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Integrating Play Therapy and Parental Objectives: Case Studies in Neonatal Trauma and Therapeutic Progress

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This article explores the dynamics between experiential play therapy (EPT) and the need to align therapeutic goals with parental expectations. Using two case studies of children 3.5 years old presenting with behavioral issues taken from a larger study, the article examines how play behaviors can be linked to early imprints, especially neonatal trauma, and caregivers' working models of relationships, highlighting the importance of understanding these connections to break the cycle of intergenerational transmission and foster healthier family dynamics. The cases illustrate how therapists can maintain the core principles of play therapy while addressing concrete parental goals, leading to sustainable improvements in the children's emotional and relational health.

Keywords: Experiential Play Therapy (EPT), neonatal trauma, therapeutic goals, parental expectations, intergenerational transmission

The early years are crucial for emotional and relational development, especially when trauma occurs during the pre- and perinatal period. Research

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shows that adverse neonatal experiences, such as medical interventions or early separation, can have lasting effects on emotional regulation and behavior (Emerson, 2020; Perry & Szalavitz, 2017; Schore, 2015). Play therapy is effective for young children to express and resolve internal conflicts, particularly from preverbal trauma (Cochran et al., 2023; Norton & Norton, 2010a).

Among play therapy approaches, Experiential Play Therapy (EPT) offers a uniquely embodied, child-led model that emphasizes co-regulation, symbolic expression, and repair of early relational wounds. Rooted in Gestalt therapy and somatic psychology, EPT draws on the body's implicit memory systems and relational field to facilitate healing (Townsend et al., 2021). Establishing clinical objectives in EPT requires a nuanced approach, as this therapeutic model prioritizes emotional expression, self-discovery, and healing through play (Norton & Norton, 2010a, 2010b). Unlike directive approaches that emphasize symptom reduction and behavioral modification, EPT resists narrowly defined goals to focus on the child's internal world and natural developmental process (e.g., Kottman & Ashby, 2024).

Therapists trained in process-oriented models, e.g., EPT, often face the challenge of reconciling broad, growth-focused goals with caregivers' desire for measurable behavioral outcomes (DiFederico, 2021; Kestly, 2014). Rather than imposing structured interventions, EPT emphasizes therapeutic attunement and flexibility, allowing play to unfold in a manner responsive to each child's emotional needs. EPT incorporates the caregiver in sessions when therapeutically indicated but allows the child to determine if and when the caregiver is needed in the room, typically as a secure base rather than active agent, a trauma-sensitive approach that preserves the child-led nature of the therapy (Norton & Norton, 2010a, 2010b).

In EPT, formulation involves linking the caregiver's working models of relationships with the child's behavior and early imprints through play therapy. The *working model* describes the internalized beliefs and expectations about relationships caregivers develop based on their attachment histories (Medina et al., 2025), which significantly influence how they perceive and respond to their child's behaviors. For instance, parents who view the world as unpredictable or threatening may unknowingly project these fears onto their children, shaping how they interpret their child's distress or resistance. *Imprints* are the deeply ingrained patterns and emotional responses formed during early experiences, such as prenatal, birth, or early relational trauma (e.g., Emerson, 2020; Evertz,

2021). Children who experienced medical interventions at birth, prolonged separation from caregivers, or high maternal anxiety in utero often develop implicit, body-based memories of distress that manifest in play behaviors and relational difficulties (e.g., Perry & Szalavitz, 2017).

A structured parent consultation process bridges play therapy principles and parental expectations. Parents often enter therapy with goals related to observable behavior, such as reducing tantrums. However, in EPT, progress is often seen in symbolic shifts in play, increased emotional regulation, and changes in relational patterns rather than immediate symptom reduction (e.g., Schore, 2015). Thus, it is critical to help parents recognize play themes as reflections of the child's inner world rather than random actions. Highlighting these markers of progress reassures parents that therapeutic change is occurring. A key component of parent consultation is reframing problematic behaviors as manifestations of early imprints rather than oppositional or defiant conduct. Children with early trauma may display behaviors that seem resistant, avoidant, or overly dependent. Parents may interpret these behaviors through the lens of their own working models, assuming their child is "too sensitive" or "difficult." Therapists can reframe these behaviors as adaptive responses to past stressors, helping parents respond with empathy and co-regulation (Perry & Szalavitz, 2017). Educating parents about how their own anxieties and interpretations influence their child's behaviors is a goal of consultation to help them shift their interactions and foster a more attuned relational dynamic (Chow, 2024; Grummitt et al., 2022), thereby reducing the transgenerational transmission of dysfunctional family dynamics.

This article explores the integration of EPT with structured parent consultation to support both child-led healing and parental insight through two case studies from a larger qualitative study investigating early trauma imprints (Devecigil & Wade, 2024). In both cases—featuring 3.5-year-old children presenting with behavioral challenges—therapists used symbolic play to access neonatal imprints while also helping caregivers revise their working models and interpret behaviors through a trauma-informed lens. These case studies demonstrate that when EPT is coupled with intentional, developmentally attuned parental consultation, therapy can bridge the often divergent objectives of deep emotional processing and concrete behavioral change.

Such integrative work not only supports healing in the individual child but may also interrupt intergenerational cycles of trauma, fostering more secure relational templates within families (Chow, 2024; Siegel & Bryson, 2020).

Through this dual focus, the present study contributes to a growing literature advocating for trauma-informed, relationally integrated, and developmentally sensitive approaches to early childhood therapy.

Methods

These two cases were part of a larger qualitative study exploring prenatal precursors of colic through play therapy sessions and interviews with mothers and EPT therapists (Devecigil & Wade, 2024). The larger study comprised 23 mother-and-child pairs, including 11 boys and 12 girls aged 31-58 months. The children were not otherwise under therapeutic care; were not taking prescribed medications; had no known previous trauma, genetic conditions, or developmental delays; and were living with their biological mother. Children with and without a history of colic, born vaginally and via cesarean section, were included. The two case studies below were chosen from this sample to illustrate contrasting presentations and histories, yet similar clinical approach and efficacy.

After interviewing the mothers, children in the larger study were assigned to certified EPT therapists who employed a modified EPT format to access womb and birth experiences in a series of up to 12 weekly 40-minute sessions with each child, followed by a 10-minute consultation with the mother. During the initial session, the purpose of the play sessions was explained to the child. Subsequent sessions began with the therapist and child and/or the mother and ended with the mother alone. All sessions took place in the first author's Istanbul office, furnished with video-recording equipment and symbolic toys.

The study was conducted in accordance with the ethical standards of the American Psychological Association and approved by the Human Research Review Committee of the California Institute of Integral Studies in San Francisco.es

Case Analysis: Barbara, 3.5 years old

Barbara's mother brought her to therapy for persistent nail-biting, avoidance of meeting new people, difficulty socializing with peers, frequent unexplained crying, shouting, and tantrums. Barbara's clinginess and separation difficulty particularly troubled her mother. Barbara avoided familiar friends, behaving as if they were strangers. At school, she often stood aloof and

distant. At home, she persistently asked her mother to play with her, indicating stress about potential separation.

Caregiver's Working Model of Relationships

Barbara's mother had a highly anxious disposition shaped by her childhood of allergic asthma, bronchitis, verbal abuse from her alcoholic father, and psychiatric medication use. Her anxiety increased after the 2023 earthquake in Türkiye. Her background suggested a working model of the world as unpredictable and threatening, requiring constant vigilance and control (Medina et al., 2025). It was hypothesized that she might project her anxieties onto Barbara, fearing that Barbara might suffer similarly or that she might not be able to protect Barbara adequately, as evident when she described Barbara as shy, cautious, quick to give up, and anxious, mirroring her own traits. She thought Barbara's anxiety would lead to introversion and difficulty with everyday challenges.

Barbara's mother was particularly attuned to behaviors that triggered her own anxieties, such as Barbara's crying, nail-biting, and resistance to self-care tasks like brushing her hair, which she tended to interpret as signs of anxiety and a lack of resilience, reinforcing her own fears. Barbara likely internalized her mother's anxieties and beliefs about herself, leading to behaviors such as transition difficulties. She might have perceived herself as needing to be cautious and having anxiety, attributes reinforced by her mother's responses. Her behavior confirmed her mother's expectations, creating a cycle of reinforcement.

The primary goals for therapy were to reduce separation anxiety and nail-biting. Progress was tracked through changes in play themes and caregiver reports. Given Barbara's separation anxiety, she initially insisted on having her mother in the sessions, which proved therapeutically beneficial. Having the mother actively participate in play helped her understand Barbara's inner world, and the therapist modeled how to offer comfort and attunement. Parent consultations focused on Barbara's play themes and helping the mother recognize how her working model shaped her interpretations of Barbara's behavior (VanFleet, 2015).

Early Imprints and Their Impact on Behavior

Barbara was the result of a planned pregnancy and vaginal birth. During the pregnancy, Barbara's mother underwent more than eight ultrasounds. In Türkiye, frequent ultrasounds are often part of regular prenatal care to monitor the baby's development and address maternal anxiety. In the last months of her pregnancy, she experienced edema and nerve compression that rendered her hands unusable. Labor began at 42 weeks. At the last moment, the doctor suggested a water birth because he said Barbara was very active and needed to be slowed down. Upon arriving at the hospital, Barbara's mother was well dilated, and Barbara was born within three hours. Barbara was taken to the neonatal intensive care unit (NICU) for meconium aspiration and started on antibiotics. Seeing Barbara connected to many devices was very difficult for the parents. COVID-19 restrictions prevented them from visiting the NICU often. Three days later, they moved into a hospital room with Barbara, whose voice was hoarse from excessive crying.

A mother's anxiety during pregnancy can imprint a sense of hypervigilance and stress on the fetus (Glover et al., 2021), which may manifest as heightened sensitivity to stress and anxiety. Separation in the NICU was extremely distressing for Barbara, which likely contributed to her resistance to separation and difficulties with self-care tasks. Such events, coupled with the discomfort of NICU interventions, can create imprints of abandonment and physical pain (e.g., Chamberlain, 2014).

Initial Exploratory Session

The initial EPT session is exploratory and foundational, establishing trust between therapist and child, and creating a safe space where the child can begin to express their inner world through play (Kottman & Ashby, 2024). Themes that emerge during these initial sessions typically foreshadow the central issues that will be addressed throughout therapy (Norton & Norton, 2010b). Barbara touched the end of the tunnel toy while standing beside her mother, and the therapist mirrored her actions. Barbara asked the therapist, "Do you have a wound?" while pointing to an imaginary wound on her leg. She took out the toy doctor's kit, examined each item, and applied Band-Aids to herself and her mother. While playing with a dinosaur toy, she reassured her mother and the therapist, saying, "It doesn't bite" and "It didn't hurt." She then checked the therapist's and mother's heartbeats.

By asking the therapist about a wound and showing her imaginary pain, Barbara was likely expressing experiences from the NICU interventions. Children who have undergone medical trauma often use play to process their experiences and emotions (Frawley & Dillman Taylor, 2024). Barbara might have been attempting to reassure herself and others through self-soothing statements, reflecting her internal struggle with fear and pain (Kestly, 2014). Checking heartbeats suggests Barbara's need to ensure her caregivers' well-being, likely stemming from her NICU separation anxiety. Heightened sensitivity to others' emotional states is a common coping mechanism in children with early trauma (Lyons-Ruth et al., 2006).

Validating the Initial Formulation

The initial formulation was supported by analysis of sessions 2-4. In session 2, Barbara played with balls, brushed her mother's hair, and fed the therapist. She restrained her mother with toy handcuffs. She gave the therapist and her mother a baby doll to dress and prepare for school, asking the therapist to make the baby swim. In session 3, Barbara again handcuffed her mother, asked the therapist and her mother to rub toy guns and knives together, and engaged in roleplay being a bee "biting." In session 4, Barbara held her mother's hand tightly, and they built a tower together with Legos. They played house inside the tent, and Barbara initiated a game of scaring the therapist by hiding and peeking out from the tent, saying "boo." Barbara's play consistently revisited certain themes.

Theme: *Nurturing and Caregiving*. Barbara's play emphasized nurturing and caregiving activities, such as brushing her mother's hair and feeding the therapist, reflecting her need to reconstruct and make sense of the disrupted nurturing during her early life. Handcuffing her mother, perhaps, symbolized Barbara's feelings of helplessness and desire for control in caregiving situations. The tent and feeding games symbolized a safe space and nurturing, which were disrupted by early separation. Building a tower symbolized unity and growth, connected to her need for secure and nurturing relationships.

Theme: *Control and Helplessness*. Barbara struggled with vulnerability and the need for control. Handcuffing her mother, asking the therapist to make the baby swim, and giving dolls to the mother and therapist to prepare for school symbolized attempts to gain control over her environment, reflecting early helplessness in the face of medical intervention and separation. The

handcuffing, guns, and knives suggested an ongoing struggle with feelings of vulnerability and aggression. The creation of a home in the tent and the "boo" game symbolized attempts to establish control and security in her environment. Play allows children to experiment with power and work through traumatic experiences in a safe environment, regaining a sense of control (Frawley & Dillman Taylor, 2024).

The analysis of Barbara's sessions validated the initial formulation that her play behaviors were connected to early imprints and her mother's working model of relationships. Understanding these linkages enables a therapist to help parents comprehend the roots of their child's behaviors, thereby breaking the cycle of intergenerational transmission and fostering healthier family dynamics. It was important to explain to the mother that Barbara's resistance to self-care tasks might be related to invasive NICU procedures, imprints that can heighten sensitivity to touch, and discomfort with personal care activities. Similarly, Barbara's anxiety about getting ready for school and other transitions might be linked to neonatal separation. These explanations could help the mother understand that Barbara's resistance was a normal response to past experiences rather than willful defiance, which could reduce the mother's frustration and increase empathy.

It was important to help the mother understand how her belief that Barbara was shy and cautious might stem from her own childhood experiences (Chow, 2024). Assisting her to see Barbara's behaviors through a lens of sensory processing and early trauma could help her respond more supportively and reduce the cycle of negative expectations and behaviors. Helping parents become aware of their unconscious projections can free them to learn developmentally appropriate child-rearing practices.

Deepening Themes and Process Arc

Sessions 5-7: Deepening Themes of *Pain and Fear*. Barbara played in the sandbox (bulghur is used in place of sand), throwing sand at mother and therapist, and pretending she was swimming like a baby in the sandbox. She continued to play inside the tent, scaring the therapist with her mother by saying "boo," and role-playing insects like bees and flies. All of these pointed to attempts to process pain sensations from her NICU intervention. Her mother reported that Barbara had stayed at her grandmother's house for the first time without her.

Sessions 8 and 9: *Gradual Separation and Autonomy*. Barbara began incorporating nurturing and positive themes in her play, such as cooking and feeding her mother and the therapist. She brushed her mother's hair, indicating a shift towards healing. Barbara's use of doctor tools, pretending to have pain in her leg, and asking her mother to apply bandages, showed her processing of medical trauma alongside positive interactions. Her greatest milestone happened in session 9, when she entered the tent alone for the first time. Her mother, accustomed to always being included, asked if she should come inside. Barbara declined, choosing instead to play independently. Afterwards, her mother said she felt both proud and slightly left out, acknowledging her separation anxieties. The tent play also changed: instead of feeding her mother, Barbara now fed baby figures, signaling more emotional independence (Schore, 2015).

Session Conclusion: *Integration and Secure Attachment*. Barbara's final session showed full integration of earlier themes. She still played medical scenarios, but no longer needed her mother's constant presence. Her mother said Barbara was far more confident in separating from her in daily life and that nail-biting had decreased. Barbara's mother had also grown significantly, learning to trust Barbara's emotional process. She began offering nurturing integrations without fear of reinforcing dependency, understanding that temporary regression had been a necessary step in Barbara's healing process. The combination of play therapy and parent consultation allowed Barbara's therapy to be both child-led and parent-supported, reinforcing progress inside and outside the sessions (Siegel & Bryson, 2020).

Barbara's case highlights the importance of attuned parental involvement in play therapy. Having her mother participate early and then gradually step back allowed Barbara to experience safe attachment while building autonomy. By session 10, Barbara had built the internal capacity to separate with confidence. The mother's behavior evolved from struggling with frustration and misunderstanding Barbara's behaviors to recognizing them as expressions of early trauma and responding empathetically. Moreover, she gained insight into how her past influenced her perceptions of Barbara.

With the therapist's help, she told Barbara her birth story when they were at home and apologized for all the hardship that happened to her, which validated Barbara's experiences by acknowledging her early struggles and feelings (Siegel & Bryson, 2020). Storytelling helps children make sense of their past and integrate those experiences into their personal narrative, fostering

resilience (e.g., Schore, 2015). The mother's apology helped restore their disrupted bond, showing Barbara that her feelings were understood and valued. The mother also began to implement more supportive parenting practices, such as allowing Barbara to take her time with transitions and providing reassurance during moments of anxiety. She became more aware of her stress and its impact on Barbara, working to create a calmer, more nurturing home environment.

Case Analysis: Zayne, 3.5 years old

Zayne was brought to therapy primarily because of toileting issues, which had begun after toilet training, coinciding with the arrival of a babysitter who stayed for 10 months when the mother returned to work. He sometimes held his bowel movements for two days and held his urine all day at school. After the babysitter left, Zayne relaxed, but the issues resurfaced with the transition to school. Zayne also tended to put everything in his mouth and would often deliberately spill his drink while looking at his mother. He screamed when leaving the house, a behavior his mother attributed to once telling him to be quiet so as not to disturb the neighbors. Despite repeated warnings, he continued this behavior, which angered his mother. She believed Zayne might be seeking parental attention, and she often responded with anger and shouting, which she knew set a poor example. She noted that Zayne challenged her more when he sensed her frustration.

Transitions were particularly difficult for Zayne, and he experienced minor accidents almost daily, such as falls or bumps. When in pain or sick, he became clingier. He displayed aggression toward peers, hitting them frequently. The mother said her husband's parenting style tended to apply pressure and force, while she preferred repetition and explanation. Both parents were often frustrated in their interactions with Zayne.

Caregiver's Working Model of Relationships

Zayne's mother came from a conservative family, and her history suggested unresolved trauma and anxiety. Although she denied domestic violence during her upbringing, her body language indicated otherwise, including avoiding eye contact and a meaningless, inappropriate smile (e.g., Siegel & Bryson, 2020). She managed stress by avoiding tense situations and diverting her attention to other things, a strategy developed in childhood. Her reserve about her past suggested a history of unprocessed emotional difficulties.

Zayne likely internalized his mother's unresolved trauma, anxiety, and avoidance, manifesting them in key behaviors, such as withholding urine to avoid the stress of using the school bathroom (Fearon et al., 2019). His difficulty with transitions and clinginess also suggested internalized anxiety. Deliberately spilling drinks and screaming might be his way of seeking attention and validation from his mother, mirroring her own need for recognition, which might have been missing during her upbringing (e.g., Reyes et al., 2024). Zayne's aggression towards peers and almost daily accidents suggested that he internalized his mother's frustration and anger, which she might project during her interactions with him (Perry & Szalavitz, 2017). Zayne's need for control over his bodily functions might reflect internalization of his mother's control issues stemming from her past (Schore, 2015).

Imprints

Zayne was born vaginally after a difficult 18-hour labor, involving a vacuum and artificial contractions. He stayed in the NICU for six days for an infection caused by the prolonged labor. Born at 37 weeks, weighing 2.5 kg, his initial months showed delayed development, which later normalized. The NICU stay and painful birth likely imprinted feelings of physical discomfort and separation anxiety (Emerson, 2020). Additionally, Zayne's early feeding seemed to have left a significant imprint. His mother regretted starting him on solid foods at six months, noting that, although he ate, he was not aware of having food in his mouth, suggesting early sensory processing issues or dissociation from sensations, which could be linked to the traumatic birth and NICU experiences, perhaps connected to his putting objects in his mouth and deliberately spilling drinks.

Zayne's retention of stool and urine, coinciding with his mother's return to work, suggested an imprint from the traumatic labor and NICU separation, possibly exacerbated by early toilet training. The stress and discomfort associated with these transitions likely reinforced his anxiety and control issues (Assimamaw et al., 2024; Schore, 2015). His mother's observation that Zayne often challenged her more when she was frustrated highlighted the cyclical nature of their interactions, in which Zayne's behaviors might be attempts for control and attention in response to his mother's emotional state (Siegel & Bryson, 2020). Zayne's almost daily falls and bumps could be further manifestations of these early imprints, with his need for additional comfort

when in pain. His aggression towards peers might be expressions of unresolved trauma and a need for security, compounded by his mother's avoidance and difficulty providing consistent emotional support (Perry & Szalavitz, 2017).

Exploratory Session

In session 1, Zayne headed straight for the cars and said one of them had lost its electricity. He lay in the sandbox as if swimming, pushing his body against the edges. He then took the guns and handcuffs. He picked up a toy train, calling it a car with a toilet, which he showed his mother. He looked through toy binoculars and said another car had a toilet. He showed his mother the tent and crawled around the sandbox with a car, using regressed body movements. He asked, "Mom, this car's wheels don't turn, right?" before burying the car and turning it into a game, burying and revealing it. He put sand in his mouth and ears, then shot the therapist with a toy gun while obviously in a dissociated state. He fired two toy machine guns and entered the egg chair, calling it a toilet. He threw a baby doll and its cradle to the ground, then asked the therapist to spin him quickly in the egg chair. His feet stuck out slightly as he played a game about visibility. The therapist, suspecting from his body language that he needed to urinate and worried he might do so (since he said the chair was a toilet), reassured him there was no toilet there. He shot at his mother and said the car's wheels could not move. He opened a doctor's bag and took out a bandage. He had a hard time leaving the session.

Zayne's swimming and pushing against the walls of the sandbox could be interpreted as feeling confined or trapped, echoing his NICU experience (Emerson, 2020). The visibility games might symbolize his feelings of being seen or unseen by his mother and others, possibly related to the parents' frustration with him. The broken and powerless cars might symbolize feelings of inadequacy or a sense that something is inherently wrong with him, possibly mirroring his mother's anxieties about him (Homeyer & Sweeney, 2022).

Zayne's fascination with a toilet and aggressive actions towards mother and therapist with the guns might represent his internal conflict and anger regarding toilet training and control, or his perception of his mother's aggression towards him during toilet training (Frawley & Dillman Taylor, 2024). His dissociation indicated a coping mechanism to deal with overwhelming emotions, perhaps related to his NICU experiences, where medical procedures might have involved mouth and ear discomfort (Ogden, 2021). Calling the egg chair a toilet

and asking to be spun might reflect his need for control and release, as well as a desire to reenact and process his traumatic experiences in a safe environment (Cummings et al., 2017). The use of binoculars could be a metaphor for attempting to bring distant or hidden issues into focus, possibly reflecting his need to gain clarity on matters not immediately apparent or acknowledged (Homeyer & Sweeney, 2022).

Validating the Initial Formulation

In sessions 2-4, Zayne repeated many of the same behaviors, playing with cars, stating they did not work, burying and revealing them, and toying with handcuffs. He made baby noises and moved around on his knees. He spent a long time shooting a toy gun and pretending to kill the therapist. He approached his mother with a car, calling it a toilet, and ignored her offer to go to the bathroom. He used handcuffs and Legos to create scenarios of being trapped and rescued. He again exhibited difficulty leaving the session, showing anxiety and a need for control (Perry & Szalavitz, 2017). In sessions 3 and 4, Zayne repeated his regressed sandbox play and engagement with the car as a self-object, noting that the wheels were broken, covering it with sand, and calling it dirty and ugly. He used a monster toy to scare the therapist and pretended to cut and shoot the therapist and the mother. In session 4, Zayne said, "Mom gets angry," poured sand on the therapist's head, and pretended to hit and scare the therapist and mother with a monster toy, while assigning roles and directing the play.

Theme: *Control and Helplessness*. Zayne's play consistently involved themes of control and helplessness. His use of handcuffs and scenarios where he controlled or was controlled reflected his struggle with feeling trapped and a need to regain a sense of control, likely stemming from the NICU intervention and separation (Perry & Szalavitz, 2017). His car play symbolized feelings of inadequacy and being fundamentally flawed, mirroring his mother's anxieties.

Theme: *Aggression and Frustration*. Zayne's aggressive play signaled internalized anger and frustration, indicating his perception of his mother's aggression, his struggle to process these emotions, and probably reenacting being trapped and in pain in the NICU (Perry & Szalavitz, 2017). His dissociation was likely a coping mechanism to deal with overwhelming stress.

Theme: *Visibility and Recognition*. The visibility game symbolized Zayne's internal conflict about being seen and recognized, probably reflecting

his mother's avoidance and frustration (Chow, 2024). Zayne's regressed behaviors indicated his struggle with early developmental trauma in the NICU, subsequent sensory sensitivities, and a need for sensory comfort.

The initial formulation that Zayne's play behaviors were intertwined with his early imprints and his mother's working model was supported. Thus, it was important to explain to Zayne's mother that his resistance to using the toilet might be linked to painful and invasive procedures in the NICU, which can lead to heightened sensitivity to touch and discomfort with personal care activities (Castellino, 2004). Delving into what occurred during toilet training and helping the mother recognize her role in it was essential, especially helping her see that Zayne's resistance was a normal response to past experiences rather than willful defiance. Reframing Zayne's behavior could reduce her frustration and increase her empathy. Additionally, it was important to explain that Zayne's anxiety about school and other transitions might be linked to separation from his parents in the NICU. Increasing awareness of how her avoidance might influence Zayne was crucial in enabling her to discern the unconscious repetition of her past in the present and her distorted perceptions of Zayne, ultimately leading to the development of child-rearing methods that were developmentally appropriate.

Deepening Themes and Process Arc

Sessions 5-7: Deepening Themes of *Pain and Fear*. Zayne's play continued to display deep-seated feelings of pain, fear, and aggression. In Session 5, he played in the sandbox, often appearing dissociated, making baby noises, and using toy trains as cars. He engaged in nurturing behaviors, like making a dessert for his mother, while also pretending to shoot the therapist and mother. Crawling through the tunnel and using doctor tools suggested a re-enactment of his NICU experiences. In Session 6, Zayne threw sand at the therapist, repeated shooting toy guns, hit a doll, and asked if it was afraid. He role-played a doctor. He put sand in the pacifier and the baby doll's mouth. Session 7 continued Zayne's alternating between comforting and hurting dolls and directing the therapist to enact specific roles. He played with the egg chair and its role as a toilet.

Sessions 8 and 9: *Integrating Positive Sensations*. Zayne's play began to incorporate more positive and nurturing themes, although aggressive behaviors persisted. He alternated between gentle care and harming dolls. He asked his

mother and therapist to play roles that reinforced his feelings of control and validation. His play with the therapist, in which he pretended to be a lion, involved him putting protectors on his fingers and then having the therapist pretend to bite them, a sign that he was exploring boundaries and power dynamics in a safer way.

Sessions 10-12: *Mastery Themes and Final Integration*. Zayne expressed a desire to regress: "Mom, I want to be a baby." His play included themes of control and defiance, such as imprisoning the therapist and dismembering a doll. He alternately harmed and protected the doll. Some of his pretend play involved dirty underpants and a toilet. In sessions 11 and 12, mastery themes emerged more clearly. Zayne no longer relied on aggression but instead found ways to incorporate nurturing and problem-solving skills. By session 12, his toileting anxiety had significantly decreased.

Resolution of Therapy

Zayne's therapy will be concluded when he demonstrates consistent behaviors indicating resolution of his initial issues. His integration of nurturing and painful themes indicated a healthier processing of traumatic imprints. Improved emotional regulation and reduced aggression towards peers will be key signs of progress (Cochran et al., 2023). Zayne's mother's transformation was crucial to the success of therapy. She shifted from viewing Zayne's behaviors as defiance to recognizing them as expressions of trauma and responding more empathetically. She told Zayne his birth story at home and apologized for the hardship he had suffered, including apologizing for later struggles and wrongdoings during toilet training. She engaged in more nurturing parenting practices.

Discussion

These two cases illustrate the range and diversity of issues that can be successfully addressed using methods to validate the initial formulation linking a child's problematic behaviors to early imprints and the parents' working model of relationships. This approach addresses the need for play therapy to emerge dynamically while also meeting parents' objectives for concrete information. The examples demonstrate that the same principles are effective with different presenting problems, even when the trauma histories vary in type and severity.

Nevertheless, it is important to qualify the results. The study was delimited to an urban Turkish population, which affects generalizability since birth practices vary by culture, socioeconomic status, region, and so forth. The focus on children aged 2.5 to 4 years enhanced comparability but limited generalizability. Moreover, mothers' reasons for participating and maternal characteristics varied widely, adding more diversity to the sample. However, using only two case histories does not show the robustness of the findings from the larger study (Devecigil & Wade, 2024), which were consistent with the dynamics illustrated here.

By allowing play to develop naturally, therapists can observe and interpret the underlying issues driving the child's behavior. This method respects the child's readiness to explore and process their experiences, fostering the safety and trust essential for effective therapy (Kottman & Ashby, 2024). At the same time, the therapist's explanations help parents connect play behaviors and early experiences, providing the concrete information they seek and assurance that their goals of behavior change may be met. Providing insight to parents about their projections helps widen their window of tolerance regarding the child's expressiveness of historical dynamics outside the therapy session. Developing and sharing the working model of the caregivers' perceptions and relationship patterns helps them understand how their own early experiences affect their child's behavior as well as their interpretation of it. Without a clear formulation, therapy can lack direction, become scattered, and potentially extend for months without significant progress. A structured framework ensures that therapy remains focused and effective (Cochran et al., 2023; Derdikman Eiron, 2021).

Conclusion

These cases demonstrate that formulation is not a rigid script, but a flexible guide, and how the same therapeutic model can be adapted to diverse needs and varying levels of complexity. While the approach may not offer an immediate solution, it effectively addresses the root of the child's issues, leading to more sustainable, long-term improvements and helping parents break the cycle of intergenerational transmission of maladaptive behaviors. By creating space for preverbal trauma to emerge symbolically through play, EPT offers young children an embodied pathway toward integration and relational repair. Working simultaneously with the child's inner symbolic world and the caregiver's outer interpretive framework honors the intersubjective and

intergenerational nature of healing. It moves beyond symptom management toward a deeper reweaving of the parent-child relationship. Such integration holds particular relevance for neonatal and perinatal trauma, where early rupture often remains unspoken yet profoundly impactful. For practitioners working in early childhood mental health, these findings underscore the necessity of holding both child-led expression and parental transformation as coequal therapeutic goals. Future research should continue to explore how somatic, play-based modalities can interface with caregiver insight to support lasting, systemic healing within families.

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