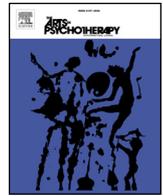




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Research Article

Re-animating vulnerable children's voices through secondary analysis of their play therapist's interview narratives

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ABSTRACT

Inclusion of the voice of the child is key to quality research processes focused on their needs and interests. The authors contend that when the voice of the child is unavailable, secondary analysis of data generated with sensitive, highly trained, child-oriented adults may provide a useful way to include aspects of the child's experiences and views. This study reports an innovative secondary analysis process in which therapy practitioner narratives were used to re-animate the lived experiences and challenges of vulnerable children. The results indicated that attending therapy was experienced as supportive for children; in being able to make choices, in being informed about decisions relating to their current circumstances and future, and the role of attendance at therapy in supporting their needs.

Introduction

This paper presents a secondary analysis of the interview data from an original study about child play therapist's understandings of the rights of the child (Edwards, Parson, & O'Brien, 2016). This follow up study used the original interview data; focusing on the question *what do children experience when they attend play therapy?* Five interviews and a written account from the original data set provided the narrative for analysis. These narratives recounted specialist therapy work with highly vulnerable children experiencing family conflict or problematic home circumstances in which life changes had occurred, or were about to ensue (Edwards et al., 2016).

The follow-up analysis resulted in the creation of four vignettes animated from the child's perspective based on stories the practitioners told when recounting their practice experiences. The method engaged the techniques and procedures of narrative inquiry (Bochner, 2012), with emphasis on the performative affordances of qualitative inquiry (Bochner, 2018). This paper presents a. the approach taken, b. the vignettes that emerged, and c. reflection on the findings.

We contend that play therapy is a well-established method for working with vulnerable children (Myers, 2017). Therefore, this paper does not seek to explain play therapy, or justify its inclusion as a therapeutic practice in child mental health service provision. The focus of the paper is the presentation of an innovative methodology for the exploration of children's experiences within, in this case, narratives of

highly trained, child-oriented adults.

Narrative inquiry

Narrative research represents "the struggles of ordinary people coping with difficult contingencies of lived experience" (Bochner, 2012, 160). Narrative analysis offers multiple ways to honour and acknowledge human experience as a site of learning and understanding (Clandinin & Rosiek, 2007) resting on an epistemological foundation that multiple narrations and interpretations of experiences are possible (Bhattacharya, 2016).

The narrative inquiry text presents "emotional, dialogic, and collaborative truths" (Bochner, 2012, 161). Rather than investigating and ascertaining facts, the researcher's interest focuses on the *telling* of the story, along with the narrative process engaged by the teller. Clandinin and Rosiek (2007) proposed that narrative research is a vital and energizing way to engage complex topics because,

...the narrative inquirer focuses on the way the relational, temporal, and continuous features of a pragmatic ontology of experience can manifest in narrative form, not just in retrospective representations of human experience but also in the lived immediacy of that experience.

(Clandinin & Rosiek p. 44)

Narrative inquiry is an accepted research method used to engage

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Table 1
Description of the method.

Close text reading to identify thematic units	<ul style="list-style-type: none"> ● Reading and re-reading the interview texts ● Highlighting sections relevant to child experiences of therapy
Interrogating similarities between thematic units	<ul style="list-style-type: none"> ● Condensing to thematic unit level
Grouping thematic units into coherent clusters	<ul style="list-style-type: none"> ● Comparison between thematic units found ● Identifying similarities between thematic units ● Creating groups of these themes into clusters
Reflecting on clusters through memo and journal writing	<ul style="list-style-type: none"> ● Deepening reflection on the clusters through further intense scrutiny of the meaning and impact of the materials
Stopping the re-reading process when no new thematic units were encountered	<ul style="list-style-type: none"> ● Choosing when to stop re-reading ● Saturation of materials
Creating a map of the contingent thematic material	<ul style="list-style-type: none"> ● Represented in Fig. 1
Writing the vignettes	<ul style="list-style-type: none"> ● Story writing from the perspective of the child with reference to thematic material generated in the first stage of the analysis ● Inclusion of therapist reflections
Reflection on the vignettes including accounting for relevance to child play therapy literature and practice	
Accounting for the links between the vignettes and the thematic clusters	<ul style="list-style-type: none"> ● As a final step in quality assurance each vignette was reviewed for the relevance to the thematic material

complex topics involving children, by accessing experiences of families and practitioners (for example, Moore, Russell, Arnell, & Ford, 2017; Navot, Jorgenson, & Webb, 2017). The researcher uses their expert understanding, and prior experiences, to elaborate meaning and engage the complexity presented.

There is no one way to undertake narrative inquiry. Every decision or step in working with the materials generated remains open-ended, or even ad hoc, including the decision about when or how the analysis might be considered complete. This aspect of narrative inquiry has been described as a journey with a “maze of roads and paths” (Robert & Shenhav, 2014, p. 13). This iterative and organic process is crucial to the development of a narrative inquiry project. However, it is recognised this can impact the challenge of demonstrating the trustworthiness of the study. The validity of qualitative studies is based on both the communicative and pragmatic relevance of the materials and findings (Kvale, 1996). Therefore, relevance can be used as one criterion of validity in research with a narrative inquiry focus. Narrative reports gain their trustworthiness from the relevance of their sources and the relevance of the findings to real-world problems.

Secondary analysis

Secondary analysis – also termed secondary data analysis - uses an existing data set to answer a different question than that of the original study. Long-Sutehall, Sque, and Addington-Hall, (2011) proposed that a strength of secondary analysis is its capacity to capture information about an elusive population where issues of sensitivity may preclude direct research with the potential participants (see also Jackson, Newall, & Backett-Milburn, 2015). Mitchell (2015) similarly endorsed the efficiencies in secondary analysis, along with the benefits of its non-intrusive nature.

Much of the literature and guidance on implementing secondary analysis involves managing large data sets; for example, information from longitudinal studies (Vartanian, 2010), or from archived widely available data sets (Tarrant, 2017). Interview based secondary analysis studies tend to have relatively large participant numbers (for example, Tarrant, Windridge, Baker, Freeman, & Boulton, 2014). However, some secondary analyses have smaller numbers of participants, and there does not seem to be a prescribed number of participants to reach saturation. Rather, the richness of the data set and the reason for the secondary analysis provide the rationale for the size of the data set.

One of the ethical challenges reported in that literature about secondary analysis of qualitative data, is data sharing (Ruggiano & Perry, 2017). The secondary analysis reported here was undertaken by the researchers from the original study. We contend that our professional experience as child therapy practitioners and researchers with children and families strengthened our undertaking of this process of analysis.

Method

Procedures for the research

After ethical approval from the relevant ethical board at Deakin University, Registered Play Therapy members of the Australasia Pacific Play Therapy Association were contacted via an email message sent from the association advising that the research study was recruiting participants.

Six play therapists made contact and agreed to participate in the original study. Five interviews by phone or in person were completed, and one respondent provided written answers to questions. Guiding questions submitted during the ethical clearance procedure formed a template for topics raised during the interviews. Sample questions asked during one interview included: *Are you able to recall an example of the way in which they [CRC] linked in to the work you were doing, and the work you were learning about? and Can you describe a scenario in your practice which has involved upholding the Rights of the Child?* Some respondents used the opportunities in the interview to direct discussion of topics important and meaningful to them. In other interviews, the respondents followed the interviewer’s responses and questions. Therefore, the topics covered were diverse across the interviews.

Analysis: developing the vignettes

Secondary analysis of the accounts of play therapy practitioners about their work informed the vignettes devised below. Deviating from the traditional idea of a narrative as co-created between the writer and reader, or the storyteller and the listener (Ricoeur, 1991), the first author undertook the analysis and generated the vignettes (Table 1).

The 26,000 words of transcript/text were read multiple times, searching for cogent and cohesive standalone narratives within the text that related to the experiences of children attending therapy. The child’s perspective narrated by the therapist was extrapolated; first by using a highlighter to emphasise the relevant text, and next by the creation of memos to create a meta-commentary on the text. Table 2 demonstrates how play therapists described navigating along a continuum of privacy and advocacy for the child. The resultant memo reflects on this experience from the child’s perspective.

Relevant aspects of the accounts created a new document through cut and paste technique. The emerging stories were included in a table with the text on one side and the researcher’s response to a guiding concept; *what does the child need?* on the other. This process of arranging and responding to the stories is similar to the segmentation and coding process in thematic analysis (Schreier, 2014). Both authors are child and family practitioners with extensive practice experience in a range of settings. The first author is a qualified music therapist who has

Table 2
 Researcher memo: example.

Therapist	Researcher
<p>...there are certain things that if they [the child] did an activity like a <i>feeling body</i> that might have information that might be a little bit off-putting to a parent, like “my mum yells at me that makes me feel sad”...then I might say “let’s keep that here in your special file” and kind of give them that sense that they have a special file where their special things can go...trying to protect their relationship with me, and also not wanting to cause ripples at home.</p> <p>I come from a point of “let’s talk to the child”. Let’s go back and see what the child wants and what they think is best for them... before I go to those meetings with everybody I’ll sit with the child and say “I’m going to this meeting, and this is who is going to be there” ...I do a traffic light technique, the red one is things that aren’t working for them, orange is it’s OK; like I don’t want to go to school but I know I have to or sometimes I don’t want to come to therapy but I come and it’s OK anyway, and green is the stuff that I love and it’s working and please keep it happening for me... that’s how I would approach that sort of meeting and situation. What does the child want? What is the child saying he or she wants or needs?</p> <p>...this particular boy just didn’t want to come [to his play therapy session], and I was like “that’s ok, that’s fine”. You know, it’s his right not to come on that day, and I certainly am not going to force him.</p> <p>...one of the rights that has always stuck out for me...is the one for children who have experienced neglect and abuse to receive attention to regain their self-worth and self-respect...adults don’t really get that as a general rule, parents or foster parents or case managers have a little bit of a hard time understanding that, that’s what happened to children who have experienced neglect and abuse because they see the <i>behaviours</i> as the concern.</p>	<p><i>The play therapist explains to the child that some things discussed will be private, and they will not have to tell others including caregivers and parents.</i></p> <p><i>The therapist navigates between the parent or the caregiver and the child to ensure that the process is confidential and safe for the child. The therapist can support the child to make decisions, for example whether to come to therapy on a particular day or not. The therapist helps the child to think about and process feelings about their choices, advocating for the child’s wishes when meeting with others who are responsible for decisions about the child’s future. The therapist uses their understanding of trauma to explain why the child behaves in certain ways, and to advocate for the child’s needs.</i></p>

experience working in mental health and psychosocial care across the lifespan; including working as a music therapy researcher and clinician in a children’s hospital for seven years. The second author is a qualified Paediatric Registered Nurse and Registered Play Therapist, she has over 30 years’ experience working with children and their families, including providing acute child and adolescent mental health, medical play, clinical play therapy and play therapy supervision.

The first author generated the segments and the thematic units, and the second author validated the choices and wording through checking carefully through the resultant analysis. The resultant topics emanating from this process were that the child attending therapy needs safety, choice, a child centred approach, and help to manage difficult experiences (see Fig. 1).

The process of developing the vignettes occurred through reflection on the thematic material generated in the analysis of the segments. Along with considering the themes, the first researcher wrote the narratives as if the child was telling her their own story directly. Writing the vignettes felt both emotional and emergent for the first author. This process resonates with Jackson, Backett-Milburn, and Newall’s (2013) account of the *emotional reflexivity* in secondary analysis. They described how “the ‘narrated participant’ (the child or young person) was communicated, was emergent, and was brought into an interactional and dynamic relationship with ourselves...” (p. 5).

As the vignettes developed, the content of each story was compared to the earlier thematic analysis from the interview data. This was to ensure that representation of all themes. Fig. 2 presents more detail of the procedures for the research.

In terms of the narrative approach taken, we were guided by Morse (2015) as to elements that needed consideration.

Results: animating the experiences of vulnerable children

Please note that in the following vignettes the play therapy approach of each practitioner has not been elaborated. Play therapists work from multiple methods and approaches, depending on the needs of the child and the training school the practitioner attended. As described above the study which included the interviews on which this secondary analysis is based did not request this information as it would likely have led to the researchers not involved in interviewing knowing who the practitioners were. Practitioner names have been changed.

Vignette 1: thinking, feeling, and hurting

I first went to play therapy when I was really little. Maybe I was 4 years old. I was sometimes upset and angry about things to do with my Mum. I was told I was not allowed to live with Mum anymore, and my Dad had a lot of problems. It was fun to go to play therapy. The room was full of toys and stuff. I had my favourite toys and things that were always there. Belinda was nice. She knew what I was feeling when I was talking or playing – that was really weird. Often when I went to the park I didn’t want to play. I would feel so tired. I only wanted to sit and watch the others children. After play therapy I would sometimes feel a bit better and want to play more, sometimes I even climbed the monkey bars and played on the swing. After a while I was told play therapy was ending. Maybe I was 6. I was allowed to go back whenever I wanted to. I usually asked to go back, or someone suggested it to me, after I had visited with my Mum. Then when I was about 12, I was told by the courts that I had to see my Mum again. It was an *order* from the court and I felt forced and made to do it. I didn’t want to. I didn’t want to see her at all. It felt better when I hurt myself and I sometimes thought of killing myself so that I wouldn’t have to see her. I told the play therapist and she explained I would need to go to a psychologist to have tests about how I was thinking and feeling. She said she could ask me the questions but she couldn’t do the tests. I said OK to that but said I didn’t want to have to talk with anyone else, I only wanted to talk with you. My Mum demanded I meet up with her and each time she did I felt really angry and sad at the same time. Dad told Mum that I was really sad and stressed out, and that maybe I shouldn’t be made to see her for a little while. Mum went ballistic. I didn’t care. I have the right to see who I want to see. When I told the therapist I would kill myself if I was made to see my Mum, everyone started asking me how I was and what I was thinking about. I was told I could choose which therapy I wanted and who I wanted to spend time with from my family. That really helped me to feel better. I am fine now. I feel okay most of the time and I don’t think about being dead anymore. No-one makes me see anyone I don’t want to.

Here the child presents with issues that are difficult for them to explain in words. This difficulty leads to self-harm and suicidal thoughts. It is preferable that children are asked about what they would like to do about their situation. When they have decisions and situations



Fig. 1. What the child needs.

forced onto them without consultation, or are placed in situations where they feel anxious, they often have little recourse to gain equilibrium except to undertake behaviours that are sub-optimal in terms of the potential for moderate to severe harm.

In the provision of therapeutic services to children, practitioners sometimes deal with difficult situations where a child’s choices and the choices of their parents come into conflict. Courts may mandate decisions that are deemed to be in the child’s best interest. The child is required to comply, even if it is not what they want. The therapist can play a role in supporting the child’s opinions to be shared with others, within the bounds of confidentiality, and the child’s wishes to be

communicated to key decision makers about their care.

Vignette 2: playing through chaos

In my family my Mum and Dad are really weird. They were always yelling and screaming. Other people made them angry then they would start shouting and fighting. Grownups said I needed *stability* and *consistency* when they were talking about me living with Mum and Dad. I remembered these words, and it was only when I was older I knew what they meant. Everyone could see how untidy and dirty it was where I lived with Mum and Dad but I didn’t mind. I

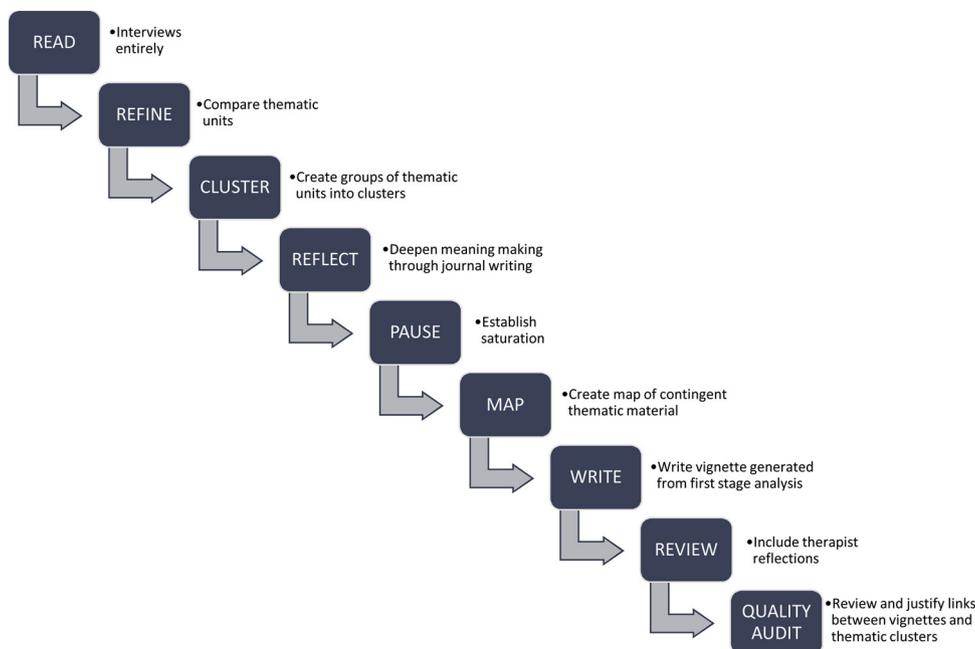


Fig. 2. Secondary analysis.

went out to play with my friends, and sometimes stayed over at their places. Someone told me I would have to live at my Aunt’s place for a while. I liked that. My Uncle had a motorbike and he would let me sit on the seat but he said it was too dangerous for me to ride with him. I saw my Mum and Dad a lot but I was always told I couldn’t go home “yet”. I never knew when “yet” would come. I went to playing therapy. It was a room with lots of toys, and Bernadette was there. She knew my name and where I came from. I drew pictures and talked about what I liked and where I wanted to live. We talked about my Aunt and Uncle, and about my Mum and Dad. It was cool. I liked that lady who had all those toys and games.

Children taken into protective custody are sometimes able to be provided with safe kinship care. This allows children the opportunity to retain connection with their family identity, and relevant cultural practices (Davis & Pereira, 2014). However, children are often not advised why decisions are being made and are not asked about what they would like to choose, or why what they would like to choose is not possible.

Vignette 3: navigating birth, death, loss

When my new baby sister was born I had great fun playing with her. When she looked at me she always smiled or laughed. I could put my head down on hers and then breathe and make gurgly noises and she would giggle. One day I saw Mum crying and then heard sirens and a policeman came and sat on the couch. I don’t know what happened but Mum was always sad after that. The policeman told me my sister was dead. I asked him when she would be coming home again and even though he was a policeman he couldn’t tell me. I had to go and live with my Dad because Mum was too sad. Dad took me to a place where I met Sally who had a big room full of toys I could play with in any way I liked. Sometimes I bashed and crashed things in there which made me laugh a lot, it felt good. Sometimes I wanted to set up the toys so one doll was my sister and then one doll was Dad, and another one was Mum until I had the dolls and teddies all lined up with their names. My Mum came to see me at Dad’s and she always brought me a present. One day I asked Mum why she was getting really fat. She laughed and said that she was having a baby. I felt scared. What if this baby died too and would it be my fault? I

asked Sally whether this baby would die too. Sally said some babies die but not all babies. That was good to know. She said I had been a baby too when I was younger and I am alive. I did not realise that. I asked Mum if there were some photos of me as a baby. She searched for a long time, and then she found one. I looked at it and thought I looked a bit like my baby sister who died but maybe babies all look the same. When my new baby sister was born I loved playing with her. She liked it when I put my head down onto hers and breathed and made sounds. She would laugh and laugh. One day I was told I had to say goodbye to her. She was going to live with another family. I really could not believe it. It was like being dead but in a different way. I said goodbye to her and played all our usual games. When I was back in the car with Dad I didn’t know whether I was going to cry or laugh so I ended up just sitting there saying nothing. My baby sister made me laugh so much so it was sad to think I would never see her again. Sally helped me to write a story about things like how I had played with my baby sister and how much I loved her. I drew the pictures and at the end of the story there is a photo that Mum took of me and my baby sister. I hope one day I will see her again. I hope it is not my fault she will not be part of our family any more.

In this vignette the complexities of a child’s perspective on family events is illuminated. Children often fill in the gaps in their knowledge by trying to make sense of absent information. The therapist assists in closing this gap, helping the child to make sense of their life story, and to clarify misconceptions (Cattanach, 2002). Mementos of sessions through stories, and pictures, are prepared to take home. These help the child to keep connection with the positive aspects of sessions, and to know that they will be held in mind during the period until the next sessions.

The therapist takes care to listen to the child, and focuses on the child’s perception of their situation. Adults often believe children will *not remember*. In fact many children remember and actually feel responsible for events that happen to those they know.

Vignette 4: making a scary mess

Everyone says to me “I hope your Mum is OK”. She is not OK. She is dying. I have to go and visit her in the hospital and sometimes she

comes home and stays in bed. She cannot play with me, she sleeps a lot and is always tired. I have to be quiet so I don't wake her up. I go to see Mary who has a big room full of boxes of sand and seeds and toys. I can blow up balloons and play chasey. It is awesome. One time I blew up balloons and made a funnel full of seeds and when the balloon popped stuff went everywhere. I wanted to do that over and over again. We could mash the seeds into the floor by stomping on them. It felt so good to make a big, big mess. We threw the balloons and batted them and popped them. They went BANG really loudly when they popped and I would scream and jump up and down. I also liked to hide in the garden so that Mary had to find me. I could scare her - ha ha! - if I jumped out when she was not expecting it. I hide really quietly. Mum can't play chasey anymore. I hope one day she will be better and we can run up and down like I do with Mary, though Mary says she gets puffed out from it. I think Mum probably will not get better. I know that.

Play therapy provides a safe and permissive environment to explore the underlying emotional concerns of the child. It is one indoor place with the freedom to be messy. This desire to make mess without consequences may represent underlying internal processes relating to lack of safety, that can be explored, and contained (Porter, Hernandez-Reif, & Jessee, 2009).

Making a mess, and *being in the mess together*, allows acknowledgement and exploration of messy, ambivalent, feelings. The therapist joins in with the child to have shared experiences led by the child's needs. Play can become a therapeutic agent for change, allowing release and catharsis (Schaefer & Drewes, 2013). In this vignette the child is supported to manage the stress of living with their caregiver through the last days of their parent's life, anticipating their departure, and somehow coping.

Discussion

These vignettes emerged from a secondary analysis of the narratives of play therapists explaining how they work with children experiencing complex and adverse life events. The proposal to engage secondary analysis to consider the child's view was a spontaneous idea developed enthusiastically within the research team.

Told from the child's perspective through the process of secondary analysis the cumulative narratives indicate that play therapy provides a space where things that can be *batted* and *popped*; stories can be told, and pictures drawn. Foundational to the needs of the child, and aligned with the affordances of play therapy, the findings indicate that through therapy the child's thoughts can be processed, feelings can be clarified and named, and the work of making choices and understanding choices made by others can be elaborated. Advocating for children's needs, and delivering responsive services that meet those needs, is the responsibility of the effective practitioner.

Child oriented therapy aims that ultimately a child's thoughts and feelings are better tolerated and understood instead of continuing to feel overwhelming and unsafe. Mess permits representation and exploration of difficult feelings; with this messiness safely managed within therapeutic parameters.

This study provides support for additional methods innovating the inclusion of the child's voice in research studies about them. Where access to the child's voice is difficult due to sensitivities regarding privacy, permissions, and vulnerability this type of secondary analysis offers a novel way to ensure that we hear their voices; albeit at one step removed from their direct storytelling of experiences.

Reflections on the limitations and implications of the study

There was no way to gain any information about the children whose perspectives are reflected in the above vignettes nor to inquire with the interviewees as to the age and demographics of the child they described

to the general population of children seen in therapy. Further information about individual children may have helped to extend the relevance of the findings for practitioners reading this paper. However, even with analysis of direct accounts of experience (for example Jackson et al., 2015) there are always challenges with the indirectness of analysis; with research procedures creating a distance from the original accounts.

The published original study promoted this extension (removed for anonymity). It may be that readers who do not consult the original study may miss some helpful nuances regarding the complexities of the work due to the limited reporting of the original findings in this secondary analysis.

Conclusion

Secondary data analysis offered the opportunity to focus closely on narrative materials generated by adult professionals about children's experience of participating in play therapy sessions. This process of analysis offered further insights into children's experiences within sessions, and their lives. There is need for further research studies that can involve children in describing the processes and outcomes relevant to their care, perhaps in combination with an adult carer, or with the support of their therapist, in *multi-voiced* accounts that allow for representation of high-level complexity and nuance (Ellis et al., 2017). This secondary analysis offered the researchers an opportunity to come closer to children's experiences as outlined by the practitioners; reflecting their stance of care and concern regarding the children's current vulnerabilities and future opportunities.

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