasticity during this stage of life creates a unique case for early intervention in children ages 2-6. It allows for treatment to permeate a mind that (1) is open to growth,

reorganization, and new strategies, and (2) is not fully committed to the path it is on. However, in order to even begin early intervention, a diagnosis and recognition of symptoms in children are necessary.

Difficulties with Recognition

Now that we know the importance of treating children with symptoms of anxiety disorders such as SEP and SOC as early as possible, let's explore what makes getting treatment so difficult. As mentioned earlier, the first step to gaining access to mental health resources is receiving a diagnosis, but the first step to receiving a diagnosis is recognizing disordered symptoms in children. This section will explore the recognition difficulties parents, teachers, and other gatekeepers face when identifying children with SEP and SOC, two internalizing anxiety disorders.

The Nature of Internalizing Disorders

Both SEP and SOC fall under the category of internalizing disorders. Internalizing disorders have covert symptoms, difficult to observe because some of their symptoms are strictly cognitive. People with internalizing disorders often keep the problems they experience to themselves because their problems relate to personal thoughts and emotions, as opposed to overtly, socially negative, or disruptive behavior (Tandon et al., 2009). In contrast, externalizing disorders have overt symptoms, easier to recognize through observations of behavior. Externalizing disorders usually receive more attention than internalizing disorders because behavioral symptoms (i.e., aggression in Conduct Disorder) are more disruptive to adult life than cognitive symptoms typical of internalizing disorders (Pearcy et al., 1993). Consequently, adults detect externalizing disorders more easily than internalizing disorders. Additionally, adults

perceive internalizing disorders as less problematic than externalizing disorders (Tandon et al., 2009), making overlooking them easier.

One study confirmed this bias by asking teachers to decide whether a child referral to a specialist is necessary based on descriptions of children experiencing internalizing and externalizing disorders. Expectedly, teachers referred children presenting with external symptoms at a higher rate than children presenting with internal symptoms (Pearcy et al., 1993). Essentially, internalizing disorders are less recognizable from the outsider perspective, and teachers do not deem them problematic enough for psychiatric intervention. In either case, children with symptoms of internalizing disorders are going without a diagnosis. Therefore, also without necessary treatment. When mental disorders do not cause outwardly problematic behavior but instead ruminate quietly within a child, internalizing disorders are likely to go unnoticed.

Parent Perception

Parents play a key role in children seeking and accessing professional resources for anxiety disorders, however, there are many barriers that prevent parents from seeking help for their child with anxiety. Reardon et al., (2018) name four stages in the parental help-seeking process, each stage leads into the other, and it all starts with the parent being able to recognize that their child is experiencing anxiety at all. Figure 2 presents the entirety of the help seeking stages from Reardon and colleagues 2018 publication. That is to say without parent recognition of anxiety, it is unlikely parents will see the need for professional help. Unfortunately, parent perception of childhood, anxiety, and diagnosis prevent parents from recognizing childhood anxiety, meaning parents never even reach the first stage of the help-seeking process.

Figure 2.
Barriers and facilitators at four key stages of the help seeking process
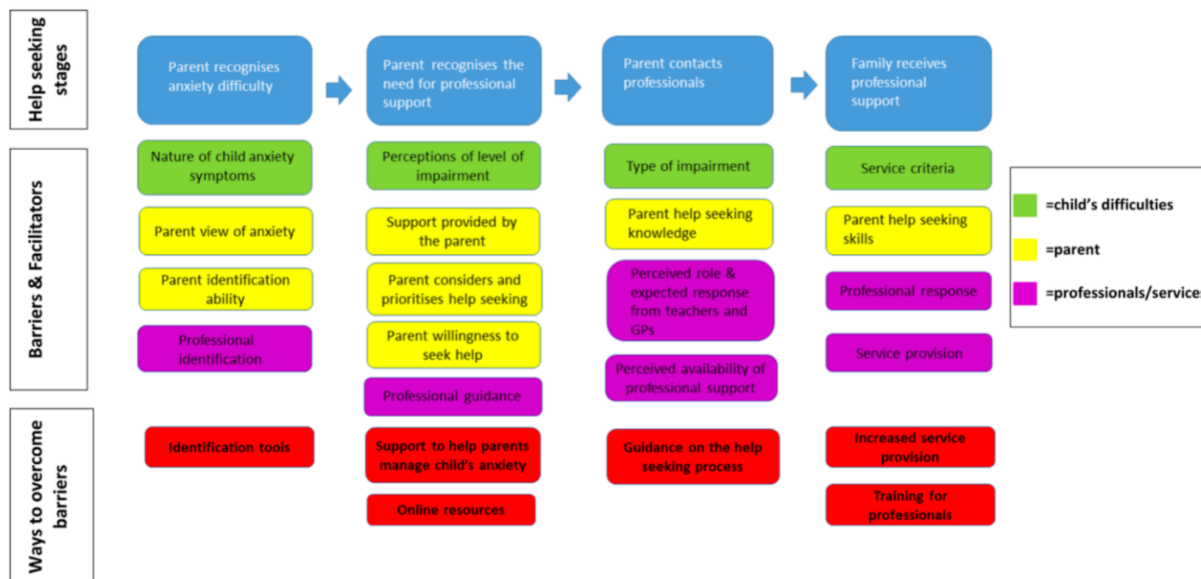
Note: Retrieved from Reprinted from What do parents perceive are the barriers and facilitators to accessing psychological treatment for mental health problems in children and adolescents? A systematic review of qualitative and quantitative studies by Reardon and colleagues (2017).

Of Childhood. The way adults view children is important in understanding how parents may easily dismiss anxiety symptoms in their children. The perception of childhood is often viewed as a time of joy and innocence. Adults are disconnected from childhood because they cannot remember exactly what it was like to be a child and rely on vague, clouded memories. For example, Wells and colleagues (2014) investigated what details adults could remember from childhood memories. The researchers found that memories were limited to what they were doing, where they were, and who was with them but omitted any other details (i.e., event duration and time) from memory. Adults also seem to recall positive life events during childhood, more often than negative ones (Leist et al., 2010). Because adults can not remember their childhood in detail and have a bias towards remembering positive over negative events, they tend to believe children experience life the way they remember childhood. This lends to the idea that children are

carefree, spontaneous, and content (Goldstone, 1986; Tandon et al., 2009). These kinds of views allow adults to be blind to children's feelings and feel the need to protect their innocence. It would not come as a surprise then that adults would push back against the idea of their children having disorders characterized by feelings that contradict their view of what childhood should be.

Of Anxiety. Parents from the study by Reardon et al., (2018) describe another barrier to an anxiety diagnosis — the idea that worry is a common childhood feeling, difficult to distinguish from disordered anxiety symptoms:

'I suspect that it's it's quite common for the younger ones to er to er have this…. I see it as part of growing up er you know the shyness' [ID 3]
'they're normal child childlike you know personality traits all children get nervous and anxious about things but is it too much or is it just you know regular' [ID.1131].
(Reardon et al., 2018).

Parents are not alone in this feeling, Muris et al., (2000) examined typically presenting children and found that nearly 70% experienced anxiety symptoms. Therefore, even if a parent can recognize when a child is experiencing one of these symptoms over an extended amount of time, it may easily be dismissed as a common childhood experience. Abnormal psychology textbooks dedicate sections distinguishing the difference between normal anxiety and fear from disordered anxiety and fear. This implies that even those who dedicate their time to studying anxiety find it difficult to distinguish the two. The difference between normal anxiety and someone who experiences an anxiety disorder is that where normal anxiety is related to a specific situation, is proportional to the problem, and is realistic, disordered anxiety is more excessive, irrationale, enduring, and unmanageable (Mashe & Wolfe, 2019). These differences are a matter of anxiety surpassing a certain threshold and because disordered anxiety and fear is

so similar to normal anxiety and fear, it is difficult to identify when fear and anxiety cross that threshold.. Therefore, parents who must recognize anxiety disorders in their children must also know where the boundary between normal and excessive is. We can assume that most parents don't have this knowledge base, making it difficult for parents to begin the first stage of help-seeking: recognizing anxiety in their children.

Of Diagnosis. When confronted with problems of anxiety in their child, parents may be blinded by their personal biases about what a diagnosis means for their child and what it says about their parenting. Parents from the Reardon et al., (2018) study admit they are afraid of being perceived as a bad parent for raising children with anxiety:

> 'you don't talk about it sometimes because you think I can't deal with the negative feedback and you're going to start saying it's me' [ID.2]
> 'it's not wanting to look like you're doing the wrong thing parenting wise' [ID.1131]
> 'because as a parent there's nothing worse than thinking I've done everything I can and I can't help my child' [ID.1212]
> (Reardon et al., 2018)

As described in earlier sections, SEP and SOC can ruminate quietly within a child without ever manifesting in a way disruptive to adults. Adding the difficulty of distinguishing normal fear and anxiety from an anxiety disorder, parents may not notice anything wrong with their child. As a result, they will have a secure sense of their ability to care for their child. Recognition of anxiety symptoms or suggestions by a teacher to seek treatment might disrupt this security. Coming to terms with their child's anxiety can be difficult for a parent who did not initially notice the signs — a diagnosis may lead to parents feeling like they failed at understanding their child. They will be afraid others will see them this way too. Ultimately, parents' perception of what diagnosis means about their parenting prevents the third and fourth

stages of the help-seeking process: recognizing the need for professional help and contacting a professional. These steps mean that parents have to take on the responsibility of their child's anxiety and fight their fear of appearing like a bad parent.

Parents also share concerns about diagnosis negatively affecting their child's life:

'I think sewed [sic] a little seed for Sally in her brain erm … the more negatives you give kids the more they're gonna tap into it and and fuel the fire' [ID.1228]
'it is viewed as a weakness it's a bit liked depression you know it's a mental health issue and it doesn't matter how you dress it up or you know all the campaigns or whatever it will always be viewed as a weakness' [ID.38]
'it'd be straight round the school within 30 seconds and she'll be she'll be you know outcast as the weirdo within the group' [ID.1228]
(Reardon et al., 2018).

Described in the compilation of parent quotes above are parents' fears of potential iatrogenic effects, perceived weakness, and bullying and bias toward their children. Iatrogenic effects are outcomes inadvertently induced by a physician, medical treatment, or diagnostic procedures. Parents fear that an anxiety diagnosis may worsen their symptoms. Research has shown that iatrogenic effects can occur after an anxiety diagnosis and beginning treatment (pharma or psycho), justifying parents' concerns (Fava et al., 2017). However, these effects were seen in adults and were attributed to the combination of psychotherapy and pharmacotherapy and the discontinuation of this treatment, meaning iatrogenic effects occur mostly after treatment ends. Additionally, research from earlier years indicates that anxiety interventions for children, in particular, do not yield negative iatrogenic effects (Albano & Kendall, 2002; Weems et al., 2009). While parents' fears are not invalid, ultimately, their fear may be preventing them from getting the help their children need. Because professionals are likely aware of this fear and how the fear is irrational, professional support and explanation can help ease these fears. However,

that would necessitate parents following through with contacting a professional, which may not happen if they fear iatrogenic effects.

Parents are also right in thinking that children without anxiety view their peers with anxiety as weak and that their children with anxiety experience bullying and judgment from their peers. Both children with SEP and SOC are viewed as less likable and less socially desirable because of their tendencies to be shy, withdrawn, and anxious (Lewinsohn et al., 2008; APA, 2013; Scharfstein & Beidel, 2015). Once again, while parents are justified in this fear, seeking professional help and treatment would mitigate the symptoms that peers judge their child for, and diagnosis helps parents get this treatment. So although symptoms of anxiety exist regardless of diagnosis, a diagnosis helps children get the treatment that mitigates the symptoms that cause other kids to judge and dislike them. However, the existing fear of complicating their child's social life (irrational or not) complicates a parent's willingness to contact a professional to give a child a diagnosis so they can receive treatment.

Underdiagnosis

The Center for Disease Control and Prevention (CDC, 2020) reports the prevalence rate of anxiety to be 7.1% for children ages 3-17 years. As mentioned earlier, researchers have reported SEP to have a prevalence rate of 4-9% in children younger than 7 (Franz et al., 2013; Paulus et al., 2015; Silove et al., 2015), and there is not an estimated prevalence for SOC in children younger than 7. These numbers and estimates are likely understating the actual prevalence rates because it is probable they are both underreported and underdiagnosed, especially in children younger than 7.

From a research methods perspective, national surveys and administrative data rely on a few assumptions that are not necessarily true (Holbrook et al., 2017). Much of the data collected from national surveys comes from parent self-report. Generally, self-report comes with many barriers to accuracy, including a variety of biases (i.e., recall and reporting bias, socially desirable responses). The other assumption national surveys and administrative data rely on is that clinicians are accurately reporting diagnoses made. A clinician may not report a diagnosis they gave to a patient because they may not see a purpose for it. Generally, the purpose of reporting a diagnosis is for patient reimbursement of treatment costs. If a person does not have insurance, there may not be a reason to report it. Additionally, there is no centralized database for this type of documentation. Medical offices do not communicate with each other. When a person visits a new medical professional they have to transfer their medical documents, or verbally explain their medical history. It is easy for data to get lost in a system like this.

Fortunately, underreported data is less of a concern because although the clinician is not reporting the diagnosis, they are still providing a diagnosis to the individual who needs it. Perhaps more detrimental to the patient outcome than underreported data is missing a diagnosis of individuals presenting with disorders. Many factors are contributing to the inaccuracy of diagnoses made by clinicians. The ways clinicians can miss a necessary diagnosis fall under two categories: under-seeking of clinicians and clinicians actively not providing a diagnosis.

Reasons for Missing a Diagnosis

Specific populations are less likely to seek help than others. Andrews and colleagues (2000) report that only a third of adults with anxiety disorders seek help for their anxiety, and even less (10%) see a psychiatrist or psychologist. Because childhood anxiety symptoms are low-referral and are internal problems (Tandon et al., 2009; Weisz & Weiss, 1991), the likelihood

adults seek help for their child with anxiety is even lower. While this is not necessarily the clinician's fault, clinicians cannot accurately diagnose someone they have not seen. The following section will explain the causes of under seeking clinicians — perceived and actual prejudices, the child's ability to seek help, and the role of anxiety.

Avoidance of clinicians occurs when patients fear facing prejudices held by the clinicians. Likely this is because they had an experience with a professional where they felt they were being judged. Because biases are present among medical professionals, the judgment patients fear is a rational fear. For example, both an implicit and explicit anti-fat bias exists among medical doctors, just as it does among the general public (Sabin et al., 2012; Phelan et al., 2015). As a result of the stigma associated with being obese, patients avoid clinical care to circumvent feeling embarrassed about their weight (Drury & Louis, 2002).

There is also a difference in help-seeking behaviors based on gender. Mental health professionals are seeing men at a lesser rate than women. Men seem to exhibit fewer help-seeking behaviors than women, while women utilize health services at higher rates than men (Cleary et al., 1982; Haavik et al., 2017). This help-seeking behavior that men exhibit may result from the stigma surrounding men's mental health. Seeking mental health is avoided by men because it makes them feel vulnerable, like they have a weakness which goes against the societal norm of men appearing strong, independent and not emotional (Pederson & Vogel, 2007). In an online survey, Haavik and colleagues (2017) measure adolescent awareness of mental health problems. In this survey, adolescents identify mental health problems faced by young people in a story. They were also assessed on their knowledge of mental health services available to them and whether they used them. Results showed that girls were significantly better at identifying anxiety and trauma reactions in the individuals from the stories, were more aware

of mental health services, and were more likely to use said services than boys. Likely, this contributes to the finding that specific populations (i.e., boys) are seeking help at a lesser rate.

Ethnic and racial minorities are also less likely to utilize mental health care. In a recent report from the U.S. Department of Health and Human Services [DHHS], 2012, racial and ethnic minorities were reported to have less access to and availability of mental health services.

There are also reasons specific to children that prevent them from seeking mental health support. Children, in particular, are less likely to see a mental health professional than adults. In three nationally representative household surveys, about 2%-3% of children ages 3-5 years old used mental health services (Kataoka et al., 2002). Reports from 2019 suggest that adults receive 14 times more mental health services than children (NIMH, 2019). One mechanism for this could be the practice of gatekeeping, which also serves as a barrier to a diagnosis that prevents the prevalence rate from being accurate. Generally, the gatekeeper's role is to recognize when someone may need to visit a mental health professional. For adults, primary care physicians are their gatekeepers. Adults can schedule their appointments whenever they feel like something may be off. They also can describe how they feel when in conversation with their primary care physician. The gatekeeper does not have the additional responsibility of deriving meaning from certain behaviors to recognize when their patient may need to visit a mental health professional.

For children, however, the process is much different. The role of gatekeeper is not only placed on the pediatrician but parents and teachers. Besides general check-ups, for a child to see a pediatrician, the adult figures in their lives need to deem the physical and mental state of children as problematic enough to visit a doctor. Since parents and teachers are not mental health professionals, what they see as a problem is vastly different across individuals (Veenstra et al.,

2008). If symptoms do not present behaviorally, parents may have difficulty recognizing their child's anxiety. Therefore, they would not take their child to see a pediatrician.

Even if parents do bring their concerns to a pediatrician, the pediatrician is still not trained at recognizing mental health disorders the same way as a mental health professional. Admittedly, this is also true for adults who see primary care physicians (PCP) but adults have the added capability of having a conversation with their PCP. When examined, pediatricians (5.7%) recognized symptoms of disorders at a lower rate than trained psychiatrists (11.8%) (Costello et al., 1988). Children rely on parents who are not mental health professionals to bring them to pediatricians who don't recognize half of the children presenting with disordered symptoms. After this trying process, professionals finally can recommend them to someone who could accurately diagnose them. A system such as this contributes to children of all ages, but especially between the ages 2-6 missing a diagnosis because they are the least likely to be able to verbally express their anxiety.

As mentioned and explained when in the difficulty with recognition section, in addition to reasons specific to children, there are also reasons specific to both SEP and SOC that contribute to missing a diagnosis in a child who has either of these disorders. Although anxiety disorders are frequent, persistent, and present in early childhood, they often go unnoticed and untreated in children (Chavira et al., 2004). The nature of internalizing disorders and parent perception of childhood, anxiety, and diagnosis contribute to the difficulty of recognizing SEP and SOC in their children. Therefore, contributing to underdiagnosis.

The under-seeking of clinicians is unfortunately not the only reason for underdiagnosis. Even patients who have access to mental health professionals seem to face underdiagnosis. Partly this is due to the stereotypes and prejudices certain groups face when visiting mental health care

facilities. For example, Racial and ethnic minorities are at higher risk than white people for certain mental health disorders and yet they get diagnosed at a lesser rate (Plant & Sachs-Ericsson, 2004). Any disparity between minority groups and whites is likely not due to actual differences in mental health but because of stereotypes and prejudices held by mental health professionals. It might actually make more sense that ethnic minority groups would be diagnosed at a higher rate than whites because of the additional risk factors they face. This is not the case. One study compared the rates of diagnosed behavioral, emotional, and developmental problems in Hispanic versus non-Hispanic white children. While controlling for parental concern, access to health care, poverty, language, and provision of an interpreter, Hispanic children were still less likely to receive a diagnosis than white children (Watt & Martinez-Ramos, 2009).

These results suggest that the prevalence rates for anxiety disorders are probably grossly underestimated for racial and ethnic minorities. Even though racial and ethnic minorities are at greater risk for anxiety, there is a bias that prevents them from receiving a diagnosis at all. All of these results contribute to the underdiagnosis of adults. Unfortunately, these same reasons magnify underdiagnosis in children. Marrast et al., (2016) examined racial and ethnic disparities in child usage of mental health services using the 2006-2012 Medical Expenditure Panel Surveys. Results found that Black and Hispanic children visited mental health care centers at half the rate non-Hispanic white children did for all types of mental health services. Ultimately, racial and ethnic prejudices and stereotypes are impacting both adult and child diagnosis.

Current Diagnostic Methods

In addition to prejudice and stereotypes held by mental health professionals, there are also reasons specific to the mental health tools accessible to professionals that cause them to

miss a diagnosis. Current diagnostic tools contribute to the underdiagnosis of anxiety disorders. This happens for several reasons: the DSM-5 is insufficient, and the tools available are only accessible to and administered by professionals. This section will elaborate on each of these issues.

In addition to detection issues of internalizing disorders discussed in the difficulty with recognition section, the standard criteria presented by the Diagnostic Statistical Manual of Mental Disorders, 5th Edition: DSM-5 may contribute to the trend of overlooking children who experience internalizing disorders. Diagnostic criteria given to mental health professionals play a crucial part in properly diagnosing children. Earlier, we looked at SEP and SOC definitions, criteria and common symptoms provided in the DSM-5. Most, if not all of the criteria presented for these disorders do not have to manifest in behavioral ways and although both disorders have possible behavioral symptoms (i.e., tantrums, aggression, reluctance to leave the house), they can easily be attributed to other things — both parents and trained clinicians don't associate this behavior with anxiety but instead with difficult and demanding children (Koch, 2003). Without clear behavioral symptoms, what is left is physical and cognitive symptoms. Cognitive symptoms typical of SEP (i.e., images of harm to loved ones) and SOC (i.e., thoughts of incompetence or inadequacy) are all felt in a person's mind without ever affecting the observable behavior parents and teachers know to look out for. Even if it does affect them physically, physical symptoms (i.e., headaches or stomach aches) can only be recognized by an adult if a child communicates their internal and physical state to adults, even then, parents may not attribute physical symptoms directly to anxiety.

Other tools available to mental health professionals that guide their diagnoses decisions do not directly contribute to underdiagnosis. The diagnostic tools themselves actually show to be

effective in identifying anxiety in children. For example, the Anxiety Disorders Interview Schedule for DSM-IV: Children and Parent Versions (ADIS), the Multidimensional Anxiety Scale for Children (MASC) and MASC-P (for parents), and the Child Behavior Checklist (CBCL) and Caregiver Report Form (C-TRF) all have well-documented test-retest reliability, validity, and significant parent and child agreement (Kristensen et al., 2010; Wood et al., 2002). The ADIS and MASC specifically show strong validity when measuring SEP and SOC (Wood et al., 2002). However, each of these tools have common limitations — they are only accessible to parents if a professional administers these forms. Therefore, the use of these tools can only occur after the final step of the health seeking process: family receives professional support (Reardon et al., 2018). As I have explained earlier, even the first step of the help seeking process (parent recognition of anxiety in children) is difficult to complete. These tools can not work on children and parents who do not visit a mental health professional. Thus, there needs to be a tool for parents and teachers to recognize when children need to seek professional help. You can find some examples of tools for parents online, but none use what I suggest the language of childhood is: play. For the remainder of this project I will be describing what play is, how children use it to communicate, and applying rationale for using play themes and play behaviors to identify SEP and SOC in preschool children.

Play

"There was a baby and a mummy. It was nighttime. Mummy had lost her baby. She said, 'Baby, baby, where are you, my baby? Baby, baby. I have lost you, my baby.'
The baby was asleep. She woke up. She climbed onto a pussycat. The cat took her outside to the train station. She climbed onto the train and the train went a long, long, long way away. It went to the snow. The baby got off the train. The baby climbed onto a doggie. The doggie took the baby to the land of snow. The baby fell asleep. The Mummy had found her baby. The

'amberbance man' put the baby in a special blanket and the baby woke up. Mummy was happy and she loved the baby." (Diane Rich, 2002).

Despite the intense approach children take to play, adults can often dismiss play as something with little value. The cultures of adults and children conflict with each other — where adults are product-orientated, children are process-oriented (Plank, 2016). The value adults derive from play stems from their view on the end product, and not on the process it took to get there. It is not possible to reduce the value of play to the quality of an end product that is constructed carefully by an adult's vision. Yet, many preschools adopt a product-oriented mindset to education, prioritizing the preparation for a higher grade level. This contributes to more time spent on didactic, academic, and content-based learning instead of child-centered, play-oriented, and constructivist learning (Miller & Almon, 2009; Nicolopoulou, 2010). This is unsettling because it works directly against the child's natural way of learning.

Instead, the child's culture determines the value of play. Play is so much more than something children enjoy engaging in, and it is more than a product that comes from it, which is not the same for content-based learning. When children receive a step-by-step, cut-and-paste art project, they are often learning more from the process than the final result. Admittedly, most teachers know this when assigning a project like the one described here because they believe the process will teach their students how to follow directions, use scissors, hand-eye coordination, etc. However, a project with an identical goal for each student limits creativity and the opportunity to express oneself through a self-actualized project. Some preschools recognize this deficit in content-based learning and commit to a play-centered education instead. Allowing children to play as a means of learning promotes their physical, social, and emotional

development in a way content-based learning can not. Understanding the definition of play is the first step in uncovering the importance and seriousness it has.

Though lacking in a universally agreed-upon definition, research on early childhood play hints towards several common understandings of play. The summarizes these characteristics into five different points:

1. play is self-chosen and self-directed

2. play is an activity in which means are more valued than ends

3. play has structure, or rules, which are not dictated by physical necessity but emanate from the minds of the players

4. play is imaginative, non-literal, mentally removed in some way from "real" life

5. play involves an active, alert, but non-stressed frame of mind

An activity does not need to have each of these characteristics to be considered play, but the more of them an activity incorporates, the easier it is to identify the emotions a child might be feeling. For example, if a child is playing a game introduced by one of their peers, or encouraged by a teacher, it is not necessarily self-chosen. The play theme would be specific to the child who created the theme rather than the child who was encouraged to play along. That being said, it is still play because it incorporates some of the other aspects of play and contributes to the child's innate desire to be involved, explore, and be fully engaged. Although the tool I will present at the end of this literature review will encompass this definition in its entirety, the focus will be on the fourth characteristic — "play is imaginative, non-literal, mentally removed in some way from "real" or "serious" life."

This type of play is known as pretend play or make-believe play. Pretend play can take place in many different forms, changing as a child develops from age 2-6 years (Piaget, 1962). Pretend play can include using an object or an invisible object to represent something else, sociodramatic play — with themselves, someone else, or an imaginary friend — and role-playing (Weisberg, 2015). The increased use of representational and symbolic activity during these years allows children to explore the world with a sense of purpose that they did not have before the age of 2 (Berk, 2012). This natural development of symbolic play can be used to understand what children are thinking and feeling. To do this, there must be an understanding that listening to children involves answering non-literal questions and concerns, with literal answers. Children can't say "I am experiencing anxiety about going to the doctor because I am afraid of getting a shot" but they can show it by pretending to be a doctor and asking to run through the scenario. This can be their way of gaining a sense of control over the situation and the adult's chance to hear the thoughts running through their child's head — if they know how to listen. In fact, play therapists rely on the idea that symbolic play can reveal internalizing disorders by making otherwise cognitive thoughts behavioral (Segal, 1973; Pehrsson, 2007).

Play Therapy

In addition to the act of play being a universal behavior of all children, the success of play therapy is based on the fact that children are better able to communicate their feelings through symbolic play strategies than they can with verbal forms of self-expression. Also, adults might be better able to understand what children are saying when they are playing than when they attempt to use language to communicate.

A review conducted by Pehrsson (2007) described the purpose of play as a way for children to express thoughts, wishes, and feelings by imagining themselves in a variety of situations. This simultaneously allows adults to interpret what children are thinking about and allows children to clarify their emotions by acting them out. Without play, children and adults experience a language barrier.

From birth to around the age of 6, children's language abilities are rapidly increasing. Over these first five years of life, they go from recognizing (comprehending the word but not necessarily using it) about 50 words at age one to recognizing around 10,000 words by age 5 (Law et al., 2017). Despite this impressive growth in vocabulary, children, especially children younger than 6, still do not possess the same language abilities as adults — they have smaller vocabularies, utilize non-verbal gestures, use fewer words (one or two sentences for 2-5 year-olds) than adults do (Gable, 2003). Most children who are younger than 6 use language as a way of naming people, animals, or objects (i.e., "dog" and "spoon"). This kind of vocabulary used by preschoolers is called referential style, where language consists mostly of referential words. Preschoolers less often use expressive style language — language used for talking about feelings, and socializing (Mash & Wolfe, 2019). The combination of smaller vocabularies and the use of referential style language more than expressive style language makes it hard for children to be specific and elaborate on their internal states. Play therapy has found a way to allow children to communicate in detail despite their limited language abilities. The history and development of play therapy attempt to break this language barrier by bridging the gap between direct and indirect expression — meaning the difference between verbalizing "I am afraid I will get kidnapped at the store" and verbalizing anxiety through play: "I need to find a way back home" after pretending to be kidnapped during play.

The first known example of play therapy comes from Sigmund (Freud, 1909). Freud analyzed a little boy who had a phobia of horses. Through his analysis, Freud was able to link Little Hans' fear of the size of the horse's penis. He did this through his observation of Little Hans' natural play tendencies. He thought that play was representative of the unconscious concerns of a child and that it allowed adults into the secret minds of children. With this belief in mind, Freud noticed Little Hans' persistent questioning of adult's "widdlers" — a word Little Hans used for penis. While the act of questioning everyone about their "widdlers" is actually a literal expression of his fear, he also expressed his fear symbolically through common play themes regarding widdlers. Freud was among the first to look at children's play to help with the diagnostic process. Just as language in talk therapy acts as a bridge between the client and therapist, play was able to present the fear Little Hans was feeling into a medium adults could understand without Little Hans ever having to explicitly state his fear.

A student of Freud, Melanie Klein (1932) also believed play could represent the inner thoughts of a child. In her work, she used play as a direct substitute for free association. This is when a therapist asks a person to freely share their thoughts or anything that comes to mind. In this way, Melanie Kline would instruct children to play in whatever way they felt comfortable. Play was able to reveal the unconscious conflicts in children just as free association did for adults in therapy (Segal, 1973). A few years later Anna Freud, followed in her father's footsteps. In 1946 she published The Psychoanalytic Treatment of Children. Pehrsson (2007) reviewed this publication and explained Melanie Klein's emphasis on the importance of establishing communication with children in a developmentally appropriate way (i.e., play).

These historic psychoanalysts demonstrate how even though play behaviors have to be interpreted by adults, irregular play or repetitive conversations that happen during play

transcribe internal thoughts and feelings of children into visible and verbal action. These early findings on play therapy have remained consistent as more researchers investigate the effect and success of play therapy. Partly this is due to the characteristics of play — how play (1) is a universal behavior of all children, (2) develops with the child, and (3) is the language of early childhood. These characteristics of play contribute to the success of play therapy.

     Play is Universal. At the beginning of their review on play therapy, Pehrsson (2007) states "of course children play; it's their job" — this quote describes the relationship between children and play as absolute. Simply put, children are going to play regardless of their circumstances, so it is important to understand the role play has in their lives. Play therapists have dedicated their lives to understanding this role and have capitalized on the fact that all children have the potential to play.

     Play is Developmental. Researchers have also attributed the success of play therapy to how integrated play is in the developmental process. Play both develops with the child and encourages child development. Mildred Parten (1932) defines developmental stages of play in the order in which they develop. From infancy to the end of early childhood, the play children engage in, adapts to the child in the following order: nonsocial activity (0-2 years), parallel play (2-3 years), associative play (3-4 years), and then eventually cooperative play (4-6 years). As children mature, they develop more skills that allow them to advance through these stages. In this sense, not only does play adapt to their developmental stage, but also advances cognitive, social, and physical development (Lillard et al., 2011).

     Socially, play allows children to form mutually rewarding relationships, and come up with solutions to problems together (Barnett, 1990; Berk, 2012). Cognitively, play facilitates the development of memory, problem-solving, abstract thinking, literacy, and academic skills

(Barnett, 1990; Bodrova & Leong, 2005; Vygotsky, 1967)**.** Because play develops with the child, the play children are engaging in is relevant and indicative of their current mental state, unlike language which develops slower than their cognitive comprehension of words and feelings (Mash & Wolfe, 2019).

  Play is language. Perhaps the most relevant cognitive benefit of play to my argument is the role it has in the development of language. Play, especially symbolic play, or make-believe play is highly interrelated with language acquisition. For example, object substitution, (e.g., using a stick as a microphone) and hierarchical combination (e.g., making dinner and then feeding the family) in play is linked to early language development (McDune, 1965; Smith & Jones, 2012; Orr, Ronny, & Geva, 2015). In their longitudinal study Lyytinen, Poikkeus, & Laakso (1997), show that children who are considered 'early talkers' also display more symbolic play than 'late talkers' and children who engage in other-directed pretense (e.g., playing with a doll) exhibit strong language comprehension and production.

  Earlier I argued that children's language abilities are limited and therefore they have a difficult time communicating their feelings to adults. However, play offers a unique opportunity for children to explore their emotions without direct spoken language. Consider the following quote from Discovering the Culture of Childhood by Emily Plank (2016):

> "Consider the scripts children incorporate into their daily play lives. In the days following a field trip to the library on public transportation, the children in my child care program played bus. In the days following intense series of tornado drills and power outages, they played emergency drills. When a family in our program had a new baby born by Cesarean, I heard a conversation between the children in my care about how they were "going to go have a C-section now. Be back soon!" The same children would later present to nurse their new-born babies. In the absence of anything out of the ordinary, children are hard at work processing the daily life of human beings they admire with themes such as work, school, babies, grocery store, hotel, camping, and firefighters. In their conversations, we hear echoes of their experiences as they reverse the power roles…

In play, children find a variety of voices they do not have in their families and child care settings" (Plank, 2016).

Play allows children to manipulate their environment to gain a sense of control and mastery over their world — play and the use of toys can compensate for underdeveloped abstract thinking and verbal skills (Deshpande & Shah, 2019). Through play, children can practice and explore possibilities and attempt to understand their experiences in a way that is not possible outside of play (Landreth, 2002). A case study on Andrew, a 6-year-old boy completing his first year of primary school showed that through his symbolic play, play therapists were able to identify Andrew's experience with an inconsistent home environment. The researchers were able to identify his concerns by observing what Andrew was expressing through his repetitive symbolic play themes of good vs bad characters, cops and robbers, and building a safe house (Campbell & Knoetze, 2010). In the end the play therapist found that Andrew was struggling with anxiety from an inconsistent home environment. Essentially, play therapists are trained in the language of childhood and their expertise allows them to understand and help children through their otherwise internalizing issues. Because play helps children both develop language skills and work through confusing emotions, if you look close enough at what and how children are playing, you can see that they are communicating.

Recognizing Anxiety at Home and School

Now that I have provided evidence supporting the need for early recognition tools for anxiety in children and have explained how children may be communicating their anxiety through play, the following question needs an answer: where can consistent observations of play be implemented? The early education system has the potential to observe children play because it

is one of the only places children can interact with a cohort of children their age (Bodrova & Leong, 2005). Especially in schools that value learning through play over didactic learning, teachers can witness unstructured make-believe play. Disorders such as SOC and SEP contribute to where and how children decide to play. This section will review the circumstances in which children with these disorders communicate through play.

However, before getting into that, I will explain two ways observing play can tell us about children's internal states. Children can exhibit play behaviors and play themes that may indicate they are experiencing SEP and SOC. I define these terms based on my analysis of the literature. Play behaviors are any behaviors that answer the questions: *when, where and how* are children playing? Additionally, play behaviors can describe the child's relationship with play. It is important to note here that play behaviors can also include behaviors that indicate withdrawal from play. Play themes answer the question: *what* are children playing?

In my attempt to create a tool for parents and teachers to recognize possible symptoms of SEP and SOC in children ages 2-7, I will apply rationale for using Benedict's Expanded Themes in Play Therapy, a play therapist coding system (McClintock & Helen Benedict's, 2009; Hillman & Benedict, 2014). *Benedict's Expanded Themes in Play Therapy* (2001) and *Meanings of Children's Play Themes* (2008) outlines typical play themes seen in play therapy settings and how to identify each of them. In 2009, McClintock & Benedict organized the play themes into several categories. The ones I compiled with relating to SOC and SEP are as follows: (1) Aggressive Themes, (2) Attachment and Family Themes, (3) Safety Themes, (4) Exploration and Master Themes, and (5) Non-play Activities. Admittedly, most of these themes can be, and often are exhibited by typical children, however, the point here is to cast a wide net, ensuring no child presenting with symptoms of anxiety misses out on opportunities to visit mental health

professionals. The goal is to provide parents and teachers with a tool to recognize the possibility of anxiety, not to accurately diagnose their children with anxiety (this can happen at a later stage) — as I have explained, the first step to the help-seeking process is recognizing the possibility of anxiety (Reardon et al., 2018).

SOC Play Themes and Behaviors

As we have seen, children with SOC tend to not play with others and withdraw from situations where they interact with peers (Scharfstein & Beidel, 2015). Because of this reason, observations of peer play at schools would miss children exhibiting symptoms of SOC that show up in interactive play themes because they are not playing alongside their peers. However, there are observations regarding how children are not engaging in play that are important to witness in school (i.e., behavioral inhibition) and observations of what else these children are doing to occupy their play time at school instead of peer play (i.e., non-play activities). Therefore, for children with SOC, it might be easiest to recognize play behaviors and activities at school and play themes at home.

Play behaviors and non-play activities. Perhaps the most obvious markers of SOC in children at school would be the lack of peer play or the tendency to play alone (Gazelle et al., 2010; Scharfstein & Beidel, 2015). Additionally, children with SOC are usually outside of conversations and do not initiate conversation or play with groups (Rao et al., 2007). Behavioral inhibition (BI) is a term that encompasses each of these behaviors. Chronis-Tuscano (2009) studied the trajectory of children exhibiting BI and found that stable BI during early childhood predicts SOC at four times the rate than children without stable BI. It might also be helpful to observe how children are responding to their peers who want to play. Scharfstein & Beidel (2015) noticed that children with SOC exhibit anxious and ineffective social responses, and in

response, their peers perceive them as less likable and less socially desirable. These are behaviors related to how children engage with play that teachers may be able to recognize in school.

In comparison, typical children tend to have high levels of collaborative play, and are less likely to play alone because between ages 4-7, children are developing associative and collaborative play (Parten, 1932; Mendez et al., 2000; Dyer & Moneta, 2006). While children with SOC experience BI and tend to not be the initiators of play, typical children have many tactics for initiating playful interactions with their peers. Engdahl (2011) found that typical children use locomotions, gestures, voice quality, facial expression, imitation, and smiles and laughter to initiate play and conversations.

Benedict (2001) dedicates a section of her Expanded Play Themes in Play Therapy to "non-play activities". These non-play activities may be the closest thing children with SOC engage in that resembles play themes at school. According to Hillman & Benedict (2014) non-play activities include art and drawing and predetermined rule based games. Compared to their typical peers, children with SOC are more likely to play alone (Gazelle et al., 2010) — an activity such as art and drawing can be a solitary activity, making it alluring to children who do not want to engage in peer play. It might be useful then to take note when children are engaging in solitary activities instead of more collaborative play themes like their peers without symptoms of SOC. It might also be useful to look at the kind of things children are doing when they do decide to interact with peers. Another activity coded under non-play activities by Hillman & Benedict (2014), was predetermined rule based games (i.e., candyland). While these games do require interaction with peers, they provide rules and structure to the play that would not be there in make-believe play. Children with SOC tend to worry about playing the "right" way

(Chronis-Tuscano et al., 2009) so games that tell them what to do and allow them to predict what others might do may provide a sense of comfort, making it easier for them to participate. With this idea in mind, looking at the type of peer engagement children exhibit may be crucial in determining if they are experiencing symptoms of SOC.

      Play themes. The idea that children are likely playing alone at school, contributes to the idea that the play themes they engage in may not be as obvious as they are at home. If children are playing alone — as children with SOC do — there is no need for verbalization. In comparison, children who engage in peer play spend a lot of time negotiating the terms of play with each other, conveniently narrating their play in a way adults can pick up on. Because children experiencing symptoms of SOC are not playing with their peers and therefore do not need to negotiate what they are playing with others, there is not much of a reason to verbalize what they are playing. At home however, the child might be surrounded by people they are familiar with. If a child has siblings, they might play with their siblings at home. Even if the child does not have siblings, children are likely to play with their parents. It might also be easier to identify play themes at home even if children are playing alone at home because parents might be able to hear a child's private speech more so than a teacher responsible for a classroom of students. According to Vygotsky, children use private speech as a verbalization of a child's internal regulation, it is not conversational language. Because private speech is a verbalization of inner thoughts, it might be useful narration of a child's solitary play in the same way negotiation between peer play is.

      Using Hillman & Benedict (2014) play themes and examples from play therapy case studies, I will explain how certain symbolic play themes can represent cognitive symptoms of SOC in children. Through analyzing literature I have found that perhaps aggressive, attachment

and family, and safety themes are the most useful for parents and teachers to pay attention. At this time, there does not exist research claiming a healthy rate for each of these play themes that we could use to create a comparative tool. However, based on what is known about SOC, and the way children's internal states are translated through play I speculate how engaging in specific play themes might reflect cognitive symptoms of SOC.

Under the umbrella of aggressive themes that could mark SOC, includes powerful figures overcoming weaker figures (i.e., pretending to be a teacher and telling students to do their classwork), aggressive content between characters, and aggressive behaviors. Aggressive play themes, especially those concerning power dynamics may be worth identifying when looking for SOC symptoms. Children with SOC often freeze during social interactions (APA, 2013). In these situations, it is possible they feel powerless, and navigating power in relationships might allow them to explore how to gain control over their environment.

Children with SOC may also engage in specific attachment and family themes. A child who fears perception and situations where there are expectations to present in public (APA, 2013) may want to work through these fears by playing out scenarios that would invoke that fear in real life. For example, Hillman & Benedict (2014) lists store and shopping under attachment and family themes. This play theme allows children to set up scenarios that involve interactions with other people. Children who show reluctance towards meeting new people, socializing, and participating in activities but choose play themes where socialization is necessary might be working through that social anxiety in the sense that play allows children to gain control and mastery over their world (Deshpande & Shah, 2019). Playing out scenarios in play is a way of gaining those skills for when children really experience the situations that make them anxious.

Another theme Hillman & Benedict (2014) lists under attachment and family themes is any play associated with being an adult. Cognitively, children with SOC are worried about their performance and doing things the right way (Chronis-Tuscano et al., 2009; APA, 2013; Mash & Wolfe, 2019). Because adults are role models for children and children believe that adults do things the correct way, playing as an adult is possibly indicative of a child trying to explore and understand how to exist. Therefore, also indicative of some cognitive symptoms of SOC.

Safety themes that occur in play may also be useful in recognizing symptoms of SOC. Safety themes often represent child desire for comfort and lack of perceived safety in their life (Green et al., 2009). I think that for the most part, safety themes relate more to instances of SEP. However, the safety theme of neglect, punishment, or abuse of the self might highlight the cognitive symptoms of incompetence and inadequacy children with SOC experience (Hofmann, 2007). This type of play might be a means of punishing oneself for incompetence and inadequacy as it includes verbal self-abuse (e.g., calling oneself "bad"), physical abuse, and putting oneself in harm's way (e.g., climbing in dangerous places) in some situations where the child believes they did something wrong in play or otherwise (Hillman & Benedict, 2014) .

Lastly, exploration and mastery themes in play are especially relevant to SOC as they are direct manifestations of the cognitive symptoms already mentioned (i.e., fears of social situations, incompetence, and inadequacy). However, unlike the rest of the play themes indicative of SOC, exploration, and mastery can often also be seen in school because they do not require peer interaction. Under the broad category of exploration and mastery, three play themes stick out to me as potential markers of SOC: exploration, mastery, and fail themes. **Exploration** consists of a child literally exploring the play options in a given room. This can be in the form of examining the toys and asking questions regarding what they can use and how to use them.

Mastery involves play that has a challenge or goal and is associated with the child's sense of competence and achievement. This form of play includes building and achievement-based activities (i.e., spelling names correctly or drawing a perfect line). **Fail** play is whenever a child attempts mastery but becomes frustrated with it and claims that they can not do what they were trying to master (Hillman & Benedict, 2014). I want to note that this is not necessarily play, but instead a behavior that occurs during play. I am including it here because it occurs alongside mastery play. Children experiencing SOC symptoms might engage in exploratory play as a way of separating themselves from peer interactions. SOC symptoms include being fearful of social interactions and withdrawing from peer play (Mash & Wolfe, 2019; Scharfstein & Beidel, 2015). Perhaps exploratory play is an example of what withdrawal from play — a common symptom of SOC — looks like. Since mastery play is a way of gaining a sense of competence and accomplishment it is not difficult to interpret this kind of play as compensation for feeling inadequate and incompetent typical of SOC. Similarly, when a child expresses to an adult directly or through clear frustration (e.g., destroying their half finished tower) that they are unable to complete their mastery play and exhibit frustration as a result, this is a literal expression of their feelings of incompetence. For these reasons, observing the way children engage in exploratory and mastery play is useful in identifying SOC, especially if this type of play is paired with expressions of failure.

SEP Play Themes and Behaviors

One of the major triggers for the onset of SEP is the introduction of formal schooling between the ages 7-8 (Mashe & Wolfe, 2019). However, children younger than 7 attending preschool or receiving child care services, can also develop SEP symptoms (Franz et al., 2013; Paulus et al., 2015; Silove et al., 2015). Attending school for the first time means children will be

away from their parents for an extended period. Additionally, teachers will implement academic expectations that the child has never experienced before (Mochamad Nursalim et al., 2018). These stressful events can trigger separation anxiety in a child, and the child may refuse or be reluctant to go to school — the DSM-5 lists school refusal as a possible symptom of SEP (APA, 2013). Because attending school has a major influence on the development of SEP, it might be best to make observations of play behaviors and play themes at school. Observing play in school would also work for children experiencing SEP because unlike SOC, children with SEP do not generally have difficulties playing with their peers (Mashe & Wolfe, 2019).

Play behaviors. As mentioned earlier, although children with SEP will play and interact with peers more so than children with SOC, children with SEP can withdraw themselves from others, become apathetic, sad, and have difficulty focusing on work and play (APA, 2013; Lewinsohn et al., 2008). Therefore, children who show adequate social skills when they do interact with their peers but ultimately withdraw from play, may be experiencing SEP symptoms. Another interesting thing to consider in terms of play behaviors is when children are exhibiting aggressive behaviors during or in reaction to play. Children with SEP can become aggressive or throw tantrums in circumstances where they are being separated from their parents (Albano & Kendall, 2002). If you take a look at a typical school routine for children ages 2-7, the morning drop off period is often accompanied by 'free choice' time where children can pick their own play activities. Due to many schools adopting this opportunity to play when children are expected to separate from their parents at the start of the day, children experiencing anxiety over separation might associate morning play with the separation from their parents. This connection may cause aggressive reactions to peer play aggressiveness towards peer play or tantrums during this play time. Children who only show aggressive behavior during morning play but not during

other times allotted to play may be especially likely to experience SEP. One other behavior that might indicate SOC, actually comes from the play themes Benedict (2001) lists. Under exploration and mastery play there is constancy play. This is any type of behavior during play that indicates the child wants stability and security in their play environment. Children who show constancy in their play want things to remain the same so they might play with the same toys, repeatedly establish identity during play as a way to keep play consistent, check to see if what they played with last time is still there, and check that at the end of the school/play day their attachment figures will pick them up. Major instances of change (i.e., moving or entering a new school) are what often triggers SEP. Therefore the desire to keep their play — the one thing children have control over — constant might be a reaction or rejection to change in their lives.

Play themes. More useful in identifying SEP symptoms in children would be the use of play themes because children with SEP do play with their peers at school. There are many play themes from *Benedict's Expanded Play Themes* that could indicate symptoms of SEP. There is a lot of overlap between play themes that relate to SEP and play themes that relate to SOC. For example, aggressive, attachment and family, and safety themes could suggest SEP as much as they do SOC. This is fine because the purpose of this tool is to encourage parents and teachers to bring their children to professionals who would know how to differentiate between the two disorders, not for the parents to know exactly what type of anxiety their child is experiencing. In addition to aggressive, attachment and family, and safety themes, children with SEP may also engage in certain exploration and mastery play themes.

Unlike SOC, play themes that allude to death may also help give adults an understanding of the separation anxiety children might be facing. According to the DSM-5, children with SEP experience persistent and excessive worry about the death of attachment figures (APA, 2013).

This might explain why children with SEP symptoms might often play out death themes — they are trying to gain control of their anxiety to prepare them for a situation where this might happen. In their literature review interpreting common play themes, Green and colleagues (2009) mention that death themes sometimes reveal a child's conflict with anxiety about separation.

Like SOC, the way children engage with play regarding good guy/ bad guy distinctions may be useful in identifying SEP. Because a lot of separation anxiety comes with the fear of strangers or being kidnapped (APA, 2013), playing out scenarios where children encounter the answer to their question "what happens when I get separated from my attachment figure?" This may require creating a distinction between good guys and bad guys.

This rationale also applies to the attachment and family play themes relevant to SEP. Green et al., (2009) understand separation themes as common in attachment disordered children. Play themes in this category we did not see earlier when discussing SOC include reunion and separation play. Separation themes include any type of play where someone leaves someone else (i.e., father leaves the house for work, child runs away, etc.). This type of play is literally playing out the child's fear of losing attachment figures. Reunion play — when characters in play return from separation — is also important to understanding the symptoms of SEP children might be enduring. Green et al., (2009) mention that if separation play includes a resolution to the separation (i.e., the return of someone who was separated) it may reflect that the child experiencing SEP symptoms manages their anxiety more so than the child that can not imagine a reunion. With this in mind, it will be beneficial for parents and teachers to look at how children resolve or don't resolve instances of separation in play when looking for SEP symptoms.

Attachment and family play themes related to SEP that are overlapping with those that are related to SOC are adult activities and themes involving stores and shopping. Albano et al.,

(2003) explain how children with SEP may become especially concerned about where and what their attachment figures are doing. Therefore, engaging in play themes regarding adult activities may be a child's way of understanding adult routines. The DSM-5 explains that children with SEP fear going to the store because it represents the possibility of getting lost, losing their parents or being kidnapped. Since stores can be a trigger for children with SEP, they might engage in play that helps them gain control over those situations in a safe environment.

Safety themes might also be present in children experiencing SEP because lack of safety is a major reason why the fear of separation exists. Children fear losing or harm coming to their attachment figure and experiencing events that will cause separation such as being kidnapped or getting lost (APA, 2013). For these reasons, broken play and danger themes are relevant when attempting to identify SEP through play themes. Broken play is whenever a character in play is broken. This could mean the character is sick or hurt. Danger themes include any play scenario where danger is identified. Possible examples include a character being described as scary, or a dangerous situation such as a fire or hurricane occurring in play (Hillman & Benedict, 2014) .

Escape play is another example of a safety theme that could be useful for identifying SEP symptoms. Escape play happens after a character in play is endangered. Following the endangerment, children will play out an escape plan without the help of a rescuer. Because children with SEP fear situations where they will be apart from an attachment figure (APA, 2013), they may use play to work through scenarios where they would have to fend for themselves: escape play. On the other hand, children may also engage in rescue play after endangerment. Rescue play is similar to escape play in that after the endangerment of a character in play, there is a process of escape but from the help of a rescuer. This kind of play mimics reunion play in that if a child can imagine a situation where a rescuer comes to help them it may

indicate that they have less anxiety than the child who imagines scenarios where they will have to rescue themselves because the child that imagines a rescuer believes that there is someone who would rescue them (Green et al., 2009). However, a child that imagines a scenario where they will have to rescue themselves might be better equipped to handle their anxiety about permanently losing their attachment figures than the child who needs help from a rescuer. This might mean that the child with higher anxiety develops better coping mechanisms than the child with lesser anxiety. This may have some relation to attachment style. Dallaire & Weinraub (2006) report that insecurely attached children are more likely to have separation anxiety than securely attached children because they lack the confidence that their attachment figures will always be there to care for them. Therefore, it stands to reason that children with SEP may also engage in self-nurturing play, another safety play theme. In self-nurturing play children will use techniques used to comfort babies to comfort themselves — this could be indicative in the child's belief that their attachment figures are unable to comfort them.

Discussion

Creating and Implementing a Tool

After this close analysis of Benedict's Expanded Play Themes in Play Therapy, side by side with typical cognitive symptoms of SEP and SOC, I have created a tool for parents and teachers to recognize SEP and SOC in preschool children (Appendix A). The questions I ask parents and teachers about their children are based both on research and speculation that certain play themes and behaviors indicate SEP and SOC. For example, in the tool, I ask, parents and teachers if the child in question initiates peer play. This is included in the tool because previous research shows children with SOC do not initiate conversation or play with groups (Rao et al.,

2007). On the other hand, I also include questions in the tool regarding play that may get at the cognitive symptoms of SEP and SOC described in the literature but have not yet been tied to play. Using literature on the cognitive symptoms of SEP and SOC, I have theorized how they might present in children's play behaviors and play themes. For example, this tool asks teachers to indicate how often the child in question is aggressive towards teachers or peers during morning play, and then afternoon play. I include this line of questioning because research has shown children with SEP become aggressive during instances of separation (Albano & Kendall, 2002). Based on this information, I theorize that at morning drop off periods when children are expected to engage in free choice play, children with SEP will be aggressive during this time. There has not been research indicating this relationship, but is merely my own speculation. In an attempt to help parents and teachers understand what certain questions mean, the tool also provides vignettes of children playing as a child with SEP or SOC might. Including these vignettes is a way for parents and teachers to recognize their child in them. To see the complete tool, see Appendix A.

I expect parents and teachers to be the main users of this tool. Earlier I briefly mention that there are online tools for parents to utilize when they have concerns that their children might be experiencing anxiety, however, there are several weaknesses with these tools involving how parents initially come to use them. To gain access to these online tools parents have to notice something wrong before even thinking about searching for an online anxiety identification tool and as I have explained, recognizing anxiety in preschool children can be difficult to do. For this reason, I suggest that this tool be a part of the preschool evaluation process, administered about 6 months after a child enters preschool. This allows time for teachers to get to know a child's typical play tendencies. To get parents involved, the preschool can require parents to utilize the

tool at home at the same time they administer the tool. This way the use of the tool is not reliant on a google search of an already concerned parent. Of course requiring parents to complete a questionnaire like the one I present in this tool may create overly concerned parents, resulting in an overwhelming amount of parents seeking professional help and eventually flipping the problem from underdiagnosis to overdiagnosis. To mitigate this possibility, I suggest that the preschool present the tool as a mandatory anxiety screening, without specifying SEP and SAD. Although the tool I provide labels for which questions go with which disorder for understanding, a final version of this tool would not tell parents why each question is being asked. Not clearly stating which questions may indicate what disorder will help prevent parents from diagnosing their children without professional input. Additionally, I suggest that results not be presented to parents alone. I imagine the parents and teachers combining their answers to the tool. At this point, the tool will identify children at risk for SEP or SOC. Although I imagine measures for mitigating parents over concern when nothing is wrong, it is also important to keep in mind that the current problem is underdiagnosis, and not overdiagnosis, so increasing parents' anxiety radar is essentially the goal of this tool.

Future Directions

There are many ways this line of research can continue in the future. I would be remiss if I thought this was in any way the final version of a tool for recognizing SEP and SOC in preschool children through play behaviors and play themes. It is missing several components before it can become an effective way for parents and teachers to recognize anxiety in their children. First, for play themes and behaviors that researchers have already established as markers of SEP and SOC, there needs to be research that differentiates typical child engagement in specific play themes and behaviors from a disordered amount of engagement in the same play

themes. In other words, research needs to establish healthy comparison rates. The tool I provide is set up to do so as it includes scaled responses. For example, a typical preschooler might occasionally play out scenarios where they are separated from attachment figures. In this case a parent or teacher might answer "rarely" or "sometimes" in response to the question "how often during play does this child act out scenarios of attachment figure separation?" However, in the case of a child with SEP, they might answer "often." Ultimately, preschoolers without SEP and SOC will have a lower overall score on this tool than children with SEP and SOC. Future research will have to establish where that threshold lies. Following that research, a suggestion can be made based on the answers parents and teachers provide on whether they should have their child see a mental health professional.

As mentioned earlier, in my creation of this tool, I have pulled from research showing relationships between certain play behaviors and anxiety but also from personal speculation. For instances of speculation, future research might look into these unresearched relationships between play themes and anxiety. Although having reasonable explanations of why they might be related, the following play themes have not been directly linked to either SEP or SOC:

- Powerful figures overcoming weaker figures

- Neglect, punishment, or abuse to self

- Exploration, Mastery, and Fail

- Art and Drawing and Predetermined rule based games

- Store and Shopping

- Adult Activities

- Broken Play and Danger

- Self nurturing

- Constancy

In addition to researching these play themes likely to indicate SEP and SOC, there are several play themes that we need more information on. In the tool I provide, I ask questions that neither an "often" or "never" answer would indicate symptoms of SEP or SOC. This is because for certain play themes, there are many different ways a child can engage in them and not every version of that play theme would indicate SEP or SOC. For example, research has shown that children who play out instances where someone dies sometimes reveal a child's conflict with anxiety about separation (Green et al., 2009). However, there does not appear to be research stating what kind of death play. The tool I have created asks questions in an attempt to distinguish between the death of attachment figures, other characters, and the death of the child in play. The differences between these answers might help establish which type of death play is most indicative of SEP. Throughout the tool, I have included several questions intended for informational purposes only, the information I am trying to pull from the answers are as follows:

- In play involving powerful figures overcoming weaker figures, is there a distinction between children who play the role of the person in power and children who play the subordinate role?

- In play involving adult activities, is there a difference between children who play out adult relationships and social interactions and children who only play out adults doing solitary activities?

- In play involving death, is there a difference between children who play out the death of attachment figures vs children who play out the death of themselves or children who kill off other characters that are neither themselves or attachment figures?

- In play involving neglect, punishment, or abuse to self, is there a difference between children who put themselves in dangerous situations (i.e., climbing to hazardous heights) and children who verbally abuse themselves in play.

- In store and shopping play, is there a difference between children who use the grocery store in play as a place for running errands and children who view it as a place where separation occurs in play?

- In danger play, is there a difference between children who play out danger from others and children who play out danger from natural disasters?

- In play involving dangerous scenarios and separation, is there a difference between children who escape without the help of a rescuer and children who rely on someone to rescue them?

Once again the tool is set up to help answer these questions by means of scaled responses. If this tool is given to parents or teachers with children already diagnosed with SEP or SOC the answers given might give us insight on the specific aspects of play themes indicating SEP or SOC. For example, if a parent of a child with SOC answers "often" to the question "how often does this child pretend to be an adult interacting with others during play?" but answers "rarely" to the question "how often does this child pretend to be an adult doing solitary activities during play?" it may mean that it is adult social activities that are indicative of SOC, and not all adult activities.

Once a final version of this tool is made and is being used efficiently, future research might want to look at the long term benefits of a tool such as this. In the introduction I mention the goal of this tool is to first decrease the number of children who go without necessary diagnosis and treatment. The tool is developed through the rationale that play is a form of child

communication. Therefore, the use of this tool may bring to parent and teacher's attention the ways children are using play to communicate. It would be useful to see whether implementing a tool such as the one I provide increases parent-child and teacher-child communication, and if it does, if this type of communication decreases the likelihood of a child developing anxiety in the first place.

Concluding Thoughts

A tool for recognizing preschool separation anxiety disorder and social anxiety disorder through play themes and play behaviors creates the chance for children with disorders characterized by cognitive symptoms to be heard. The tool will not only let parents and teachers know when they should seek professional support, but also get parents thinking about how else their child might be communicating with play.

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Appendix A

Separation Anxiety and Social Anxiety Play Behaviors and Themes Screening Tool For Teachers
and Parents
(SSPBT-TP)

Coding Key:
a = "often" answer suggests symptoms of SOC or SEP
b = "often" answer suggests typical play behaviors or play themes
i = informational purposes

1. Gender of Child: Female   Male   Other: _____
2. Date of Birth of Child: __ __ / __ __ / __ __ __ __

Contextual Questions and Non-Play Related Questions (yes/no).

Social Anxiety Disorder and Separation Anxiety Disorder

1. Has there been any major life changes in this child's life (i.e., recent move, new school, death in the family)?

Circle: Yes   /   No

      a. If yes, specify: _____

Play Behavior Questions (rated on a 4-point scale: 1-never, 2-rarely, 3-sometimes, 4-often).

Social Anxiety Disorder and Separation Anxiety
Behavioral Inhibition/ Social Withdrawal/ Active Isolation/ Social Reticence:
1. When play opportunities arise during the school day how often does this child interact with other peers? (b)
   (1) Never
   (2) Rarely
   (3) Sometimes
   (4) Often

2. During free-choice time, how often does this child engage in solitary activities (i.e., art and drawing)? (a)

(1) Never

(2) Rarely

(3) Sometimes

(4) Often

3. How often do peers actively reject and isolate this child? (a)

    (1) Never

    (2) Rarely

    (3) Sometimes

    (4) Often

4. During free-choice time, how often does this child remain unoccupied while watching other children play? (a)

    (1) Never

    (2) Rarely

    (3) Sometimes

    (4) Often

5. When this child is engaging in peer play, how often does this play involve make-believe? (b)

    (1) Never

    (2) Rarely

    (3) Sometimes

    (4) Often

6. When this child is engaging in peer play, how often does this play involve predetermined rule-based games (i.e., Candyland or duck duck goose)? (a)

    (1) Never

    (2) Rarely

    (3) Sometimes

    (4) Often

7. How often does this child initiate peer interaction and peer play? (b)

    (1) Never

    (2) Rarely

    (3) Sometimes

    (4) Often

Social Anxiety Disorder

<u>Anxious and Ineffective Social Responses</u>:

1. In response to peers initiating interactions with this child, how often does this child use soft speech (i.e., low volume and high pitch)? (a)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

2. When this child is engaging in peer play, how often are they contributing verbally? (b)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

3. In response to another child's inappropriate behavior or bullying during play, how often does this child respond assertively? (b)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

Separation Anxiety Disorder

<u>Withdrawal from play but with good social skills otherwise</u>:

Social Skills Questions

Questions 3 and 4 from <u>Behavioral Inhibition/ Social Withdrawal/ Active Isolation/ Social Reticence</u>.

Questions 1-2 from <u>Anxious and Ineffective Social Responses.</u>

1. When playing with peers, how often is this child willing to share toys? (b)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

Withdrawal Questions

Questions 1-2, and 5-7 from <u>Behavioral Inhibition/ Social Withdrawal/ Active Isolation/ Social Reticence</u>.

<u>Aggression during morning play in response to separation</u>:

1. How often is this child aggressive towards teachers or peers during morning play opportunities? (a)

    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

2. How often is this child aggressive towards teachers or peers during afternoon play opportunities? (b)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

Constancy:
1. When playing with peers, how often does this child insist on repeatedly establishing character identity? (a)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

2. When returning to play how often does this child play with the same toys they played with during the last play session? (a)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

3. When returning to play how often does this child return to previously played with toys?(a)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

4. When returning to play how often does this child check on things previously established during play sessions (i.e., a fort that they built)?(a)
    (1) Never
    (2) Rarely
    (3) Sometimes

(4) Often

5. How often does this child change play themes?(b)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

Play Theme Vignettes (pronouns in vignettes will be altered to match the reported gender of the child from the demographic section of the questionnaire) and Questions (rated on a 4-point scale: 1-never, 2-rarely, 3-sometimes, 4-often). In this section of the questionnaire, vignettes have been provided for parents and teachers to see examples of how certain play themes might show up in play.

Social Anxiety Disorder

<u>Aggressive Themes</u>:

<u>Vignette</u>: *When Drew first started preschool, peers would try to initiate play but Drew would refuse or ignore peers. Similarly, when Drew encounters unfamiliar family friends, Drew will shy away from playing with them. Instead, Drew will play with dolls by themselves when guests are over. When playing with dolls, Drew will often play out teacher-student, parent-child, and king-subject relationships with a focus on the power role. For example, in a teacher-student relationship, Drew will use the power of the teacher to make the other dolls learn how to write their names. Sometimes, Drew will make the students get upset with the teacher and start crumpling up their papers.*

Powerful Figures Overcoming Weaker Figures Questions
1. When playing with dolls, figurines, or anything that can represent people and relationships, how often does this child represent relationships where one individual has a clear power role (i.e., teacher-student relationship or parent-child relationship)? (a)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

2. If inserting themselves into a role, how often does this child play the role of the person in power (i.e., teacher)? (i)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

3. If inserting themselves into a role, how often does this child play the subordinate role? (i)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

Aggressive Content Between Characters
1. In play, how often does conflict occur between characters? (a)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

Attachment and family themes:

Vignette: *When meeting people for the first time, Jordan often hides behind their parents or freezes up when asked a question by someone unfamiliar to them. At home however, Jordan embraces social interaction in play. Jordan's parents notice that Jordan sets up scenarios where they must interact with others. For example, Jordan will set up a farm stand where they will pretend to interact with customers. Additionally, Jordan's mother works as a waitress so she frequently talks about the customers she encounters at work. In play, Jordan will mimic these stories by pretending to serve people at a restaurant. Jordan's father is a construction worker who will discuss his day's work at the dinner table. Jordan's fathers work is reflected in Jordan's play when Jordan organizes a construction team to build a mega garage for all their toy cars and trucks.*

Store and Shopping Questions
1. When playing alone how often does this child create scenarios that would involve interacting with others in the real world (i.e., working as a grocer)? (a)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

Adult Activities Questions

1. How often does this child pretend to be an adult in play? (a)
   - (1) Never
   - (2) Rarely
   - (3) Sometimes
   - (4) Often

2. How often does this child pretend to be an adult interacting with others during play (i.e., making a phone call)? (a)
   - (1) Never
   - (2) Rarely
   - (3) Sometimes
   - (4) Often

3. How often does this child pretend to be an adult doing solitary activities during play (i.e. doing make-up)? (i)
   - (1) Never
   - (2) Rarely
   - (3) Sometimes
   - (4) Often

4. When pretending to be an adult, how often does this child act out adult relationships (i.e., going on a date)? (a)
   - (1) Never
   - (2) Rarely
   - (3) Sometimes
   - (4) Often

Safety Themes:

Vignette: *At home Georgie, a five-year-old often plays with the building blocks in the living room. From the kitchen, Georgie's parents can hear exclamations of "I can't do this" and "I'm so bad." When Georgie becomes too frustrated, Georgie gives up on using building blocks and begins to play 'the floor is lava,' climbing to hazardous heights. One time Georgie's parents had to bring Georgie to the hospital because Georgie climbed high enough so that when they fell, they broke their thumb. Georgie's parents keep a close eye on Georgie now because Georgie often puts themselves into dangerous situations.*

Neglect, punishment, or abuse to self Questions
Questions 1-2 from Exploration and Mastery Themes: FAIL

1. In response to perceived failure during play, how often does this child respond with verbal self-abuse (i.e., "I'm bad")? (a)
   (1) Never
   (2) Rarely
   (3) Sometimes
   (4) Often

2. How often does this child put themselves in dangerous situations during play (i.e., hazardous heights)? (i)
   (1) Never
   (2) Rarely
   (3) Sometimes
   (4) Often

<u>Exploration and Mastery Themes</u>:

<u>Vignette</u>: *On the first day of preschool, Clarke spends allotted free time at school alone. When Clarke's peers try to establish superhero roles on the playground, Clarke instead examines the sandbox, the slide, and then swings away from the superhero action. Initially, Clarke is hesitant to use any of these play materials without first asking a teacher or instructor if it's okay. As the school year continues and Clarke becomes more familiar with the play options available on the playground and in the classroom, Clarke still does not join in on group play activities. Instead of joining in on peer household play, Clarke decides to play with legos alone. Clarke wants to build a garage for cars but never finishes because Clarke tears it down aggressively after a few trials. Clarke also often gravitates towards the puzzle section of the classroom. Whenever Clarke finishes a puzzle, Clarke often asks the teacher to look at it.*

Exploration Questions
1. In novel play situations, is this child hesitant to use play material without confirmation from an adult? (a)
   (1) Never
   (2) Rarely
   (3) Sometimes
   (4) Often

2. How often does this child ask about the play material available to them? (a)
   - (1) Never
   - (2) Rarely
   - (3) Sometimes
   - (4) Often

3. When opportunities to play with others arise does this child reject the invitation to join and instead hover around solitary play options? (a)
   - (1) Never
   - (2) Rarely
   - (3) Sometimes
   - (4) Often

Mastery Questions

1. When opportunities to play with others arise does this child instead choose solitary play options (i.e., building blocks)? (a)
   - (1) Never
   - (2) Rarely
   - (3) Sometimes
   - (4) Often

2. How often does this child engage in play activities that are goal-oriented (i.e. highest tower)? (a)
   - (1) Never
   - (2) Rarely
   - (3) Sometimes
   - (4) Often

3. How often does this child engage in open ended play (i.e., uses blocks as cars)? (b)
   - (1) Never
   - (2) Rarely
   - (3) Sometimes
   - (4) Often

4. During play how often does this child look for approval from teachers or instructors (i.e., showing off a completed tower)? (a)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

Fail Questions
1. When attempting to complete a self-initiated play activity (i.e., building a tower), how often does this child verbally exclaim "I can't do it"? (a)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

2. When attempting to complete a self-initiated play activity, does this child become frustrated and halt the activity? (a)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

Separation Anxiety Disorder
Aggressive Themes
Vignette: *Chandler, a 3-year-old moved from their home in Oklahoma to Texas. When beginning a new preschool program in Oklahoma Chandler was initially withdrawn from peers but eventually began to initiate social interactions. Chandler engaged in peer play when there were instances of superheroes versus villains, cops versus robbers, and sharks versus mermaids (Chandler's personal favorite). As this kind of play progressed, Chandler started expressing "I'm going to kill that shark with my magical mermaid powers, or else the shark is going to kill us all."*

Good vs Bad Guy Questions
1. How often does this child create good guy/ bad guy distinctions in their play? (a)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

2. When engaging in good vs bad guy play, how often does this child want to kill off the bad guys? (a)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

Death Play Questions
1. How often does this child incorporate death into play? (a)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

2. How often does this child kill off representations of attachment figures (i.e., parents or siblings) in their play? (a)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

3. How often does this child enact their own death in play? (a)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

Attachment and Family Themes
Vignette: *When Jessie first started preschool two years ago when they were 2 years old, they were very shy in the classroom setting. Now, as a four-year old about to graduate preschool, Jessie often struggles with letting their parents leave in the morning. Jessie's parents express that when it is time to get ready for school, Jessie often complains and does not want to go. After the initial drop-off at school, Jessie seems to mingle well with the other children. When playing 'brother and sisters' with peers, Jessie states "mommy and daddy went on a trip and did not bring us, we have to take care of us." When the other children try to say that the parents will be back soon, Jessie insists that the parents are going to be gone for a long time and might never come back. To prepare for their time away from their parents, Jessie initiates trips to the store by creating a buddy system to ensure "no one gets left behind." If Jessie initiates play at school, it*

is normally along these lines. Jessie will also pretend to be parents of other children, often stating where the parents are going, what they are doing, and when they will be back.

Separation Questions

1. How often during play does this child act out scenarios of attachment figure separation (i.e., parent leaving home)? (a)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

2. How often during play does this child act out scenarios of themselves separating from attachment figures (i.e., running away from home)? (a)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

Reunion Questions

1. When separation does occur during play, how often does this child act out a reunion? (i)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

Adult Activities Questions

Question 1 from Social Anxiety Disorder Attachment and Family Themes: Adult Activities

1. When pretending to be an adult, how often does this child act out adult routines (i.e., go to work, cook dinner, shower, clean the house)? (a)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

Store and shopping Questions

1. How often is the grocery store or shopping center a place of separation in this child's play? (a)

(1) Never
(2) Rarely
(3) Sometimes
(4) Often

2. How often is the grocery store or shopping center a place to act out getting errands done in this child's play? (i)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

Safety Themes:

Vignette: *When playing with peers, Riley, a three-year-old preschooler, likes to disturb the play by instituting natural disasters. When a group of the preschoolers organize a wolf pack scenario with a leader of the pack, a mommy wolf, and baby wolves, Riley yells "run tornado." Following Riley's lead the wolf pack runs to their den where they become trapped from falling debris. When they are safe in the den Riley points out that one of the 'wolves' legs is bleeding. In these situations sometimes Riley will initiate a plan to help fix the 'injured' character and escape the situation. Other times, Riley will state that if they stay put, someone will come to rescue them. This time Riley got the other wolves help to stop the bleeding by packing dirt into the wound and then they got started on digging themselves out of the den. Another time when a similar situation occurred, Riley told the others they need to wait for someone to come get them.*

Broken play Questions
    1. How often are characters getting sick or hurt in this child's play? (a)
        (1) Never
        (2) Rarely
        (3) Sometimes
        (4) Often

Danger Questions
    1. How often does this child endanger characters in their play by natural disasters (i.e., fire or tornadoes)? (i)
        (1) Never
        (2) Rarely
        (3) Sometimes
        (4) Often

2. How often does this child act out scenarios of people threatening harm to them or to others (i.e., a kidnapper or robber)? (a)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

Escape Questions
1. When playing out dangerous situations, how often does this child escape without help from a rescuer? (a)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

Rescue Question
1. When playing out dangerous situations, how often does this child escape with help from a rescuer? (i)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

Self-nurturing Questions
1. How often does this child play out scenarios where adults provide comfort (i.e., hugs or affirmations) after a dangerous or scary event occured in their play? (b)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

2. How often does this child comfort themselves (i.e., hiding under a table or sucking thumb) after a dangerous or scary event occured in their play? (a)
    (1) Never
    (2) Rarely
    (3) Sometimes
    (4) Often

Appendix B

Play Theme Descriptions, Explanations, and Related Questions

	Aggressive Themes			
	Death Play	**Powerful Figures Overcoming Weaker Figures**	**Good vs Bad Guys**	**Aggression**
Bendedict's Description	"This is coded when anyone dies or is dying (even if a character is absent andonly talked about). Includes death in symbolic form (e.g., inanimate object, such as, a car or airplane dies by crashinf or running out of gas. Do code for death when the child talks of a character's impending demise, as in "She's going to die" or "I'm going to kill that monster"	"Here there is no clear good/bad designation. The emphasis is interpersonal power, not on aggression or on good/bad distinctions. Typical examples would be a powerful figure that overcomes all others, but does so through interpersonal strength, not clear aggression or containment (SAF). Includes teacher/student, or parent/child, or boss/worker play, where the one figure has the power to tell the other what to do. For example, "parent tells child to eat his dinner or clean up his room."	The key issue here is overt designation of goodness or badness of the character; if not so designated, it belongs in another code. The goodness/badness distinction may be made even if a character is not actually referred to as a "good guy" or a "bad guy", but only when a value term is used. You should assume that characters who are normally good, such as, superman, may be coded as good guys. In addition, characters who are normally bad, such as, a monster or a witch, may be coded as bad guys, unless otherwise designated (as in an unusual case of a "good monster" or a "mean superman.	"Aggressive content that occurs between characters, as well as, aggressive content in the child's behavior out of roles, as in "He angrily threw toys around the room."
SEP	X		X	
SOC		X		X
Why?	According to the DSM-5, children with SEP experience persistent and excessive worry about the death of attachment figures (APA, 2013). This might explain why children with SEP symptoms might often play out death themes — they are trying to gain control of their anxiety to prepare them for a situation where this might happen. In their literature review interpreting common play themes, Green et al., (2009) mentions that death themes sometimes reveal a child's conflict with anxiety about separation.	Aggressive play themes, especially those concerning power dynamics may be worth identifying when looking for SOC symptoms. Children with SOC often freeze during social interactions (APA, 2013). In these situations, it is possible they feel powerless, and navigating power in relationships might allow them to explore how to gain control over their environment.	Because a lot of separation anxiety comes with the fear of strangers or being kidnapped (APA, 2013), playing out scenarios where children encounter the answer to their question "what happens when I get separated from my attachment figure?" This may require creating a distinction between good guys and bad guys.	Aggressive play themes, especially those concerning power dynamics may be worth identifying when looking for SOC symptoms. Children with SOC often freeze during social interactions (APA, 2013). In these situations, it is possible they feel powerless, and navigating power in relationships might allow them to explore how to gain control over their environment.
Related SEP Questions	How often does this child incorporate death into play? (a) How often does this child kill off representations of attachment figures (i.e., parents or siblings) in their play? (a) How often does this child kill their character in play? (i)		How often does this child create good guy/ bad guy distinctions in their play? (a) When engaging in good vs bad guy play, how often does this child want to kill off the bad guys? (a)	

Related SOC Questions	When playing with dolls, figurines, or anything that can represent people and relationships, how often does this child represent relationships where one individual has a clear power role (i.e., teacher-student relationship or parent-child relationship)? (a) If inserting themselves into a role, how often does this child play the role of the person in power (i.e., teacher)? (i) If inserting themselves into a role, how often does this child play the subordinate role? (i)		When conflict arises between characters in play, how often does this child make the characters fight? (a)	

Attattchment and Family Themes				
	Reunion	**Separation Play**	**Store and Shopping**	**Adult Activities**
Benedict's Description	"Reunions or returns from separation. This must be explicit, such as a parental character returning from a trip or a character being returned after being kidnapped but the emphasis must be on their reconnection following separation."	"Whenever someone leaves or separates from someone else, such as, mother going shopping and leaving child at home, or some character moving away. May include the child packing a suitcase for when the police comes to get the bad boy, or a character running away. This code can also be used to indicate separation has just occurred, as in a child character saying "I can't find Mommy" even though the actual separation is not played out directly. To code SEP, it must be clear that the characters are in fact going to separate."	"Any activity where a child sets up a store, has the therapist be a storekeeper, or has a character go shopping for things. This does not include any places of business, such as, a doctor's office, where one does not go to do shopping."	"Any activity clearly associated with being an adult, such as, going steady, going on a date, putting on make-up, etc."
SEP	X	X	X	X
SOC			X	X

My Reasoning Based on Literature	Green et al., (2009) mention that if separation play includes a resolution to the separation (i.e., the return of someone who was separated) it may reflect that the child experiencing SEP symptoms manages their anxiety more so than the child that can not imagine a reunion.	Green et al., (2009) understand separation themes as common in attachment disordered children. This type of play is literally playing out the child's fear of losing attachment figures.	**SOC Reasoning:** A child who fears perception and situations where there are expectations to present in public (APA, 2013) may want to work through these fears by playing out scenarios that would invoke that fear in real life. For example, McClintock & Benedict's (2009) lists store and shopping under attachment and family themes. This play theme allows children to set up scenarios that involve interactions with other people. Children who show reluctance towards meeting new people, socializing, and participating in activities but choose play themes where socialization is necessary might be working through that social anxiety in the sense that play allows children to gain control and mastery over their world (Deshpande & Shah, 2019). **SEP Reasoning:** The DSM-5 explains that children with SEP fear going to the store because it represents the possibility of getting lost, losing their parents or being kidnapped. Since stores can be a trigger for children with SEP, they might engage in play that helps them gain control over those situations in a safe environment.	**SOC Reasoning:** Another theme McClintock & Benedict (2009) lists under attachment and family themes is any play associated with being an adult. Cognitively, children with SOC are worried about their performance and doing things the right way (APA, 2013; Chronis-Tuscano et al., 2009; Mash & Wolfe, 2019). Because adults are role models for children and children believe that adults do things the correct way, playing as an adult is possibly indicative of a child trying to explore and understand how to exist. **SEP Reasoning:** Albano et al., (2003) explain how children with SEP may become especially concerned about where and what their attachment figures are doing. Therefore, engaging in play themes regarding adult activities may be a child's way of understanding adult routines.
Related SEP Questions	When separation does occur during play, how often does this child act out a reunion? (i)	How often during play does this child act out scenarios of attachment figure separation (i.e., parent leaving home)? (a) How often during play does this child act out scenarios of themselves separating from attachment figures (i.e., running away from home)? (a)	How often does this child represent the grocery store in their play? (i) How often is the grocery store or shopping center a place of separation in this child's play? (a) How often is the grocery store or shopping center a place to act out getting errands done in this child's play? (a)	How often does this child pretend to be an adult in play? (a) When pretending to be an adult, how often does this child act out adult routines (i.e., go to work, cook dinner, shower, clean the house)? (a)

Related SOC Questions		When playing alone how often does this child create scenarios that would involve interacting with others in the real world (i.e., working as a grocer)? (a)	How often does this child pretend to be an adult in play? (a) How often does this child pretend to be an adult interacting with others during play (i.e., making a phone call)? (a) How often does this child pretend to be an adult doing solitary activities during play (i.e. doing make-up)? (i) When pretending to be an adult, how often does this child act out adult relationships (i.e., going on a date)? (a)

Safety Themes

	Broken and Danger Play	Escape and Rescue	Self-Nurturing	Neglect, Punishment, or Abuse of Self
Benedict's Description	"In broken play some character is broken, sick, or hurt and needs to be fixed. Also includes tearing down a house or a house falling down" and in danger play is "whenever a specific danger is identified in the play. This might be a dangerous person who is described as scary or going to get us, etc. (monsters, bad guys) or a dangerous situation (fire, tornado, locked in someplace, character all alone). It might occur with either aggression or rescue but can occur alone."	"Escape is whenever a character escapes from a bad situation without help from some rescuer. It is considered a rescue if a character is made safe by or assured of safety by a "rescue" figure. Rescuer can be "super duck", a policeman, someone who adopts abandoned child, someone who tells a hiding character it is safe to come out of hiding so as to relieve that figure from previous threat, etc. Scored whether rescue succeeds or a rescue is attempted, but fails and the character is still in danger. For rescue to occur there must be a clear rescuing character and a clearly rescued character."	"Any time the child uses baby things to obviously comfort him or herself, as when the child takes the bottle, hides under a table and sucks, pretends to eat food, etc."	"Any time a child withholds nurturance from the self or punishes the self as when a child hits himself when he does something he things is wrong. Includes the child climbing in dangerous places or placing himself in real danger in the room. Also includes verbal self-abuse as in calling the self "bad."
SEP	X	X	X	
SOC				X

My Reasoning Based on Literature	Children fear losing or harm coming to their attachment figure and experiencing events that will cause separation such as being kidnapped or getting lost (APA, 2013). For these reasons, broken play and danger themes are relevant when attempting to identify SEP through play themes.	Because children with SEP fear situations where they will be apart from an attachment figure (APA, 2013), they may use play to work through scenarios where they would have to fend for themselves: escape play. On the other hand, children may also engage in rescue play after endangerment.	Dallaire & Weinraub (2006) report that insecurely attached children are more likely to have separation anxiety than securely attached children because they lack the confidence that their attachment figures will always be there to care for them. Therefore, it stands to reason that children with SEP may also engage in self-nurturing play, another safety play theme. In self-nurturing play children will use techniques used to comfort babies to comfort themselves — this could be indicative in the child's belief that their attachment figures are unable to comfort them.	The safety theme of neglect, punishment, or abuse of the self might highlight the cognitive symptoms of incompetence and inadequacy children with SOC experience (Hofmann, 2007). This type of play might be a means of punishing oneself for incompetence and inadequacy as it includes verbal self-abuse (e.g., calling oneself "bad"), physical abuse, and putting oneself in harm's way (e.g., climbing in dangerous places) in some situations where the child believes they did something wrong in play or otherwise (McClintock & Benedict, 2009).
Related SEP Questions	How often are characters getting sick or hurt in this child's play? (a) How often does this child endanger characters in their play by natural disasters (i.e., fire or tornadoes)? (i) How often does this child act out scenarios of people threatening harm to them or to others (i.e., a kidnapper or robber)? (a)	When playing out dangerous situations, how often does this child escape without help from a rescuer? (a) When playing out dangerous situations, how often does this child escape with help from a rescuer? (i)	How often does this child play out scenarios where adults provide comfort (i.e., hugs or affirmations) after a dangerous or scary event occured in their play? (b) How often does this child comfort themselves (i.e., hiding under a table or sucking thumb) after a dangerous or scary event occured in their play? (a)	
Related SOC Questions				Questions 1-2 from Exploration and Mastery Themes: FAIL (When attempting to complete a self-initiated play activity (i.e., building a tower), how often does this child verbally exclaim "I can't do it"?; When attempting to complete a self-initiated play activity, does this child become frustrated and halt the activity?) In response to perceived failure during play, how often does this child respond with verbal self-abuse (i.e., "I'm bad")? (a) How often does this child put themselves in dangerous situations during play (i.e., hazardous heights)? (i)

Exploration and Mastery

	Constancy	Exploration	Fail	Mastery
Benedict's Description	"This play indicates a need on the part of the child for stability or security. It is as if the child wants assurance that things will clearly remain as they have been, e.g. relationships will endure, toys will remain in the play room, and personal identities will not change, etc."	When a child is checking out toys in the room, asking questions about what is available or how thing work. The key point here is that the child is trying to obtain information about things in the room.	"When a child attempts mastery and cannot do it. It may include express frustration or verbalizations of "I can't do it". Code when the child describes self as unable to master something even if they don't actually attempt the task."	"Includes when child builds something or masters a challenge. Typical toys for this include bristle blocks, legos, puzzles, building with blocks if trying to see how well can balance or how high one can build them. Most instances of building things that do not fall under BRG or SAF will be coded as MAS. In mastery play, the child seems to be seeking a sense of competence or achievement, so code for achievement oriented activities, such as "tried to write her numbers correctly", or "tried to draw circles just right". Code MAS, for instance, if child showing off for the therapist, as in "showed off his muscle, etc."
SEP	X			
SOC		X	X	X
My Reasoning Based on Literature	Major instances of change (i.e., moving or entering a new school) are what often triggers SEP. Therefore the desire to keep their play — the one thing children have control over — constant might be a reaction or rejection to change in their lives.	Children experiencing SOC symptoms might engage in exploratory play as a way of separating themselves from peer interactions. SOC symptoms include being fearful of social interactions and withdrawing from peer play (Mash & Wolfe, 2019; Scharfstein & Beidel, 2015). Perhaps exploratory play is an example of what withdrawal from play — a common symptom of SOC — looks like.	When a child expresses to an adult directly or through clear frustration (e.g., destroying their half finished tower) that they are unable to complete their mastery play and exhibit frustration as a result, this is a literal expression of their feelings of incompetence (Hofmann, 2007).	Since mastery play is a way of gaining a sense of competence and accomplishment it is not difficult to interpret this kind of play as compensation for feeling inadequate and incompetent typical of SOC.

Related SEP Questions	When playing with peers, how often does this child insist on repeatedly establishing character identity? (a) When returning to play how often does this child play with the same toys they played with during the last play session? (a) When returning to play how often does this child return to previously played with toys? (a) When returning to play how often does this child check on things previously established during play sessions (i.e., a fort that they built)? (a) How often does this child change play themes? (b)		
Related SOC Questions	In novel play situations, is this child hesitant to use play material without confirmation from an adult? (a) How often does this child ask about the play material available to them? (a) When opportunities to play with others arise does this child reject the invitation to join and instead hover around/explore/look at solitary play options? (a)	When attempting to complete a self-initiated play activity (i.e., building a tower), how often does this child verbally exclaim "I can't do it"? (a) When attempting to complete a self-initiated play activity, does this child become frustrated and halt the activity? (a)	When opportunities to play with others arise does this child instead choose solitary play options (i.e., building blocks)? (a) How often does this child engage in play activities that are goal-oriented (i.e. highest tower)? (a) How often does this child engage in open ended play (i.e., uses blocks as cars)? (b) During play how often does this child look for approval from teachers or instructors (i.e., showing off a completed tower)? (a)

Non-Play Activities	
Art and Drawing	**Games**
"When the child is drawing or painting. Writing would also be included here as in the child got a marker and wrote his name. Sometimes it will co-occur with MAS and both should be coded. If an obvious theme is conveyed through the drawing, such as, telling a themed story."	"Rule based games, such as, Candyland, checkers, or Talking , Feeling and Doing usually will just stat played the games. Does not include not rulebased activities, such as, puzzles."

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SEP		
SOC	X	X
My Reasoning Based on Literature	Compared to their typical peers, children with SOC are more likely to play alone (Gazelle et al., 2010) — an activity such as art and drawing can be a solitary activity, making it alluring to children who do not want to engage in peer play.	While these games do require interaction with peers, they provide rules and structure to the play that would not be there in make-believe play. Children with SOC tend to worry about playing the "right" way (Chronis-Tuscano et al., 2009) so games that tell them what to do and allow them to predict what others might do may provide a sense of comfort, making it easier for them to participate.
Related SEP Questions		
Related SOC Questions	During free-choice time, how often does this child engage in solitary activities (i.e., art and drawing)? (a)	When this child is engaging in peer play, how often does this play involve make-believe? (b)When this child is engaging in peer play, how often does this play involve predetermined rule-based games (i.e., Candyland or duck duck goose)? (a)