**EXPERTS IN PLAY:**

**EXPLORING THE DEVELOPMENT AND USE OF PLAY-BASED**

**EVALUATION METHODS IN FACILITATING CHILDREN'S VIEWS OF**

**NON-DIRECTIVE PLAY THERAPY**

**VOLUME ONE**

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# ABSTRACT

**Aims**

This study investigates the use of play-based evaluation methods, developed by the author, in non-directive play therapy practice. A review of the child therapy literature demonstrates that there has been limited development of child-centred methods to ascertain children's views. Whilst there has been development of appropriate methods for gathering children's views in other settings, these do not fully translate to the complex setting of therapeutic interactions. The study aims to record children's views of play therapy as expressed through play-based evaluations; explore their use as a new method and, finally, explore what conditions are needed to fully facilitate children's exploration and sharing of their views when using play-based evaluations.

**Methods**

The study employs a qualitative methodology utilising video observation as a less intrusive method for data collection of the children's views that are expressed during play-based evaluation. The videos are analysed in two main ways: to record the children's views and to explore the process between therapist and child during the interaction. Pre- and post- questionnaires are used to gain information regarding the children in the study and the therapists' perceptions. Utilisation of computer-assisted software, visual methods of analysis and in-depth micro-analysis of video observation are combined to create an innovative and thorough methodological approach. Exciting new methods of visual representation are employed to present the findings in a way that respects the need for participant anonymity whilst allowing the reader greater access to the non-verbal processes described.

**Conclusions**

The study shows that play-based evaluation techniques are important and flexible methods for facilitating children's views of child therapy. The study shows how therapists take different approaches to delivering the sessions. It is argued that those therapists who incorporate their therapeutic skills effectively, maintain flexibility and sensitively attune to the child during the session, enable the child to explore their views more fully.

## CONTENTS

## PART THREE:
## FINDINGS AND DISCUSSION

# TABLES

# ILLUSTRATIONS

## ACKNOWLEDGEMENTS

I would like to thank everyone who has contributed, advised, supported and helped me to 'complete the course'.

**DECLARATION**

Some of the material in chapter five in this thesis was previously published in:

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This article is included in the appendix.

## CHAPTER ONE
## INTRODUCTION

This study explores the use of play-based evaluation techniques in play therapy practice. The thesis is focused on two areas, first the children's views of play therapy expressed during play-based evaluations and second process issues evident during play-based evaluations.

In this first brief chapter I provide a personal reflexive account. I outline my interest in the topic and the development of play-based evaluation techniques. I describe the rationale for the study and proceed by describing the main details of the study and the structure of this thesis. In proceeding chapters I provide a review of the literature before turning to the methodology where I return to a reflexive style which is interwoven with an account of the methods employed. In the findings and discussion I continue these two interweaving strands of discourse albeit to a lesser extent.

## Background and Rationale

My interest in children's views has its roots in my professional background as a Children's Rights Officer and my experience of working with children with communication difficulties, where my work has focused on listening to the child's 'voice' in all modes: verbal and non-verbal. I was drawn to 'non-directive play therapy', referred to in this thesis as NDPT, due to the inherent respect for the child conveyed in this approach and the belief that, given the right conditions, the child will find their own way along the therapeutic journey to health (Wilson and Ryan, 2005). NDPT is a therapeutic approach to helping children and young people with emotional and behavioural difficulties that is based on Rogerian principles of person-centred counselling (for a detailed description of these approaches see Wilson and Ryan, 2005 and Rogers, 1951 respectively). This method of therapy follows the child's lead and develops at the child's pace. It is sometimes known as 'child-centred' play therapy[1]. There is a belief that the work should focus on the issues the child deems important rather than guiding them to particular issues believed to be important by their parents,

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[1] NDPT is sometimes referred to as humanistic or child-centred play therapy, particularly in America. In Britain the term child-centred is used more broadly, therefore the term NDPT is used here as it more commonly referred to in the UK where this study was undertaken.

teachers, other professionals and the therapist herself[2]. Through training and experience as a non-directive play therapist I witnessed these theoretical concepts realised in practice

However, when it came to the end of therapy, I felt there was something missing. While a child-centred ending is emphasised and promoted, the child's voice about what they thought to play therapy was often not sought. Instead parent reports or opinions from other professionals in the child's life, such as teachers or social workers, were often relied upon. Sometimes objective outcome measures were used to measure the child's 'experience'. Due to drives toward service-accountability within various different agencies in the UK[3], in which play therapists are employed, 'child-friendly' evaluations were sometimes offered. However, truly *child-centred* evaluations had not been developed. The evaluations in use were usually paper-based questionnaires for children to complete which felt incongruous with expressive approach I was using in the playroom. It seemed that when children's views were sought the agenda that was followed was often an adult agenda to meet political targets.

Turning to the literature and research base I found very little in the *child therapy* literature regarding child-centred evaluations. Jo Carroll's and Dorothy Brownlie's work - also play therapists by training - are notable exceptions. However, Carroll particularly describes a number of barriers to accessing children's views of therapy, including significant gatekeeping issues, the selection of children to the study being made by therapists rather than the researcher, the difficulty of accessing 'unconscious material' the influence of parents, some of whom were present in the interviews. I was interested in evaluation methods, to seek children's views, which could be integrated into day to day clinical practice, rather than relying on outside researchers undertaking 'one-off' short term evaluation projects.

There is of course a much wider and well-developed literature base on children's views in the broader context of services accessed by children. However, even here there are gaps, particularly in relation to ascertaining young children's views of complex experiences such as a therapeutic intervention. I will expand on this in chapter three.

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[2] While there are both male and female play therapists I use the feminine term 'herself' here and throughout this thesis to refer to the play therapist. This is for ease of reading and, while there are more male therapists joining the profession, it is still a female dominated role.
[3] Including an agency I worked within.

## Development of Play-Based Evaluation Techniques

Initially in my clinical practice I made a record of children's verbal and play responses expressed in play therapy sessions which alluded to children's thoughts and feelings about the play therapy process itself. I maintained this record throughout the process of the therapy intervention. While I felt that there was some merit in such an approach, I recognized that I was still very much in control of selecting what I believed to be salient and I was not giving the child the opportunity to comment on the process in their own right. During a training day which focused on directive play-therapy techniques I realized that one of the techniques, 'Broadcast News' (Kaduson, 2001), would be highly adaptable to interviewing children in a child-centred way. I revised and developed this technique. In its new evaluative form I re-named it the 'Expert Show'. I was driven to develop further techniques to gain children's views of the therapy they were receiving and adapted other play-based therapeutic or assessment techniques. I developed two further techniques at this point. First 'The Miniature Playroom', which was motivated by further training in play-based assessments, namely 'Story Stems' (for an overview see Woolgar, 1999). The second technique 'The Puppet Interview' was inspired by a child in my own clinical practice. This child had used puppets for the entire intervention. Thus the logical step seemed to be to use these for the evaluation session. These techniques will be discussed in full in chapter five.

I piloted these new techniques in my own practice with 12 children aged 5 ½ – 10 years old and felt that, with help from the children themselves and thoughtful supervision, several methods had been developed which might benefit the play therapy world at large (Jäger and Ryan, 2007). The techniques themselves had evolved over the first pilot period in my clinical practice. This led to my development of semi-structured interview schedules with clear guidelines for other therapists to use the play-based evaluation techniques with their own cases.

## Aims of the Study

The aims of the study were:

- To explore the use of play-based methods as evaluation tools.
- To contribute to the research on evaluating play therapy interventions with children and young people with emotional and behavioural problems
- To record children's views of play therapy interventions.
- To gather rich qualitative data on the process of play therapy.

- To further understand the ways children construct meaning with their therapists in shared, emotion-laden experiences through action-oriented, imaginative ways, in addition to their verbal memories for events.

Whilst the overall aims of the study remained consistent throughout the study the specific research questions posed were refined and added to as the study progressed. These research questions will be fully detailed in chapter six on the methodology and returned to throughout the presentation of my findings.


## Design of the Study

In addition to a literature review and a summary of the pilot study, this study consists of two phases of data collection and three stages of data analysis. The first phase in collecting data entailed training play therapists to create a sample of therapists who would use play-based evaluations in their own practice. I trained 32 other non-directive play therapists in the administration of play-based evaluation techniques. The second phase involved recruiting therapists and children to the study to collect data on the use of play-based evaluation. 7 of the trained therapists were recruited. These therapists video-taped the play-based evaluations they undertook with children. After gaining consent from parents and children, the therapists sent these videos to me for analysis along with a pre- and post-evaluation session questionnaire containing information about the child and intervention and the therapists' views. The resulting sample was 20 videos of therapist-child dyads undertaking a play-based evaluation session. The age of the children ranged from 5.6 years – 13.9 years.

The data analysis stage entailed three phases. First, an analysis and recording of the children's views expressed verbally and non-verbally through play and other forms of non-verbal communication. Second, an analysis of the process issues arising during play-based evaluations across all cases. This led onto a third area of in-depth micro-analysis of the process in four cases. I analysed segments of the video tapes focusing on the therapist-child interaction from an attachment perspective. I was specifically interested in the inhibitive and facilitative factors during the interaction and the impact this had on the child's ability to explore and express their views of play therapy.


### Influences on the study design

The final design of this study was influenced by my experience of gatekeeping difficulties when researching child therapy interventions. Following the initial pilot

study undertaken in my own clinical practice, described above, my plan had been to use the techniques along with other methods of data collection to gain children's, parents' and therapists' perspectives of a therapeutic intervention. It was my intention to be an 'outside' researcher using the techniques to interview the children at the end of their therapy intervention. However, I encountered some of the same difficulties as Carroll (2000) in terms of access and recruitment. I was only able to follow the entire research procedure with one family and had to abandon that particular project.

In a second attempt to incorporate play-based evaluations into a substantive study I joined a research team who were comparing and contrasting two group parenting programmes; Filial Play Therapy (see Bratton et. al. 2006) and The Webster Stratton Incredible Years Parenting Programme (see Webster-Stratton and Reid, 2008). However, recruitment difficulties and time constraints meant that I focused on the reported study. I have since returned to the data collected in this larger research project and I am currently completing the analysis and report.

These avenues of exploration with play-based evaluations are worthy of note as they enabled me to utilise play-based evaluations in two further settings as an 'outsider'. This helped to refine the interview schedules which were used to train therapists in the reported study. The difficulties in conducting studies which involved direct access to child participants and collection of a large amount of data led me to develop the methodology described above. Access to therapeutic encounters through video observation at the end of the intervention proved less intrusive. In addition this approach enabled me to promote participatory activity in play therapists own clinical practice.

**<u>Structure of the Thesis</u>**

In chapter two I provide the backdrop for this thesis by presenting an overview of the existing research-based literature on play therapy. I provide a brief history, description and rationale of play therapy. I focus on one particular form of play therapy, namely NDPT, which is the approach taken by therapists participating in this study. I proceed by reviewing the research into the efficacy of play therapy. I highlight the emphasis on conducting 'outcome' research which is reviewed alongside studies focusing on the 'process' of play therapy. A gap identified in the play therapy literature is the child's

perspective of the therapeutic process. This under-representation of children's views is not unique to play therapy.

In chapter three I broaden my literature base by reviewing the literature on gaining children's perspectives of their experiences more generally and set this in an historical Children's Rights context along with considering methods researchers have used to gain children's views of their experiences. I then return to the child therapy context and detail the studies in the play therapy context.

In chapter four I briefly review the literature on facilitative and inhibitive factors in therapeutic relationships. I argue that application of the extensive attachment and developmental literature base has proved fruitful in the context of both adult psychotherapy and play therapy. I detail McCluskey's (2005) study of video-taped adult-adult interactions in adult psychotherapy and argue that her application of Stern's work on affect attunement (mother-child interactions) is worthy of adaptation to the context of interactions within play therapy.

In the second part of this thesis I present the methodology. Chapter five details the pilot research. I argue more fully that using play based techniques to facilitate children's views of their therapy is an area which warrants development. I describe the four play-based techniques I developed and present the findings of my first pilot study using these techniques in my own clinical practice. I draw upon the findings of the further two studies mentioned above. I suggest that the findings from this pilot stage indicate that it is desirable for the child's own play therapist to undertake such evaluations as part of the therapists' own practice. I argue that video-recordings of such sessions provide the qualitative researcher with rich data for analysis.

In chapter six I outline the methodology of the main study. I describe the purpose and structure of the empirical study, the participants involved, and the procedure undertaken; including a consideration of the strengths and limitations of the methods employed. I highlight the ethical issues this research raises and address problems and dilemmas which occurred throughout the research process and how I resolved them.

In part three I present the findings and analysis of three key areas. First I present the children's views of play therapy as expressed in their evaluation sessions in chapter

seven. This is broken down into four sections: the beginning of play therapy, the middle, in terms of the environment and the middle in terms of the play therapists' role and relationship with the children, and the end of play therapy. I have chosen to present a discussion of the findings relating them to current literature after each main section. The therapists' views and understanding of the child's communication is interwoven in this presentation. I then dedicate a chapter to the micro-analysis of four dyads. This seems to demonstrate the importance of therapists being attuned to children's verbal and non-verbal communication during play-based evaluations to fully facilitate an exploration of their views. Next I present a chapter on further process issues observed. Here I consider the strengths and weaknesses of each technique, I comment upon the accessibility of these techniques for all children in therapy, in relation to age, gender, disability, and culture. I consider the contra-indicators for play-based evaluations and detail the power and consent issues evident in the sessions. Again I include a discussion of the findings after each of these sections.

In the final chapter the conclusions of the study are presented. This summarises the theoretical and practice implications made in chapters seven through nine for play therapists, those working in the therapeutic and helping profession, and child researchers from all disciplines. Areas of future research are highlighted.

# PART ONE:
# LITERATURE REVIEW

# CHAPTER TWO
## PLAY THERAPY: AN OVERVIEW OF THEORY
## AND PRACTICE BASED RESEARCH

## Introduction

In this chapter the context for this research is provided by defining and describing the intervention under study, namely play therapy. An account of the rationale for utilising play in child therapy is provided. There are many different strands of play therapy which will be briefly reviewed in this chapter. A fuller description of NDPT (Non-directive play therapy), the specific approach researched in this thesis, will be given. The development and research relating to this particular approach is detailed in this chapter. The chapter concludes by noting that although the child's 'voice' has been emphasised in the development of the approach, there has been a relative lack of listening to the child's 'voice' regarding the intervention itself.

## Play Therapy: A Definition

Play therapy is currently defined by the British Association of Play Therapists as:

> "…a way of helping children express their feelings and deal with their emotional problems, using play as the main communication tool" (2009).

Wilson, a proponent of NDPT, provides a definition which emphasises the interpersonal relationship aspect in play therapy:

> "…a means of creating intense relationship experiences between therapists and children or young people, in which play is the principal medium of communication" (2000:257)

In addition to the emphasis on relational aspects NDPT, is described as a 'non-intrusive' approach (Wilson and Ryan, 2005).

## The Use of Play in Child Therapy

As Bergen (1998:xi) notes "play is *pervasive*, infusing human activity throughout the lifespan".  Play has been recognised as an essential part of children's development across the disciplines and has been studied from a range of perspectives including

education, psychology, linguistics and sociology (see Fromberg and Bergen Eds., 1998). The numerous and overlapping functions of play from physical development, to language development through to social interactions have been studied extensively. Here the rationale for utilising play in child therapy specifically is considered. This issue has been explored and developed by a number of authors over time. The intrinsic value of play as therapeutic was recognised by Winnicott (1971:50) who stated: "Playing is itself a therapy."

Anna Freud and Melaine Klein both saw the value of play as a means of communicating with young clients. However, Axline (1989) was the first to *explicitly* emphasise that, rather than verbal language, play is the natural form of communication for children:

> "Play therapy is based upon the fact that play is the child's natural medium of self-expression. It is an opportunity which is given to the child to 'play out' his feelings and problems just as, in certain types of adult therapy, an individual 'talks out' his difficulties" (Axline, 1989:9)

Thus it was recognised that there were differences in the ways children and adults communicate and therefore utilising the medium of play was recognised as fruitful. As Bratton et. al. recently clarify:

> "Developmentally, children lack the cognitive ability to meaningfully communicate their thoughts, feelings, and experiences through the abstract means of verbal language. The concrete objects (toys, art, etc.) and other play-based experiences provided in play therapy afford children an age-appropriate and emotionally safe means to express their difficult experiences" (2005:1).

As Wilson and Ryan (2005) acknowledge, play takes many forms[4]. However, child therapy particularly utilises 'symbolic' play, sometimes referred to as 'imaginative' or 'pretend' play. They reason that play is an:

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[4] See 'A taxonomy of play types' (Hughes, 2002)

"…highly adaptive activity of childhood and has an organising function in development. It makes use of largely non-verbal symbols, and is one of the principal ways in which children develop understanding, explore conflicts and rehearse emotional and social skills." (2005:4)

**<u>Play Therapy: A Brief History</u>**

Play therapy first originated in the psychoanalytic field of therapy. Dorfman (1951) reports that Anna Freud and Melaine Klein were independently utilising play to translate psychoanalytic therapy to child clients. At these early stages it seems that Anna Freud, rather than using play as a integral part of the therapy, utilised it to develop a positive relationship between analyst and child, before the 'real work' began. Similarly Klein developed a 'Play Analysis' akin to adult-style free associations whereby play was directly interpreted to the child, again as a pre-cursor to more traditional verbal psychoanalysis.

Landreth (1991) reports that a significant development in play therapy was the work of Jesse Taft and Frederick Allen in the 1930's. They developed an approach termed 'relationship play therapy' which focused on the present, the here and now. The primary focus was reportedly the curing nature of an emotional relationship whereby the child was given responsibility for the growth process. David Levy's (1939) and Gove Hambidge's (1955) work entailed the therapist directing the child's play to 're-work' distressing events (cited in Landreth, 1991).

Adult person-centred psychotherapy developed by Carl Rogers expanded relationship therapy (see Rogers, 1951) and was adapted by Virgina Axline for child clients and named 'Non-directive play therapy'. The underlying premise of these humanistic approaches is that all humans have an innate drive toward health and well-being. There is an emphasis on trusting the child to lead the way. Dorfman (1951) cites the continued influence of some aspects of Freudian thinking on the development of NDPT including permissiveness, catharsis, finding meaning in apparently unmotivated behaviour and play as the child's natural language. She also highlights the influence of Rankian concepts including the reduction of power inherent in the 'analyst-patient' relationship by allowing the child to take the lead and responding to expressed feelings rather than 'analytic content'.

Wilson and Ryan (2005) report that the practice of NDPT experienced a period of lowered interest. They suggest it was hindered by both dubious use of the method and incomplete development of the theoretical underpinnings; not only in terms of developmental research and personality development, but the specific links with Rogerian psychotherapy. NDPT has since been modified and adapted to take into account current thinking in terms of theory and practice. Landreth in the US and Ryan and Wilson in the UK have published widely on these developments and the use of NDPT specifically (see for example, Landreth, 2001; 2002 and Ryan and Wilson, 1995; Wilson and Ryan, 2001; 2005, Ryan 2007).

Bratton et. al. (2005) acknowledge that the field of play therapy grew dramatically in the 1980's and 1990's and further development of directive approaches and other theoretical orientations grew. These include Gestalt play therapy (Oaklander, 1994); Alderian play therapy (Kottman, 1995) Ecosystem play therapy (O'Connor, 2000) and some authors recommend utilising different play-therapy approaches to fit with children's specific 'disorders' rather than following one approach (see Schaefer's 'Prescriptive play therapy 2001 and Schaefer and O'Connor, 1983). However, as stated above the focus in this study is on NDPT. Therefore a fuller description of this approach is provided below.

### Description of Non-Directive Play Therapy

Wilson and Ryan highlight Axline as the chief exponent of NDPT and acknowledge her significant and continued influence on practice. Those who do not follow non-directive practice themselves have commented on the value of some of Axline's principles. Winnicott (1971:68) commented on Axline's work being a good example of the possibility of undertaking psychotherapy at a deep level without making interpretative statements. He states:

> "…the significant moment is that at which the child surprises himself or herself. It is not the moment of my clever interpretations that is significant".

As stated above, NDPT is based on Rogerian person-centred psychotherapy, a humanistic approach utilising the core conditions of empathy, congruence and unconditional positive regard (see Rogers, 1951). Mearns and Thorne (2000:83) impress that the core conditions of the humanistic approach are an "attitudinal expression of a

belief system about human nature and development, and about the healing qualities of relationship". Axline proposed eight principles of NDPT. These detail the type of relationship the non-directive play therapist strives to develop with children in order to provide the responsive and accepting environment thought to be conducive to self-growth. These principles encompass warmth, acceptance, permissiveness, respect, patience and allowing the child to lead setting only those limits necessary to anchor the therapy in reality[5].

These principles continue to underlie NDPT today. Similar to Rogerian adult psychotherapy (see Mearns and Thorne, 2000) NDPT seems to have suffered from mis-interpretation. The term '*non*-directive' is most likely unhelpful here. Using negation to define an approach arguably contributes to critics and therapists within the profession mistakenly seeing the approach as one of passivity. The need to distinguish the approach in such a way can be understood in terms of the historical context. Rogers and Axline wanted to distance the approach from other methods where the therapist directed the clients to particular subject matter and used interpretation to bring about meaning (Wilson and Ryan, 2005). The authors suggest that this term, which was used to describe the central style of the therapist: reflection, has led to the implication that the therapist merely mirrors or parrots the client and that the client has 'free rein'. The term 'non-directive' was intended to illuminate one central part of the process: "encouragement to clients to identify and bring to the session what they wish" (2005:19). Wilson and Ryan (2005) clarify that in actuality Rogers was clear that the therapist does focus or direct her responses to the clients' feelings and behaviour

**Development of NDPT**

Wilson and Ryan (2005) have comprehensively set NDPT within the broader developmental frameworks of children's mental development. In particular Piaget's theory of cognitive development, Erikson's theory on emotional and social development and Bowlby's attachment theory are applied to NDPT. All of these theories have been drawn upon by a number of play therapy researchers to further our knowledge and understanding of the processes of NDPT. Attachment theory has been applied most extensively to deepen our understanding of the therapeutic relationship (for example see Ryan and Wilson, 1995; Ryan, 2004a, 2004b). Attachment theory, and

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[5] See appendix 1 for a full reproduction of Axline's eight principles.

its relevance to understanding therapeutic relationships, particularly within NDPT is explored more fully in chapter four.

An exciting development has been the foundation and development of Filial Play Therapy, a form of NDPT in which the therapist teaches and supervises parents/carers to undertake therapeutic play sessions with their own children (see Guerney, 1964 and more recently VanFleet and Guerney 2003; Van Fleet et. al., 2005). Whilst I focus on *individual* NDPT in this review, the influence of filial play therapy is important to acknowledge. There is a growing literature on including parents and carers in play therapy generally (see Hill, 2005 and Freisinger, 2005, unpublished). This qualitative literature and quantitative outcome research suggests that there are significant advantages in terms of outcomes and process when parents/carers are included in therapeutic work with children (reviewed below). This is recognised and reflected in play therapy practice, including the cases researched in this study. Many therapists are now involving parents to varying degrees during 'individual' NDPT interventions or after a period of individual sessions they are transferring the child, and family, to filial play therapy interventions.

In terms of NDPT practice a central issue which has been developed by Landreth and Guerney is the consolidation of the level of permissiveness to allow in the playroom. Whilst there is still variation in the practice of therapeutic limit setting the rationale and practice of setting limits has now been well explored and established. Most recently O'Sullivan and Ryan (2009) have expanded the theoretical underpinning of therapeutic limit setting within NDPT through the application of attachment theory. They explore the use of limits to provide emotional containment for the child and promote emotional self-regulation. I return to these concepts in chapter seven and explore the application of attachment theory in furthering our understanding of the process in NDPT in chapter eight.

A second practice issue which has received considerable attention and development in the UK is the use of congruence in NDPT. The practice of congruence within play therapy has received little attention in the literature. However, it has been taught in depth in the UK, certainly within one of the central training programmes[6]. Ryan and

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[6] At The University of York.

Courtney (2009) detail its use in their recent paper. It appears the application of Roger's core condition of congruence does not receive much emphasis in the training or practice of non-directive play therapists in the US. This would account for the lack of attention to this aspect of the humanistic approach applied to play therapy in the literature base[7].

The rationale, underlying philosophy, main principles and development of NDPT have now been described. I now turn to the research base and present the support for the effectiveness of the approach below.

**The Research Base**

As Wilson and Ryan (2005) assert, the play therapy research base is mostly American based. It has mainly been undertaken post 1970, over 2,200 publications were known of at the turn of the century (see Landreth, et.al. 2000). The vast majority of these studies have been 'process' studies. A wide range of children with varying presenting problems have been studied. However, Bratton and Ray's (2000:81) overview of experimental studies demonstrated that there is "sparse evidence of play therapy's effectiveness". More recently Wilson and Ryan (2005:20) conclude that both outcome and process based research remains scanty. I briefly review this research concentrating on studies focused on NDPT below.

**Outcome Studies**

Kazdin (2000) reports that there are more than 550 therapies used in the treatment of children and adolescents. Weisz and Kazdin (2003) highlight that whilst non-behavioural therapies are favoured in practice behavioural and cognitive-behavioural therapies account for 70% of the outcome research. Reviews of treatments for children and adolescents have been conducted by Carr (2000); Fonagy et. al. (2002)[8] and most recently by Kazdin and Weisz (2003). However, there is little evidence either for or against psychodynamic and humanistic based child therapies.

As Bratton et. al. (2005) highlight, similar to other forms of psychotherapy, there have been a number of play therapy studies which have not met rigorous scientific standards, additionally the majority of studies have included a small sample size and therefore

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[7] This is predominantly American.
[8] Findings included some evidence of effectiveness for systemic therapy with anorexia and depression and clear supporting evidence for CBT with general anxiety, phobia, depression, conduct disorder (in older children) and for some physical symptoms.

generalisability has been limited and resulted in exclusion to the aforementioned reviews. To address these limitations, several authors have conducted meta-analyses of the child psychotherapy literature. However, most of these included very few play therapy studies (Bratton et. al., 2005). Bratton et. al. argue that this has been due to play therapy not being seen as a viable method.

LeBlanc and Ritchie (2001) conducted the first meta-analysis of purely play therapy studies. This was based on 42 studies. They found an average treatment effect size of 0.66 standard deviation. This can be considered a medium treatment effect (Cohen; 1988)[9]. Bratton et. al. (2005) conducted a meta-analysis of treatment outcomes which doubled the number of studies reviewed by LeBlanc and Ritchie to expand their findings. Bratton et. al.'s study provides us with the most comprehensive evidence supporting the efficacy of play therapy. Their extensive literature search included unpublished studies which may have been rejected for publication due to small sample sizes. This was a strength of the study and addressed the oft-made criticism of meta-analyses of publication bias. They located 180 studies. These were screened and systematic criteria were applied. Their review included 93 controlled outcome studies on play and filial therapy published between 1953 and 2000. All of the studies "made use of a control or comparison group design, along with pre-and/or post measures, and reported sufficient statistical data to calculate treatment effect" (2005: 379). The average age of the child receiving play therapy was found to be 7.0 years and approximately ⅔ of participants were male.

Their results revealed a mean effect size of 0.80; a large treatment effect for play therapy interventions with children. Furthermore the authors found a significantly larger treatment effect size (p<.03) for 'humanistic' (NDPT) play therapy (mean effect size 0.92) compared to 'nonhumanistic' (or directive) treatments (mean effect size 0.71). The authors stress that *both* results show that both models can be considered effective. They also caution careful interpretation due to limitations in defining an intervention as humanistic or non-humanistic due to the limited information from the studies to draw upon. They highlight that there is often a lack of consistency in treatment within the two groups and there were far more studies in the humanistic category to draw upon (78%).

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[9] A small treatment effect would be denoted by a standard deviation of 0.20, a medium treatment effect a 0.50 and an effect size of 0.80 would be considered a large treatment effect, Cohen (1988).

The authors also found a significant difference ($p<.01$) when individual or group play therapy (mean effect size 0.72) was compared to filial therapy (1.15). The authors explore a number of possible explanations for such a difference including the likelihood that the children receiving filial therapy had fewer presenting problems at the point of referral. Similar to LeBlanc and Ritchie (2001) Bratton et. al. (2005:382) revealed a curvilinear relationship between number of sessions and effect size. The two studies report similar durations for optimal treatment effects: 30-35 and 35-40 sessions respectively. However, Bratton et. al. (2005) highlight that analysis of their results indicate the optimal number of sessions may be lower in filial therapy. In terms of child characteristics, the analysis revealed no difference in treatment effect across age, gender nor presenting issue.

Bratton et. al. (2005:385) conclude that whilst their study provides strong support for the efficacy of play therapy, their attempts to analyse the factors contributing to effectiveness were hampered by a lack of specificity in many of the studies. They highlight the continued need for well-designed studies to systematically address the relationship between treatment variables and treatment outcome. Furthermore they highlight the lack of studies that compare play therapy to another treatment intervention and call for future researchers to undertake such research.

Outcome research is undoubtedly important in establishing the effectiveness of play therapy, particularly in the current climate of accountability and focus on developing a 'scientific' evidence-base (Fonagy et. al. 2002; Kazdin and Weisz, 2003). However, the contribution of process studies should not be overlooked. The use of multiple research designs is advocated by the American Psychology Association[10] in their taskforce paper on evidence-based practice (2005:7-8). They acknowledge the benefits of different research designs answering different types of research questions. They assert that: "Psychological practice is a complex relational and technical enterprise that requires clinical and research attention to multiple, interacting sources of treatment effectiveness" (2005:8).

In Gilroy's recent overview of evidence-based practice, EBP for short, in the UK and it's relationship to art therapy she argues that "…art therapy should develop a pluralistic

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[10] Many American play therapists have a background in psychology and research directions are influenced by the APA's recommendations (Ryan, V., personal communication October 2009).

evidence base *appropriate to the discipline,* one that challenges the implicit hierarchies and beliefs that underpin evidence-based practice" (2006:2, italics added). This assertion is equally valid in play therapy. Gilroy particularly highlights the use of visual and creative research methods to explore visual, creative therapies. In addition she highlights the 'user's voices as important sources of 'evidence'.

Gilroy advocates the combination of quantitative and qualitative measures as a way of meeting the EBP agenda whilst finding an appropriate fit with the values and strengths of art therapy. Gilroy asserts that outcome studies need not conform to the standard format. Instead they could incorporate richer description of the intervention, narrative description, image replication and the client's voice to expose the 'interior' of art therapy interventions. This is a focus of the current study regarding play therapy interventions.

New initiatives such as the Quality Framework for Qualitative Research (Cabinet Office, 2003) are developing consensus on what constitutes high quality qualitative research. It is hoped that such initiatives will help to put qualitative research on a similar footing to experimental and quasi-experimental research. It is hoped that this will lead to the inclusion of qualitative research in systematic reviews such as the ones conducted by the Campbell Collaboration (Flick, 2007).

**Process Studies**

As stated above the majority of studies in play therapy have focused on 'process issues'. The initial research consisted of single case studies. The first in-depth case study in play therapy was Axline's dedicated book to a single case 'Dibs in Search of Self' (1964), which continues to be cited today, in generic child research sources, as an exemplar of detailed case studies illuminating complex processes to help us understand practice (see Greig, Taylor and Mackay, 2007). Many case studies have followed, both in the form of vignettes to illustrate particular approaches, techniques and processes (see for example, Landreth, 1991) and in the form of narrative case studies which provide greater depth, apply theory or present further analysis (see for example, Ryan and Wilson, 1996). It is beyond the scope of this review to detail them here[11]. However, a collection of case studies worthy of note are Ryan and Wilson's (1996) which includes a good level of

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[11] The reader is directed to Carroll (2000) for further discussion of the use of narrative case studies in the play therapy literature.

reflexivity and incorporates an 'unsuccessful' case[12] which is relatively unique for practitioner researchers.

Process studies, particularly single case studies in play therapy, have been criticised for their dependence on 'anecdotalism' and 'researcher bias' (see Cerio, 2001). Whilst the potential biases in case studies should not be denied (Yin, 2003), the historical context needs to be taken into consideration and a fuller understanding of the value of qualitative research, in particular the ways in which quantitative and qualitative research can work in collaboration rather than in opposition is needed. The need for further robust quantitative studies is clearly warranted. However, the value of qualitative approaches which follow systematic procedures and utilise the mechanisms available to enhance the quality of qualitative research (see, Flick, 2007) should not be minimised. I return to these issues in the methodology chapter of this thesis.

As Wilson and Ryan (2005) highlight there are a number of studies, such as Nordling and Guerney's (1999) which are based upon clinical observations and application of specific theoretical models which enhance our understanding of the therapeutic process in play therapy. In the UK Wilson and Ryan (2001) made a preliminary study of 11 children with mild behavioural/emotional difficulties, who had received short term NDPT[13] from trainee therapists which considered both process and outcome issues. Themes that the children addressed in therapy were tracked and analysed. The child's progress was independently rated by both authors following Kazdin et. al.'s (1990) criteria: an identifiable decrease in distress, psychological symptoms or maladaptive behaviour, or an identifiable improvement in pro-social behaviour. The reported presenting problems at the beginning of therapy, the records of the play therapy sessions,[14] and parental/referrer report at six month follow-up were used to assess progress. In 6 of the 11 cases substantial resolution was reportedly achieved, 4 showed partial resolution and 1 showed deterioration (reportedly following disclosure of child abuse). A further finding was that 10 of the 11 carers self-reported an improvement in their parenting skills or sense of well-being. Whilst this study was small it produced promising results and further work, particularly on tracking themes over the course of NDPT, to highlight process issues, is being developed (Ryan, 2008).

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[12] Further exploration of this case is provided in Ryan (2004) and the importance of exploring 'unsuccessful cases' is discussed further in this thesis in chapter eight.
[13] Eight sessions
[14] Drawn from transcripts of video or audio recordings

Josefi and Ryan's (2004) single case study of a 16 week intervention with an autistic child is a further example of the use of video recordings to track themes in play therapy. This was combined with quantitative analysis of the video-recordings, including an independent rater, to track observable changes in the therapist-child interaction. This included the type of activity initiated by the child and the type of interaction occurring between therapist and child. The findings highlighted an increase in pretend play and the child's development of autonomy. Parental report was also sought which corroborated findings.

The use of video recording is enabling greater access to analyse both outcome and process issues in play therapy. Systematic observational instruments are being developed to track process issues in play therapy (see Perry and Landreth, 1991 and Faust and Burns, 1991). Carroll (2000:15) argues that although these instruments may be able to track "verbal and some non-verbal interactions between therapist and child, the quality of the relationship will remain intangible". It seems that therapists can become anxious that our attempts to objectify and fully describe the 'therapeutic relationship' do not convey the richness of the experience.

Child therapy is by its nature a highly personal and sensitive process to study. Certainly those who have studied non-verbal interactions in adult psychotherapy have been criticised for conducting time-consuming research producing results which are clinically trivial (Davis and Hadiks, 1990). However, turning to the literature on parent-child interactions in the attachment literature (see Stern, 1985) and therapist-client interactions in the adult psychotherapy literature (see Scheflen, 1973 in family therapy, Charny, 1966, Davis and Hadiks, 1994 and McCluskey, 2005) provides a window into possibilities of undertaking observational analysis at a deep level to begin to capture the 'quality' of the relationship. These more sophisticated studies, which employ trained observers, have produced clinically important and interesting results. Here further attention to the non-verbal communication and the interaction between the dyad of mother and child or therapist and client is paid. This arguably reveals some of the nuances which comprise the 'quality' of a relationship. Making full use of less obtrusive methods to study therapeutic processes which enable systematic and thorough analysis is essential. This is a topic I return to in relation to the findings of this study in chapter nine.

Gilroy (2006) argues that the movement toward EBP tends to "provoke anxious reactivity rather than reflection and creativity" (2006:3). She argues that "EBP is a contested paradigm and a social and political phenomenon that should not be engaged with uncritically" (2006: 5). However, she urges arts therapists to do so. Equally play therapists need to be open to engaging with outcome based research and exploring a range of research methodologies to contribute to our understanding of the therapeutic relationship, rather than simply declaring that it is an enigma. As Gilroy, (2006) usefully asserts: "The arts and therapeutic practice involve relationship and are about individuals and diversity, and research comprises a hugely diverse range of methods and practices. *All* open up the world" (2006:3 italics added). One area of qualitative research which has received little attention is the children's views of the world of play therapy. I turn to discuss this next.

## The Child's Perspective

Wilson and Ryan (2005:2) acknowledge in their second edition that over the past decade there has been "increasing recognition of therapeutic needs of children" and that the importance of hearing children's voices has been emphasised by central government. Whilst the child's voice is arguably 'heard' *during* NDPT, as stated in chapter one, it is somewhat lacking in terms of their views of the therapy itself. For a therapy which emphasises the importance of listening to children on all levels, during the intervention, it is perhaps somewhat surprising that gaining the views of children about the intervention itself, in an equally child-centred manner, has received little attention.

One possible reason for the relative neglect of this area may be the dominance of US research in play therapy. Whilst the UK is moving toward an agenda with a stronger and more focused children's rights agenda[15] the US as a whole have not followed this trend. In fact the US is one of the only countries who have not ratified the 1989 UN Convention on the Rights of the Child (Unicef, 2009). Furthermore the way in which play therapy and similar interventions are funded in the US is often through insurance policies. This arguably makes it more difficult to include *qualitative* evaluation and user perspectives as part of the 'treatment' intervention which is being paid for. When the

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[15] I expand on the historical and political context of children's rights in the UK in the next chapter.

pilot research from this study was presented by the author at an international conference for play therapists, these issues were reported, by leading US based therapists and researchers, to be prohibitive to developing practice in this area. In contrast UK play therapists have been highly responsive to recognising the need and developing ways to incorporate children's views of play therapy practice.

Despite the possible difference in political outlook and government agendas, the outlook of the non-directive therapist internationally, their value base and view of 'childhood', is strikingly similar to the advocates of children's rights and follows the trends of sociology (see James and Prout, 1997). Forethought and consideration of the child as a person in his own right, worthy of respect, is very clearly apparent in the early writings on NDPT. For instance, Dorfman (1951) suggests writing a letter directly to the child if an appointment is missed. This is a practice many other child professionals still do not practice today and is seen as innovative or unusual in many settings[16]. Four of Landreth's (1991:50) ten tenets[17] have strong correlations with a children's rights perspective. These are as follows:

1. Children are not miniature adults and the therapist does not respond to them as if they were.
2. Children are people. They are capable of experiencing deep emotional pain and joy.
3. Children are unique and worthy of respect. The therapist prizes the uniqueness of each child and respects the person they are.
4. Children have a right to remain silent. The therapist respects a child's decision not to talk

Whilst inherent in the writing on NDPT what appears to be missing from these tenets is the child's right to be consulted and participate in the decisions made regarding their care. Therefore I propose an additional tenet to incorporate this central concept:

Children have a right to be consulted. The therapist creates opportunities for the child to express his/her views. The therapist takes the child's views seriously when planning and delivering the therapeutic intervention.

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[16] This is currently being promoted as 'new' good practice in some CAMHs teams for instance.
[17] See appendix 2 for a complete reproduction of Landreth's ten tenets.

This would encompass therapists' discussing initial engagement in therapy, progress meetings and the ending process with children, thereby consulting with them about their views throughout the therapy process. I turn to the area of children's rights and the research on children being consulted about services they are engaged in with specific focus on child therapy in the next chapter.

**<u>Conclusion</u>**

The development of providing children with a developmentally sensitive approach to therapy which utilises their natural means of communication, play, has been set out. The efficacy of using this approach has been discussed and the 'missing voice' of the child with regard to their views of using such an approach has been highlighted. In the next chapter I provide the historical, political and sociological context of adults seeking children's views, before returning to the context of play therapy to review the small number of studies which have considered the child's 'voice'.

# CHAPTER THREE
## RESEARCHING CHILDREN'S PERSPECTIVES

**Introduction**

In this chapter I review the literature on ascertaining children's views of the services they receive. As stated earlier, overall in the therapy literature, children's views are under-represented. Prior to critically reviewing the studies in this area, I broaden my review of the literature, taking into account participatory research with children in related fields. First I outline the historical and political context and consider the influence of the children's rights movement and how this has affected both therapy practices and research. I comment upon the influence of changing models of childhood on the way research is conducted 'on' 'with' or 'for' children. I review current research methods employed with young children and briefly outline the research on children's memories. In this section I draw mainly upon the research with child witnesses. This provides some cues which need to be taken into consideration when designing research that is focused on enhancing young children's ability to share their views and experiences.

Having established the broad framework of participatory research with children, I specifically focus on the subject of this thesis; children's views of play therapy. I acknowledge the sparse research undertaken in this area and review the limited number of studies in child therapy. I argue that the development of play-based methods is needed to meet the challenge of accessing children's views of child therapy in a meaningful way. I briefly outline the four different play-based techniques developed in my own clinical practice, previously reported in Clinical Child Psychology and Psychiatry (Jäger and Ryan, 2007). These techniques will be presented in full in chapter five.

**Seeking Children's Views**

There has been an increasing interest, over the past decade, in ascertaining children's views of the services they use. This has been due to both services' drive towards accountability and children's rights advocates' desire to truthfully represent children's views. There have been significant national initiatives which have led to national guidelines which push forward the participation agenda. A landmark in this major shift toward children's participation was the establishment of the 1989 Children Act which

requires social workers to take children's views into account when making decisions which affect them. The 'Working Together' (DoH, 1999) report made concrete proposals of how this should happen. The Children's National Service Framework (DoH 2003) requires a child-centred orientation for children's services delivered by the National Health Service:

> "At the heart of this National Service Framework is a fundamental change in our way of thinking about children's health. It advocates a shift with services being designed and delivered about the needs of the child. Services are child-centred and look at the whole child…"
> (DoH, 2003:2).

The aims set out in the National Service Framework include professionals communicating directly with children and a service which is child-centred and responsive to the child's individual and developing needs. Furthermore the views of children need to be taken into account and valued at all stages of service delivery (DoH, 2003). Specifically, feedback on the care and services children and young people receive is highlighted. This had become central to thinking in the modernisation of CAMHS (Aynsley-Green, 2005). A recent policy paper entitled 'The future of mental health: a vision for 2015' stated that "The balance of power will no longer be so much with the system, but instead there will be more of an equal partnership between services and the individual who uses, or even chooses, them" (SCMH, 2006:1).

Alongside the drive to ensure a more child-centred and user-led framework to services, as stated in the previous chapter, emphasis on evidence-based practice (EBP) is high on the agenda (Roth and Fonagy, 1996; DoH, 2000). In such a climate, evaluation of 'new' interventions is valued (Plante et. al., 2001). However, the roots of EBP are within medicine and, whilst it is based on practice being informed by research Gilroy (2006), argues that it is driven by economic imperatives and power hierarchies which potentially restrict services that do not conform to the 'value-laden framework' of EBP. In EBP the *type* of evaluation which is valued is outcome research. Specifically one research methodology is privileged above all others – the Randomised Control Trial (RCT). User's voices are not considered as a valid contribution to the evidence base from an EBP perspective. Thus, a clear tension between these two agendas is evident. As stated in the previous chapter, Gilroy makes a clear argument for the incorporation

of quantitative and qualitative approaches to contribute to a sound evidence base of creative therapies. This would appropriately include user's views. Arguably EBP does not need to be diametrically opposed to the participation agenda. However, it is important to be mindful of EBP discourse potentially undermining the value of children's voices.

In the wider arena societal perceptions have shifted which, in part, accounts for the increased interest in children's participation in both research and service evaluation. In particular there has been increased societal awareness of children's rights generally and a perceptual shift in the way in which we conceptualise childhood. There is general agreement that children have the right to have their views *directly* ascertained. The next section sets this out in more detail.

### Children's Rights: An Overview

It is important to understand this current position in terms of the political and historical context. It is only comparatively recently, 1889, that children have been afforded protection rights from cruelty. Remarkably this was some sixty years after similar legislation outlawed cruelty to animals (Franklin, 2001). Children's rights and their status within the family have been addressed by the Children Act, 1989, the Child Support Act, 1991 and the Criminal Justice Act, 1991. Children are no longer viewed as passive objects of parental rights but as legal subjects in their own right. (Mahon et. al. 1996).

In addition to legislative changes nationally, the UK government endorsed children's rights through the ratification of the UN convention on the Rights of the Child (1989)[18] in the international arena. Of particular note to the participation agenda is Article 12:

> State parties shall assure to the child who is capable of forming his or her
> own views the right to express these views freely on all matters affecting
> the child, the view of the child being given due weight in accordance with
> age and maturity of the child.

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[18] See Unicef (2009)

Therefore there has been a significant shift in societal attitudes towards children and the value of what children have to say is being acknowledged, both in terms of offering us important contributions about children's own lives (Gersch et al., 1993) and in terms of what they can tell us about how effective a service is and the impact on their lives (Cooper, 1993; Gersch, 1996).

Whilst Franklin (2001) acknowledges that the ambition of the UN Convention has not been fully realised in the UK, he details the significant progress that has been made. Franklin helpfully groups this progress into five broad areas: *Intellectually* he argues that children's rights have achieved a 'degree of respectability'. He asserts that the children's rights agenda now seriously influences not only voluntary and charitable organizations, but informs government policy making and legislation. *Politically* Franklin refers to children's rights becoming "contested territory for mainstream political parties" (2001:3). In the *Legal* arena the careful balance between protectionist and participatory rights is highlighted, although Franklin concedes that in practice the judiciary's default position is one influenced by paternalistic assumptions of children's incompetence. Nevertheless, the guiding principles of The Children Act 1989 consider not only the child's welfare but their right to participate in decisions where possible and appropriate. A fourth area of change identified is *Institutionally*. Franklin highlights the growing appointments in recent years of personnel such as Children's Rights Officers, Ombudsmen and Children's Rights Commissioners internationally. In addition, a growing number of Youth Councils and forums in schools are indicative of the growing recognition of children's right to participate. Franklin does acknowledge that there are debates regarding the tokenistic aspect of some of these developments. Turning to the *International* arena, Franklin comments upon the growth in significance held by the UN Convention, referred to above. However, he admits that no legislative changes have taken place to support Britain's ratification of the Convention which has resulted in the Convention carrying little weight. Often teachers and welfare practitioners, and particularly children themselves, are unaware of the Convention, therefore it has little real benefit.

**Children's Rights in Play Therapy**

Training and awareness of children's rights has grown considerably over the past two decades. Emphasis in this area, particularly in social work training, has become commonplace. However, until relatively recently, applying a children's rights

perspective to play therapy has received little attention[19]. As described above, NDPT defines itself by being child led. Perhaps the assumption has been that such an approach inherently values the rights of the child and therefore further consideration is not necessary. However, therapy interventions involve complex interactions and decisions regarding children's complex lives. Therefore exploration of children's rights during their engagement in such a context seems warranted.

The three main areas of children's rights Provision, Protection and Participation in relation to play therapy are briefly considered here. As Farnfield and Kaszap (1998) highlighted in their research, children often felt that the *provision* of services to help them with emotional and behavioural problems came too late. This may be partly due to the thresholds for mental health services, in which many play therapists work, being too high. In other cases it may be due to 'protection needs' taking precedence. Careful decisions regarding the provision of therapy are necessarily advocated in statutory settings (see Wilson and Ryan, 2005). Thus therapists' careful assessment of the child's right to have a service provided and their right to protection is needed at the earliest stages of any possible intervention.

In terms of the child's right to participate, it seems that NDPT promotes children's participation within the actual play therapy sessions. Axline's fifth principle which details deep respect for the child's ability to make their own choices seems to particularly reflect this premise. However, the level of participation afforded to children does vary throughout the process of play therapy. Applying Hart's (1992) 'Ladder of participation'[20] seems helpful in conceptualizing the variants over time. The metaphor of a ladder unfortunately gives the impression of a hierarchical system whereby the 'top rung' is the most desirable. However, Hart argues that the intention is to promote a graduated approach to conceptualizing the level of participation afforded to children. Arguably such a graduated approach makes it harder for opponents of children's participation to simply dismiss the involvement of children on the grounds that young people are unsuited to make complex decisions. I briefly outline the ten graduations in Table 1 and then relate them to the process of NDPT:

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[19] The author began delivering Children's Rights training on one of the BAPT play therapy courses in 2004, the first known training on this topic in the UK.
[20] This is a generic model and was not designed to reflect participation specifically in child therapy. However, this model has been applied widely across children services.

Table 1: Hart's Ladder of Participation.

| Steps | Stage | Description |
|---|---|---|
| 10 | Children and Young People in Charge | Children and young people decide what to do. Adults only get involved if children ask for help |
| 9 | Young People Lead With Help From Adults | Children and young people lead in deciding with help from adults. |
| 8 | Joint Decision Making | Adults and children decide things together. |
| 7 | Consultation | Adults consult with children and young people and consider their opinions carefully, and then adults decide taking all the options into account. |
| 6 | Invitation | Adults invite children's and young people's ideas, but they make the decisions on their own terms. |
| 5 . | Tokenism | Adults decide what to do, but children and young people are allowed to decide some minor aspects |
| 4 | Decoration | Adults decide what to do, but children and young people just participate by being there. |
| 3 | Manipulation | Adults decide what to do and ask children and young people if they agree. |
| 2 | Adults Rule Kindly | Adults make all the decisions. Children are told what to do and are given reasons and explanations. |
| 1 | Adults Rule | Adults make all the decisions. Children are told nothing except what they must do. |
| 0 | No Participation | Children and young people are not given any help or consideration at all. They are ignored. |

The beginning of the therapy process is the point of referral. As Brownlie (op. cit.:6) highlights "…children rarely have any control or real level of consent" at this stage of the process. However, in the author's own clinical practice and other therapists' practice, self-referrals within a school setting have been encouraged and do occasionally take place. A further practice has been to offer children three sessions and then invite them to choose whether or not to continue with the further sessions arranged (Ryan, personal communication October 2002). Thus at the point of referral a range of practices which fall between step 2 through to step 8 on Hart's ladder of participation is offered. It is important to note here that step 10 is not seen as something desirable and in the child's best interests at the point of referral. The context of the situation and the individual differences of the children need to be taken into account when taking a children's rights perspective. The complexities which need to be considered are beginning to be discussed in the literature, but not in relation to therapy (see for example Schofield, 1998: *Making sense of the ascertainable wishes and feelings of insecurely attached children*).

During the intervention itself there is a high level of child participation and the majority of the time is spent between graduations 7-10 in NDPT practice. However, during review or progress meetings, variation is again seen from graduation 2-8. Some therapists, including the author, routinely invite children and young people to attend at least part of the review. However, it appears, as reported by Brownlie (op.cit:77) others do not.

From the play therapy practice literature it appears that it is at the end of therapy that once again there is a lower level of participation. Most children are not *explicitly* consulted about therapy ending. Rather parental and other professional's report, observation of behaviour and therapist's assessment of the progress of themes emerging in children's therapy are the prime indicators (see Wilson and Ryan, 2005). However, within training and in several therapists' clinical practice, consideration of the child's view regarding ending therapy is sought. Here a range between 0-8 probably reflects the variation in practice. As mentioned above, children's views of therapy *after* the intervention have rarely been sought. In most cases 0, no participation, would likely reflect practice. In others children are given a paper-based questionnaire. However, it is questionable how accessible and meaningful these are to children and how responsive services are to the feedback. This could be seen as participation in the range of 3-6. Using Hart's generic model of participation to analyse the process of play therapy highlights the variance in practice, and particularly the lowered level of participation at the end of the intervention.

The background of children's rights in the wider arena and specifically within NDPT has been given. I now turn back to the research arena to review studies on seeking children's views of the services they are engaged in. I focus on primary school aged children, the largest client group who access NDPT, and the focus of this thesis. This leads me to focus on the methods used to ascertain young children's views and important considerations such as the implications of the research on children's memories.

**Children's Rights in the Research Arena**

Despite the rather uneven picture of children's rights, described above, a perceptual shift has taken place. This shift can also be seen in the research field. Darbyshire (2000) suggests, paradoxically, that in the desire to "understand and improve" the lives of

children the child can become lost; a concept he termed as 'the missing child'. He argues that the majority of research focusing on children's experience was 'research on' children rather than 'research with' or 'research for' children. Now the focus has shifted to the latter. Darbyshire et. al. (2005) comment upon the "profound effect" the Economic and Social Research Council (ESRC) 'Children 5-16 Programme: Growing into the 21st Century' has had on research related to children. Furthermore they argue that this programme has promoted international awareness of "…the 'new sociology of childhood' as a major conceptual shift in how we understand the nature of childhood and children's worlds" (2005:420). Importantly children are "conceptualized as social actors, capable of affecting as well as being affected by their environment" (Murray, 2005:58).

As stated above, there is now a relatively large and growing literature on children's views of a whole range of services they use and other types of interventions they take part in.  Examples from the existing research literature include Noon, (2000) on child protection case conferences, Bell (2002) on child protection investigations, Bell and Wilson (2006) on family group conferences, Bond (1995) on family centres, Sandbaek, (1999) on child welfare and protection services, Morris (1999) on disabled children's views of their placements, Triangle (1999; 2000) on disabled children's views of residential respite centres and health and education services, and Munro, (2001) on Looked After Children's views. However, research on children's views of therapy interventions has been rather sporadic and patchy.  Examples include Axline (1950), Carroll (2002) and Brownlie (2006, unpublished) on children's views of play therapy, Ross and Egan (2004) on service users' experiences of a Child and Adolescent Mental Health Service (CAHMS), Day, et. al.'s exploratory study (2006) of children's views of mental health care, and Strickland-Clark et. al., (2000) on family therapy (these will be reviewed below). As Davies and Wright (2008) highlight in their review, primary-school aged children and younger are particularly underrepresented in the area of child therapy.

For some groups of children and young people the participation movement has progressed at a much slower pace than others, including young people with significant communication and/or cognitive impairments (Morris, 2003) and those who are fostered or adopted (Murray, 2005). Both Morris and Murray found significant gate-keeping barriers to these children participating in research. Morris was often told that there was

no point in the young person participating as "he won't be able to tell you anything" (2003:332). Assumptions were often made that the researchers would want to talk to an adult involved in the young person's care rather than the young person themselves. Sometimes Morris was denied access as adults decided that the young person would be upset by participating.

Although gatekeeping issues arise in all research with children, Murray's (2005) research highlights the magnification of this barrier for children looked after by the Local Authority. Murray puts forward a convincing argument that her findings "reflect the pervasiveness of a protectionist model of children and young people over a citizen-with rights model" (2005:57). Murray (2005) emphasises that clearly sometimes adults have valid reasons for protecting this group of children from research. However, she identifies many times when the reasons given by gatekeepers were suggestive of a belief that research per se was harmful or that children would be incompetent or unable to express their view.

The above examples demonstrate that, whilst there has been a move away from children, in general, being seen as in need of protection, incompetent or unable to share their views, it is clear that some children (who are disabled, fostered or adopted) are often not afforded the same rights as others. The challenge for adults, as existing children's service user research, and indeed developmental research generally has amply demonstrated, is to find methods of evaluation for all children that truly reflect their views and are non-harmful. A further task for researchers is to persuade gatekeepers that children have a right to make their views known and that they will not be put at undue emotional risk in the process. Furthermore Kirby et. al. (2003) acknowledge that whilst there has been a mushrooming of participation activity, there is a need to ensure that this activity is sustained, embedded into practice, meaningful to children and effective in bringing about change.

## Current Research Methods with Young Children

Hennessy (1999) provides the first review of studies which attempt to measure children's satisfaction of services. Hennessy's (1999) review encompasses research in education, paediatrics and mental health services. An omission in Hennessy's review is literature from the field of social work and social policy. Hennessy highlights the lack of information in the majority of studies reviewed regarding the administration of the

measures. Furthermore, he suggested that the measures used may not actually reflect the aspects of the service which are important to children. Much of this research involved the administration of questionnaires with children evaluating their teachers. Hennessy (1999) located only one qualitative study focusing on preschool experiences. This was in fact a retrospective study of older children's recollections of preschool experiences (Huttunen, 1992). Here the children were invited to write an essay on their experiences. In paediatric services Hennessy found that parents were largely treated as the sole clients. A few studies which relied on questionnaires and one which relied on a structured interview format were identified. Within mental health services there were similar findings of the use of questionnaires mainly aimed at adolescents.

A relatively recent evaluation study of a Child and Adolescent Health Service for Looked After Children disappointingly conveyed a perspective from the researchers themselves that pre-adolescent children were incompetent at sharing any meaningful view. Callaghan et. al. (2004) provide this brief comment as explanation for inviting only 12 of the 45 children and young people eligible to participate directly in their research: "Only 12 young people were available for interview at follow-up, either *because they were pre-adolescent*, [my italics] they did not wish to be interviewed, or, in three cases, their social work did not wish them to be interviewed" (2004:135). The research included the collection of standardised outcome data along with administering a structured questionnaire for carers and young people. While the quantitative data is useful and should not be minimised, the carers' opinions along with the clinicians' views and interpretations completely overshadow the data which was collected from the young people. Furthermore it is clear from their structured protocol for young people that little attempt had been made to adjust the protocol to make it more accessible and appealing to young people.

Aubrey and Dahl's (2006) systematic review of participatory research with children and young people included the fields of social work and social policy. This review highlighted that the focus remains to be older children and young people's views. Kellet and Ding (2004) conclude that researchers have often considered children below the age of eight years old to be incompetent interviewees. However, they argue that poor data from young children can be explained by the use of inappropriate interview techniques, rather than children's lack of competence. There are only a few studies focusing on

effective techniques used to interview primary school aged children and younger. There is a clear need to develop the methodology in this area.

Hill (1997a) provided a review of the *techniques* employed with children to elicit their views of the services they receive. These include observation, self-completion questionnaires, individual interviews, focus groups, use of vignettes, written and/or pictorial prompts, drawing, role play and the use of technical aids. Others, such as Hogan (1997), who advocate the use of unstructured questioning and particularly free recall when interviewing children, argue that this allows children to clarify their thinking and provides more accurate, comprehensible reports of their experiences. In addition, Aubrey and Dahl's (2006) review of children's views of the services they receive concluded that effective strategies used to engage children under the age of twelve were those which included the use of enactment, props, drawing and computer-based approaches (e.g. Clark, 2001; Wesson and Salmon, 2001). The MOSAIC approach, employed by Clark and Moss, (2001 and also Clark and Stratham 2004), was adapted from participatory appraisal techniques[21], for use in early years settings with three-four year olds. In this multi-method approach several techniques such as mapping, use of photographs, taking researchers on a tour of the environment and interviewing key people in the child's life are all brought together to form a picture.

In the field of geography, researchers tend to use a variety of methods with young children often congruent with their subject such as these mapping activities (Morrow, 2001). Geographic research in the health setting by Darbyshire et. al. (2005) provides an interesting example. The authors present an engaging discussion regarding multiple methods employed in their childhood-obesity focused research on children's views of place, space and physical activity. The authors report on the use of informal focus groups, mapping and 'Photovoice'[22] as techniques to capture children's experiences.

They assert that intuition suggests that a broader and more in depth understanding of children's views should be gained from using such a variety of methods. They helpfully highlight both the advantages gained and the difficulties with such an approach in their own study. One particular difficulty highlighted with the use of creative methods, such

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[21] Originating from rural development projects.
[22] The use of photos to tell the child's story rather than relying on verbal communication. For example, the child is able to use the camera to take photos of their favourite area in the nursery.

as drawing or taking photographs, is this leading to an 'adultist approach' which the researchers were endeavouring to avoid. The authors argued that, as they did not talk to the children about the photographs they had taken due to time and funding constraints, the adults interpreted, and potentially misinterpreted, the photographs. In order to move away from 'adultist' research which focuses on research 'on' children rather than a more participatory stance, Darbyshire et. al (2005) argue that it is not enough to merely adapt the methods implemented. Rather they highlight the importance of critically questioning and reflecting upon the whole process of a research project; from the generation of the research questions right through to the final dissemination. The transparency offered by Darbyshire et. al.'s (2005) discussion is a useful contribution to the debate on research 'with' or 'for' children and helps maintain a focus on the 'bigger picture' rather than creating a tunnel vision approach which focuses on the methods used in a study at one point only in the research process. An aim of this thesis will be to offer the reader a similar level of transparency and reflection.

## Children's Memories and Use of Language

When considering appropriate research methods to employ with children, consideration of the development of memories and use of language is important. Hogan (1997) argues that it may be the way in which research studies have been conducted which has given rise to inconsistencies in children's accounts and therefore fuelled the argument that young children are neither credible nor reliable informants. The developmental research on children's memories has been drawn upon particularly by researchers in the forensic setting. The application of this research to children as witnesses in the court setting has much to offer in our understanding of the ways in which adults can enhance the credibility and reliability of children's accounts. It is outside the scope of this thesis to provide a comprehensive review of this vast area. However, some of the relevant findings to children's recall of their experiences of play therapy are briefly presented here. The reader is guided to Wilson and Ryan (2005) for a more comprehensive review of children's mental development and the implications for play therapy.

## Verbal Recall and Language Development

Fivush (2002) reports that verbal recall of past experiences begins when children are just 18-20 months old. She cites Bauer and Wewerka's (1997) research, which indicated that a significant predictor of children's recall abilities was their level of language competence at the time of the event. Children from about the age of three are able to

share detailed memories. She highlights that, similar to adults, children are more likely to provide such detailed accounts when the events are distinctive rather than recurring events. Recurring events result in the child creating a general script reporting things which usually occur rather than novel specific actions associated with a specific occasion. This has implications for children's recollections of play therapy sessions; for instance differences in children's accounts may be evident dependent on the length of the intervention more specific information may be gleaned from children who have had shorter interventions.

Saywitz (2002) highlights the importance of understanding children's development of language in order to support children in providing the most credible accounts they can. Adjusting our approach as researchers and ensuring we are knowledgeable with regard to young children's capabilities is needed, rather than disregarding young children's views as incompetent. Research on language development provides important information for us to understand and interpret young children's communications. For instance, Saywitz (2002) emphasizes the need to break down linguistically complex questions to several short questions, in order to elicit reliable information. She asserts that when children are confronted with sophisticated vocabulary and complex linguistic structures they do not seek clarification, nor indicate that they have misunderstood. Instead they try to provide a reply, knowing that it is their turn in the conversation. She stresses that accuracy is greatly increased in young children's responses when questions using simple grammar are asked.

**Co-construction of Events**

Fivush (2002) highlights the research on reminiscing and the significant difference in recall if a child has jointly discussed the event with an adult. She cites Pipe et. al.'s (1996) experimental study where 5 year old children were engaged in role play with an adult. In one condition the play was narrated in a detailed manner, in the second condition the play was narrated in a general manner, using general terms for the child's actions. Children made fewer errors and recalled more information in the first condition compared to the second. This is interesting when relating this to individual play therapy sessions as the therapist 'narrates' in detail what the child is doing, thinking and feeling. Fivush (2002) suggests that children's recall of events is profoundly affected by the ways in which children and adults co-construct an event through language.

An interviewer's knowledge of an event has also been shown to have an effect on the accuracy of children's accounts. When the interviewer had full knowledge of an event 3-5 year olds produced more accurate accounts than interviewers who had incorrect or no information (Pettit et. al., 1990, cited in Gertsch-Bettens et. al., 2003). This has implications for *who* should interview children about their experiences of play therapy; an 'insider' or an 'outsider'. This is an issue I return to in chapter five on the development of the pilot research.

Young children in particular are known to be less suggestible when questioned by another child (Ceci, Ross and Toglia, 1987; Kwock and Winer, 1986). Saywitz (2002) suggests that this may be because young children may assume the interviewer already knows what happened or may be overpowered by their authority. She argues that objectivity is likely to be enhanced "…by a non-judgmental atmosphere, devoid of accusatory, stereotypic, or condescending remarks" (2002:10). This is certainly the atmosphere Play Therapists aim to create for children in their therapy sessions (See Axline's eight underlying principles of play therapy, 1989[23]).

**Emotion-laden Memories**

Baker-Ward and Ornstein (2002) acknowledge that research in the laboratory setting is significantly different to children's memories for emotionally laden events. However, they recognize the importance of drawing on this developmental framework to help us understand the operations of the memory system. Baker-Ward and Ornstein (2002) highlight that some experiences are not stored in memory, due to low interest in the experience from the child, the effects of stress, or miscomprehension of the event. The authors note that experiences which do get stored in a child's memory vary in strength. Both the frequency and duration of exposure and prior knowledge of an event have an effect. The memory retrieval process is influenced by the context the interview is conducted in and the context at the time of encoding.

Although research with children on emotionally-laden events is fraught with ethical dilemmas, there has been research on children's memories of stressful experiences such as painful medical procedures. Fivush (2002) reports on her research which made a useful contribution in this area. Her study considered not only children's memories of

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[23] These are re-produced in appendix 1.

stressful events but compared these with children's memories for more emotionally positive events. Interestingly children recalled the same amount, and yet different kinds of information about both types of event. Children were more descriptive and gave information about people with regard to positive events. Therefore the focus appears to be on what is happening externally. In contrast children reported on their own and others emotions more for negative events. The focus seemingly turning to internal thoughts and feelings.

These processes are likely to be far more complex when considering traumatic experiences such as abuse, particularly because children's defences, such as dissociation, at these times are stronger (see Terr, 1988 & 1991 for an overview of the effects of childhood trauma on memory systems). Crittenden (1995) asserts that insecurely attached children who have experienced maltreatment often struggle to develop coherent memory systems. She argues that this is due to the lack of a predictable world in which to organize internal expectations. This is an important consideration when studying NDPT as many children referred for play therapy have had such experiences. Wilson and Ryan (2005:38) argue that play therapy helps children "to make conscious and give symbolic representation to troubling thoughts that are largely outside of their conscious awareness". They suggest that NDPT offers children an opportunity to process these experiences on a bodily and sensory level rather than purely via verbal recall. Therefore interviewing children about their experiences and memories of play therapy is far from straight forward. Utilising methods which access both left and right hemisphere brain processes - the former thought to dominate cognitive verbal language processes and the latter thought to dominate in processing visual emotional affective communications (Schore, 2003) - seems indicated.

**Children's Testimony: Enhancing Children's Accounts**

There is also discussion within the literature on children's testimony on interviewing methods used to enhance children's accounts. Similar to the research reviewed above, in this area researchers also advocate the use of prop-based interview techniques as they "…help children comprehend what adults are asking them, directing and guiding their recall" (Pipe et. al. 2002: 161). They highlight that young children tend to be reliant on external cues when recalling past events. The use of props helps facilitate this memory process by providing such concrete visual cues. In addition the use of props has been found to extend the memory search process (Pipe et. al. 2002). However, in the forensic

context emphasis is placed on the child not being able to interact directly with the props due to concerns about the effect this may have on the accuracy of children's accounts.

Pipe et. al. (2002) report that, in the context of children's testimony, enactment with dolls, toys, and scale models significantly increased the number of errors in children's reports. They suggest that this may be due to the low level of similarity between the toys and the experience the child is asked to talk about. In the context of asking children their views of play therapy, this is less likely to be an issue due to the obvious high level of similarity between using toys in the interviews and the experience the child has had in the playroom. Furthermore, active involvement with the toys may activate right brain processes during the interview. This is arguably a desired outcome within an interview of children's experiences of play therapy. The challenge in this context is developing data analysis techniques sensitive to non-verbal communications shared within the session. As described in chapter five two of the techniques developed in this study include active involvement with toys.

Pipe et. al. (2002) argue that a second reason, for the increase in errors, is that younger children particularly may become distracted by the toys and use them as play things in their own right, rather than representing what has happened in the past. This is particularly the case if the interviews take place a long time after the event and/or if several novel distracter items are included. This may be more of a concern when interviewing children about their experience of NDPT and was taken into consideration in the research design of the current study.

Pipe et. al. (2002) commend the use of photographs enhancing children's accounts. Rather than the children taking photographs themselves, as suggested by participatory researchers above, photographs here are used as a way of enhancing children's retrieval processes. The authors also comment on the use of drawing to aid children's memories. They suggest that if the nature of the event, such as a medical examination, and the method used to elicit information from children, such as drawing, are not particularly salient, then it is unlikely that drawing will assist children's retrieval processes. As they point out the interaction between the nature of the event and the technique used to interview children requires further research. Clearly creative methods, use of props and toys has a high level of salience with play therapy interventions; an issue I will return to in my discussion on techniques used to evaluate different modes of therapy below.

Thus far I have outlined the historical and political context of children's participation in services. The relevance of children's rights to the process of play therapy has been presented. I have given a brief overview of the research methods currently employed in seeking young children's views in the wider field. I have argued that evidence from developmental research can be drawn upon when considering appropriate methods to aid children's recall of events. I now return to the specific arena of child therapy, the subject of this thesis, and critically review the specific studies which consider children's views of the intervention, making particular reference to the methods employed.

## **Children's Views of Child Therapy**

Determining young children's views of their own therapy is even more challenging to obtaining their views of other services and experiences, due to the sensitive and confidential nature of therapy sessions (Carroll, 2000). Similar to research with children looked after by the local authority, the gatekeeping issues and concerns seem to be magnified with this group of children. This is particularly due to professionals' concerns over the potentially damaging effects participating in research may have on a group of children who are perceived to be emotionally vulnerable. For instance, Strickland-Clark et. al. (2000) found family therapists were concerned about the disruptive and/or unsettling effect that interviewing children about their sessions may have. However, the authors reflect that the children did not appear distressed by the actual interview process and in general seemed pleased to be asked their views. This 'professional concern' may be compounded when the child attending therapy is also a disabled, fostered or adopted child (see Murray, 2005 and Morris, 2003 reviewed above).

In her review of the evaluation literature on therapeutic play interventions Carroll (2000:11-12) asserted that "…children's opinions have not yet been sought regarding the process or outcome of the therapeutic intervention provided for them". With the exception of two small studies which mention children's own views of therapeutic play (Axline, 1950; and Cleveland and Landreth, 1997, reviewed below), I would concur with this finding. Carroll's own study (2002) contributed to this new area. Since this time two other studies of children's views of play therapy have been conducted (Green and Christensen, 2006, and Brownlie, op. cit. reviewed below).

Other researchers are also beginning to seek children's views of other forms of child therapy. This remains limited however. A recent search on studies which include children's views in therapy interventions revealed only nine studies, one of which was a study where the intervention was mental health assessment (Ross and Egan, 2004 reviewed below) and a second (Farnfield and Kaszap, 1998 reviewed in the next chapter) was a study of children with emotional and behavioural difficulties who shared their experiences of 'helpful and unhelpful professionals'. This included 'therapists' among a range of other professionals. One further study was identified which incorporated children's views of therapy (Hill, 2006a[24]). However, due to significant recruitment difficulties only three of the seventeen children were interviewed, two of whom were fifteen and the third was four. Only one quote from the four year old was recorded. Therefore it is not included in this review. However, it stands as another example of a study where there were significant gatekeeping issues and also a lack of appropriate research methods to use with very young children. Hill reported that the child-centred methods he had prepared were only suitable to those aged 7-11years. I provide a brief overview of these studies before detailing more fully, those specific to play therapy.

**Group Therapy**

Curle et. al.'s (2005) evaluation study of a six-week group therapy intervention for ill or disabled children (aged 7-12) included semi-structured interviews with both parents and children. The authors do not explore the strengths and weaknesses of their use of semi-structured *verbal* interviews with children. They do provide an interesting and useful discussion regarding the general methods employed when undertaking evaluation research of therapy from participants' perspectives. Participants felt that face-to-face interviews were advantageous and communicated a sense of the researcher valuing their opinion. This was in contrast to questionnaires where participants felt they would not be able to express the complexity of their experience. Participants felt observations may be off-putting and affect behaviour. However, they felt this effect was likely to be reduced with video and felt an advantage of this method was that it was less intrusive. The current study combines the use of semi-structured interviews and observation, the development of which will be discussed in chapters five and six.

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[24] Whilst Hill's main study is published, the findings regarding the children are as yet unpublished (Hill, 2006b).

**Family Therapy**

Strickland-Clark et. al. (2000) sought children's views of Family Therapy (5 children aged 11-17). The authors highlight that one of the main aims *in* Family Therapy is to help family members hear the child's voice and yet paradoxically the child's perceptions *of* Family Therapy has been largely ignored. An interesting technique which was used in their methodology was the use of video playback. First a semi-structured interview was followed, by an 'outside' researcher, asking the children to identify helpful and unhelpful aspects of the therapy sessions. If an event was identified, this part of the session was replayed to the children using the video tape of the session and asked to comment on what they were thinking and feeling during the excerpt. Therapists were also interviewed and asked to reflect on the excerpt children had chosen. However, such an approach raises ethical issues. The potential for the children to become distressed when watching themselves in therapy is not addressed by the authors, nor the complex implications regarding confidentiality of the therapy itself.

Stith et. al.'s (1996) research also interviewed 16 children 5 -13[25] years of age and their parents regarding Family Therapy. They utilized semi-structured verbal interviews with the children. Stith et. al. (1996) report a key finding that play was identified as an important component of the therapy sessions by latency age children. Both parents and children, of all ages, suggested that more focus on activities and play would enhance the therapy. Stith et.al. (1996) usefully explore ways to implement this in the clinical setting, including incorporating play therapy training in the professional training of family therapists. However, they neglect to apply this to the ways in which children's views *of* family therapy are sought.

**Mental Health Treatment and Assessment Interventions**

Day et. al. (2006) conducted a study on children's views of the CAMH service they received, 44 children and young people who had been closed to CAMHS over the past 12 months were approached. Mainly due to parents' refusal to take part the authors were limited to a small sample: Eleven 9-14 year olds were involved in an initial focus group interview. The participants were divided into three groups dependent on age. Four children returned for a follow up focus group session. The authors helpfully provide details of the children's ages, number of sessions attended (ranging from 1-29), the

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[25] One was aged 5, the rest of the cohort were 8 years or older.

presenting problems, the type of intervention offered (including CBT[26], individual psychodynamic therapy, child-centred therapy, parent-child sessions), and the clinicians' view regarding whether or not the problems had been resolved. Day et. al. (2006) acknowledged that the lack of children below the age of nine, and the lack of participants from minority ethnic groups is a limitation of their study.

During the first focus group the facilitators presented several tasks and structured questions for the children to complete in order to elicit their views. Toys and art were used to make the session more 'child-friendly'. For instance children were given a magic wand and asked if they could cast a spell and what would they change about the sessions they'd had. A strength of the study, and unique in this field, was the ongoing consultation with children and their participation in analysing the themes of the research. Children who attended the follow up group were presented with a booklet which detailed the themes the researcher had identified with example quotes. The children were asked to discuss the accuracy of these themes and whether or not these made sense from their perspective. One theme was adjusted following this process. The authors reported that the themes "…echo the central importance of building and maintaining helping relationships with children so that they feel included and taken seriously, at a pace that reflects their individual needs rather than the requirements of the clinician or their parents" (2004:153).

Importantly a meeting involving all the clinicians in the service was convened to discuss the views which had been expressed by the children in the research and to implement changes following the feedback children had given. Training on the use of play and creative activities was the result of this exercise. Also an investment in play and art equipment was made. This demonstrates the authors' commitment to taking children's views seriously.

Ross and Egan (2004)'s preliminary study, mentioned above, included thirty CAMHS service users who had assessments, ranging in age from 5-15 years. In this study a cartoon story board, named 'The Pictorial Critical Incident Technique', was used to elicit children's perceptions of mental health assessment procedures. Children were able to express a range of feelings using this method; both positive and negative experiences were reported. A third of younger children did not depict themselves as being part of the

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[26] Cognitive Behavioural Therapy.

assessment. The authors emphasise the need to integrate creative methods in mental health assessments to involve children more fully.

It is worthy of note that it is not only in Child Therapy that 'client's' perspectives have traditionally not been sought. This pervades the research in mental health treatment and therapy with young people (Buston, 2002 and Bury et. al, 2007), but also extends through to adult clients views of therapy (Macran et. al. 1999). Here again a drive to listening to clients views of therapy has begun.

## Children's Views of Play Therapy

Virginia Axline, a chief exponent of play therapy, sought the views of children in her 1950 study. Since this time the views of children have been neglected in the play therapy literature. In this section I critically review each of the studies identified in this specific area.

## An Historic Study

Axline's study was retrospective. The children in the study were interviewed by their own therapist, which the reader assumes was Axline. Twenty-two children and young people were interviewed, post-therapy. The children ranged in age from 4-12 years (at the beginning of the intervention). Unfortunately the reader is not supplied with the length of time between the intervention and the interview in all cases, nor the length of the intervention itself. Two time frames which are provided are five years and three years post intervention. The children had received individual and/or group therapy. The children are drawn from a sample of thirty play therapy cases which had been 'successful'. Unfortunately Axline's criteria for categorizing the case as 'successful' are not explicit, only that they were deemed to be successful by the therapist immediately after the intervention and at one-year follow up. The rationale for excluding 'unsuccessful' cases is not clear. She states:

> "The reason for confining this study to 'successful' cases only was to attempt to gain some insight into the children's perception of the experience, their interpretation of it and their memory of it". (1950: 54)

Whilst this seems an important area to explore, the same insights from children who had experienced an 'unsuccessful' intervention seem central in furthering our

understanding of the child's experience of play therapy. Thus, researcher-bias is likely in this sample. Axline does comment though, in her conclusions, that a study of children's therapeutic experiences which were deemed 'failures' would be useful.

Axline drew on therapy records and extrapolated statements children had made during the play therapy intervention itself which indicated their views and perceptions of their experiences. The presented excerpts particularly highlighted the children's ability to verbalise the link between their actions and behaviour to their feelings. Axline reports that this 'insight' led to changes in behaviour. She reports quite remarkable verbal reflections from one four year old girl who repeatedly took paint from another child:

"I wonder why I want every jar of paint she has?...I guess it's just because she's got it and I wanta take it away from her" (1950: 55).

She details one child's reflections of changes in his feelings and behaviour over time. Axline argues:

"The manner in which the children express such thoughts – the tone of voice, the gleam in their eyes, the spontaneous gestures and expressions indicate that the play therapy experience is an emotional experience that brings about reorganization of meanings, concepts, feelings, self-understanding" (1950: 56).

Axline details such non-verbal behaviour in her transcribed quotations. Whilst the accuracy of these non-verbal communications is likely to be limited due to these statements being drawn from therapy case records, pre-video recording, her attention to these details when exploring a modality such as play therapy seems central and is often lacking in later studies.

Axline describes the therapist/interviewer taking an unstructured approach, in the individual interview, where she simply asked children if they remembered 'their therapist'. Only the children's responses are detailed. Whilst it is suggested that the therapist/interviewer allowed 'space' for the interviewees to explore their thoughts,

there are occasionally long transcripts of what appears to be monologue from children. This negates the interactional aspects of the interview and the likely co-construction which occurs in all interviews, even when the interviewer takes a non-directive unstructured stance.

Part of Axline's sample included twenty-four children who had previously undertaken a therapeutic group for non-readers - therefore not a 'clinical sample' - four of whom also received individual play therapy. Axline describes a focus group approach with the whole group, followed by a request for each child to write the best thing they remembered. Axline identified a difference between the children who had attended the group alone and the four children who had received individual interventions. All children commented on what they did or learned; however "personal feelings of attitudes towards themselves" (1950: 58) were recorded by the four children who had received individual play therapy.

Unfortunately the number of children Axline presents in the analysis and the number of children reportedly involved in the study do not tally. However, no rationale for the selection of children to present is given. Thus further researcher-bias toward the most articulate and positive children is possible. A strength of the study is the triangulation of data. Axline compared the child's recollections of the intervention with the therapy notes and also drew on information regarding the child's functioning at the point of referral, immediately after the intervention and at the point of interview. It is unclear whether this information was gained from parents, teachers, or others.

Axline offers several interesting interpretations of the data in her conclusions. She asserts that NDPT sessions appeared to be 'emotional experiences' for children where they gained self-awareness and subsequent control over their emotions. Certainly some of the children's accounts reported by Axline provide compelling evidence to support this assertion. She highlights two cases in particular where a change from passive experience of the world to active living in the world seemed to be described. She particularly highlights the focus on the *therapeutic relationship* described by the children, although this may have been influenced by her first question of whether they remembered 'their therapist'.

Axline presents a seemingly un-edited letter which was received in response to the research, rather than taking part in a verbal interview. Axline allows this to 'stand alone' and for the child's words to speak for themselves.  The child's words are particularly articulate and prove a comprehensive analysis in their own right. This is an interesting early example of presenting the 'authentic child's voice' and allows the reader direct access to the data, enhancing its credibility (Flick, 2007). This choice of presentation feels congruent with Axline's view of the purpose of therapy, as she later states in her conclusions that play therapy allows the child "the freedom and room to state himself in his own terms exactly as he is at that moment in his own way and in his own time" (1950:62). It is somewhat surprising, therefore, that whilst NDPT has grown and therapists continue to promote these values during the therapy intervention itself, a drift away from seeking children's views of play therapy has occurred.

**A Filial Play Therapy Study**

A return to this venture was made by Cleveland and Landreth (1997). They highlighted this gap in the research. The authors noted only two small contributions to the field. First, Bavin-Hoffman's (1994, unpublished[27]) study where *parents* had been asked their views about the child's experience of play therapy and second, a video of play therapy by Nancy and Mike Smith entitled "The Value of Play Therapy" where, reportedly, several children were interviewed about their own experiences of play therapy.

Cleveland and Landreth's (1997) study focused on 'children's perceptions of filial therapy.'[28] Five children aged 3-8 were interviewed by an independent researcher. Two sets of siblings were interviewed together. In addition it appears, at least in one of these sibling interviews, the filial play therapist was also present and used her familiarity with the children to further assist facilitation of the children sharing their views. This research relied on verbal semi-structured interviews. The authors reported that the children were able to describe what they did in filial therapy sessions and verbally reported that it was 'fun'. However, the authors reported that they were unable to elicit any information to their insight-oriented questions aimed at revealing how filial therapy

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[27] Whilst data regarding the parents' perceptions of filial therapy and perceived changes in their relationship with their child is published in Bavin-Hoffman et. al. (1996), data regarding parent's views of their child's experience is only detailed in Bavin-Hoffman's (1994) unpublished doctorate thesis.
[28] As described in chapter two filial therapy is a form of NDPT in which the parents are seen as the therapeutic change agents and hold special therapeutic play sessions with their own children (see VanFleet, 1999).

affected the parent-child relationship. They suggested that the children "did not seem able to verbalise their feelings about their experience" (1997:24).

Cleveland and Landreth (1997) resorted to dedicating over half of their article entitled 'Children's perceptions of filial therapy' to data from parent interviews. The authors conclude that "the filial sessions were very important to both Josh and James, *regardless of their responses earlier*" (1997:27 italics added). Thus the parents' views took precedence over the child's and the child's view that the play sessions were 'just fun' were diminished rather than seen as an integral and important part of play therapy from the child's perspective. However, the view expressed from the children is an important one and is consistent with the literature on the value of play in child therapy. As Winnicott (1971) asserts, playing and having fun are necessary to relax and promote creative exploration, and are recognised as an important part of the therapeutic process. Arguably 'having fun' may be the only way children can describe the process of emotional safety. It is argued that play provides emotional distance from traumatic or difficult experiences in order for children to gain mastery (Wilson and Ryan, 2005). Alternatively children may be referring to other aspects of the play therapy process. For instance social play which many children are able to develop within the enhanced atmosphere of play therapy.

Unfortunately Cleveland and Landreth (1997) present very little detail about the views expressed by children. They acknowledge that one of the reasons play therapy is so helpful is that it utilises the child's natural way of communicating, namely playing (Axline, 1989). They also note that it is expected that children will not be able to verbalise the complex changes in relationships which the parents shared. This leads them, rather incongruously, to suggest that more structured self-report forms might be more appropriate, instead of integrating play into the interviews. The use of self-report forms seems to rely heavily on language and the methods employed to access adults views of experience.

**A Study on Individual Play Therapy**

A more substantial and comprehensive study followed in the form of Carroll's (2002a; 2002b) aforementioned doctoral research. This focused specifically on children's views of individual play therapy. Carroll interviewed eighteen 6-14 year olds using a semi-structured interview format. There was one 6 year old in the sample, three 9 year olds

and the remaining participants were over 11 years old. Therapists were also interviewed, although Carroll allowed the children's voices to take centre stage in the presentation of her research. Most of the interviews took place after the therapeutic intervention. However, the time lag from the end of the intervention and the interview varied considerably, from being on the brink of ending (thus therapy was still in process), to eighteen months after the intervention. Unfortunately Carroll does not detail these differences in relation to each child. The length of the actual therapy varied greatly. Five participants received short term therapy of 8-13 weeks, five participants received mid-term therapy of 17-23 weeks, seven received long term therapy of 1-2.5 years and one participant had reportedly received a seven year intervention. The participants were interviewed in the home setting which included the caregiver or other family members sometimes being present.

Carroll comments upon the significant gatekeeping issues she faced when approaching professionals about her research. Carroll highlights a limitation of her study regarding the sample of children who participated. She states that therapists selected the children and therefore are likely to have chosen children for whom the therapist felt the play therapy intervention had been successful.

Carroll (2002b) began the interviews with a factual questionnaire regarding the child's experience of play therapy. The rationale for doing so was to trigger children's memories of a comprehensive range of experiences. She states that she provided the children with play and art materials during the interview. However, she does not detail any non-verbal communication in the published presentation of her findings. Although she does mention that the 'materials also prompted play' (2002:186), it seems these materials were not primarily used to facilitate the children's expressions; rather they were used to put them at ease and prompt further discussion. In her full thesis she notes that some children drew and one participant used the toys to act as an audience. This is somewhat expected given that Carroll's interview schedule prompted use of the drawing materials but not explicit invitation of demonstrating with the toys what had happened. Furthermore, the older age range of most participants in the study and Carroll being a stranger in a first meeting at the participants home, where other family members were present, also indicates that use of the toys was less likely. As will be described in chapter five the current study integrates play materials into play therapy evaluation interviews with child participants.

Carroll's decision to use audio recording only, rather than video, limits the recording and analysis of non-verbal communication. This is another area the current study focuses upon and adds to the field, with video recording used throughout. Carroll (2002) states that the children emphasised the value of talking during their therapy. However, once again, given the age range of children in her study, one would perhaps expect more use of verbal communication. It is possible that the age of the children and the fact that Carroll was an 'outside' researcher may have heightened participants' desire to highlight the importance of talking in their play therapy sessions and 'minimise' the play as 'just fun'. Furthermore for some the time lag between their therapy ending and the interview taking place may have had a significant effect here. Participants may have felt the need to emphasise their maturity. In fact one child explicitly rejected the toys Carroll brought with her stating that he didn't do that anymore. Carroll does reflect that the verbal nature of the interview may have added to this effect.

Carroll presents the themes from the interviews under five main headings: 'Introduction to Play Therapy', 'Relationship between Child and Therapist', 'The Therapeutic Process', 'Children's Likes and Dislikes' and 'The End of Play Therapy'. She reports that eight children understood and could articulate why they thought they were going to play therapy and others were not sure. Participants emphasised the importance of the room and materials. Six participants shared their dislike of rooms which were 'dark and gloomy' or 'dirty' or 'too crowded'. Some disliked having to change rooms and some found the toys uninviting or were unimpressed with them. Carroll refers to these dislikes as practical difficulties. However, this is a therapist's perspective. It seems from a child or 'user's' perspective that these 'practical difficulties' communicated a sense of not being cared for or looked after well by their therapists. In contrast two participants shared their feelings of being cared for by the therapist because their therapist had made sure the room was the right temperature or was using a new playroom.

Carroll found that both therapists and children talked about the importance of carers being involved in supporting the therapy; for example the journey to and from the therapy session was deemed important by one child. Carroll noted that children were highly observant about the physical attributes of their therapist. Whilst this may be so, it may have been somewhat expected given that Carroll asked children to draw their therapists and thus a focus on 'visual' data was led by the interview guide. Participants

also shared their experience of therapists' being kind, friendly, humorous, and 'a bit bossy' and someone who 'didn't get knotted'. Carroll reports that children shared mostly positive experiences about play therapy. However, it is clear from the children's quotes that there were several things children did not like and arguably it is positive that participants felt able to share things that were more difficult. Such views should not be minimised when reporting findings of a study.

The importance of choice was highlighted by four participants. Maintaining confidentiality was an important issue raised by seven of the children. Children shared that ending therapy was a difficult process and four participants were able to identify specific positive changes which they attributed to play therapy. Carroll (2002b) suggests that a limitation of her research is the lack of information regarding the process of play therapy and the relationship this has to outcomes. She states that the children were unable to contribute ideas regarding the process of change and how it has been achieved. However, she does not suggest possible ways of supporting children to share their thoughts and feelings on the therapy process more fully.

There were several incidences where the child's view and the therapist's report were in conflict. Whilst Carroll acknowledges these occasions, she was not able to effectively explore these discrepancies. This issue is addressed in the current study and thorough explorations of these issues are considered in chapters seven and nine in particular. In Carroll's study the time lag, for some children, may have significantly compromised their ability to accurately recall their experiences. Carroll boldly claims that the different time lags made no difference to how 'vivid' the participants' views were. However, she avoids further exploration of this issue, which is likely to have had an impact on accuracy and account for some discrepancies between therapist and child participant reports. Carroll interprets her findings and the child's ability to share his or her experience in relation to the age of the child participants at interview. Given the varying length of the interventions, and the time lags between intervention and interview, consideration of the child's age during the intervention itself would have enhanced Carroll's explorations.

A strength of the study is Carroll's consideration of the child's understanding of the research process. For example, she invited the children to be involved in the anonymisation process by asking them to select pseudonyms themselves. This helps to

enhance children's understanding of the confidentiality afforded in the study itself and was drawn upon in the current study.

**A Study on Trainee Play Therapists**

Two recent small scale studies have followed. Green and Christensen's (2006) US study focused on elementary-school aged children's views of two trainee play therapists in the school setting. The model employed by the trainees reportedly 'lent towards' NDPT. However, it is clear from the children's quotes that an eclectic approach was taken. It was unclear whether individual or group play therapy was under study: a combination of both models was suggested from the children's quotes[29]. Their sample included 7 children, 6 girls and 1 boy, aged 6-11 (5 of whom were 8+) who had received between 5 and 35 sessions.

The authors followed Carroll's lead by conducting verbal interviews with toys and props available for use. However, similar to Carroll they audio taped their interviews. The authors reported that attention was paid to non-verbal communication and was documented in a journal directly after the interview. However, the authors did not document any play behaviour nor non-verbal communication in their paper. Furthermore they purposefully restricted their sample to participants who had good verbal abilities to answer questions about their experiences of therapy. The authors note that play therapy is based on the belief that the child's natural method of communication is play, thus the verbal method employed to investigate a non-verbal modality of therapy seems contradictory (2006:81). Their justification for this approach included practicalities and the suggestion that verbal inquiry is "…the most direct route to children's perceptions" (2006:81). The current study provides a strong counter example of non-verbal, play-based methods being both practically possible and providing direct access to children's views of play therapy.

A potential strength of Green and Christensen's (2006) study was the triangulation of sources: the authors report undertaking a document review. Unfortunately it seems that this was employed rather inconsistently. Whilst some of the documents reviewed were related to the child's play therapy sessions in other cases only the therapists'

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[29] See 'Jasmine's' quote p.75.

qualification documents or a list of the methods they employed appear to have been accessed.

Green and Christensen (2006) report that a central theme was the 'Importance of Choice': it seemed that children preferred the time that they were able to choose in the sessions compared to the therapist directed time. They also highlight that children perceived playing as 'just fun' and talking as a way to release difficult feelings. However, one child articulated the unique combination of playing and talking available to children in play therapy:

> "Jasmine: [I like to] talk and play [in counselling]. When I talk, I get more stuff out. When I play, it's more active. I think playing is to show really what happened and how it happened". (Green and Christensen, 2006:74)

Green and Christensen (2006) suggest that therapists may utilise fun activities to direct the child's attention away from their specific problems. Whilst this may be the case, as argued above it does seem that some children, like Jasmine, are referring to a deeper process.

Themes related to the therapist included the experience of empathy and understanding within a trusting relationship and a focus on feeling safe and relaxed. Children often mentioned sand play, role play and art. Several changes were reported by children as an outcome of attending therapy. These included making better choices at home, decreased anxiety, increased confidence and self-esteem, and an increase in sociability.

**A Study Incorporating the 'Draw and Write' Technique**

Brownlie's (2006, unpublished[30]) study, which was developed and undertaken concurrent to the study reported in this thesis, employed a creative method to facilitate Scottish children's views of play therapy. She employed a 'Draw and Write' technique, first employed in the classroom setting by Wetton and Williams (1989, and latterly by Wetton and McCoy, 1998 and Wetton and King, 2003) and in the developing world to elicit views on community health (Pridmore and Bendelow, 1995). Brownlie's study utilised the 'Draw and Write' technique as the central method of facilitating children's

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[30] MA thesis.

views in recognition of the need to draw on less verbal methods. However, as Brownlie explains, the drawings themselves are not analysed. Rather they are intended to be prompts to the child's recall.

A strength of utilising this technique with children attending play therapy was the flexibility of offering the child opportunity to draw, write or talk or request the interviewer scribe. This enables the technique to be individualised, to some degree, to the child's choosing, which mirrors a degree of the choice inherent in NDPT. Furthermore, as Brownlie asserts, it addresses the potential differences across a large age range (4-12 years). However, Brownlie did not include toys, thus the range of choice afforded to children in play therapy sessions was not replicated. In the current study an aim with the methods developed was to achieve a high level of salience to the intervention itself.

Brownlie developed an adapted schedule in conjunction with the principle author and developer of the technique, Noreen Wetton. Brownlie reportedly asked children to talk about what they were thinking or feeling and why they were referred for play therapy before asking them to write or draw about their experiences. Brownlie guided them through six specific areas: 'a time they felt OK', 'a time they felt bad', 'what, if anything, helped', what their perceptions of the therapist's job was, whether or not anything was different since attending, and how they felt about ending. Brownlie also invited any further reflection on their experience. This sequence shows some overlap with the areas developed concurrently in the current study. As will be described in chapter five and six the focus in this study has been structuring a schedule which follows the chronological process of play therapy. Themes regarding likes and dislikes and the attributes of the play therapist are then interwoven into this framework.

In Brownlie's research a pilot study of five children was undertaken and subsequent changes to the schedule were made, including the use of the play therapists' name rather than referring to the 'play therapist'. Reportedly many children seemed unfamiliar with this job title, or the term 'play therapy'. In the main study, recruitment difficulties led to a reduction in sample size from an aimed twenty to an actual ten. Children aged 6-14 years were recruited to the main study, five girls and five boys. There was one 6 year old, one 7 year old, two 9 year olds and six over the age of 10. Unfortunately Brownlie did not collect referral information specific to each child; rather the cohort were a

convenience sample drawn from the same centre. Brownlie purposefully selected her sample from those who had received a minimum of twenty sessions. This ranged from 28 to 58 sessions (average 43). The sample was drawn from four different therapists. None of the girls had any disabilities, one boy had learning difficulties and a second had ADHD. Six of the children had received individual play therapy and four had received group play therapy. Five participants had not completed the therapy intervention. Clearly for these children it was not possible to gain their views on the ending process. One child had completed her therapy a year and two months prior to interview. Thus there was large variance in the timing of the interview. Brownlie's stated rationale for her selection of children who had received a minimum of 20 sessions was drawn from Leblanc and Ritchie's (2001) assertion that the results of their meta-analysis indicated that this was the minimum number to evidence effectiveness. However, without the information regarding referral or other measures to assess effectiveness, this rationale appears weak and once again there appears to be a bias toward 'successful' cases.

A strength of Brownlie's research was her implementation of a Peer Group review mechanism to reduce her bias as a potential 'beneficiary' of positive findings; both in terms of her role as researcher, but also her position as a play therapist and therefore in part an 'insider'. Consulting with professionals, outside of the profession of play therapy, arguably allowed a more independent review of Brownlie's findings as these professionals did not have a vested interest in positive findings. Such positive bias is also an issue in the current study. A debate regarding the strengths and weaknesses of 'insiders' and 'outsiders' and the ways in which this has been minimised in the current study is explored in chapter five and six.

Brownlie offered a pre-interview meeting with the children to help build rapport and minimise the difficulties of being an unknown researcher or 'outsider'. However, the parents of the children in the study did not wish to attend an additional meeting to the actual interview. A strength of Brownlie's approach was offering the children choice of venue: home, school or the therapy centre; again to increase the child's level of comfort during the interview itself. Interestingly four children chose the home setting and their therapy had terminated. Two chose school and had had their therapy in the school setting and the four who selected the centre were still having therapy at the centre at the time of the interview. Brownlie attempted to address some of the inherent power imbalance in adult-child relationships by taking the 'least adult role' whereby the adult

requests the child's help in understanding the experience they have had (see Corsaro and Molinari, 2000 and Mayall, 2000).

Brownlie undertook a thematic analysis of the data and suggests that the data was analysed by attending to both children's explicitly expressed views and attendance to indirect communication such as tone of voice or body language. However, in her presentation of the findings very little detail or analysis of this 'indirect communication' is recorded. It is not clear how the sessions were recorded and whether or not video was used. Video appears unlikely given the presentation of her results. This is a weakness which is addressed in the current study through use of video-taped sessions analysed in depth in terms of both verbal and non-verbal communication.

A strength of Brownlie's presentation of the results is the reproduction of several of the children's drawings. Acceptance of visual representations in qualitative research to communicate the participants' experiences and developments in visual analysis has increased over the past decade (see van Leeuwen and Jewitt, 2001, Banks, 2007 and Prosser, 2009). The visual presentation enabled the reader some access to the child's non-verbal voice. Interestingly all but two of the drawings presented include one or more stick figures only. In the two exceptions one is a drawing which also included objects from the playroom and one is a drawing of a more fully formed figure. Brownlie comments that, unlike the pilot research, children did not draw the playroom in detail. Whilst it was Brownlie's intention to use drawing as a prompt rather than analyse the drawings themselves, a record of the 'process' of the image-making, rather than purely re-production of the 'product', would have enhanced the presentation (see Malchiodi, 1998).

One difficulty Brownlie faced was children's anxieties about their competence at drawing. This indicates that despite the technique allowing some flexibility, children may need a range of methods to express themselves in individualised ways as they experience in NDPT (see Wilson and Ryan, 2005). Interestingly one child who had struggled to respond retrieved his box of toys and things he had made in group play therapy and showed these to the researcher. This prompted descriptions and memories of his sessions. This supports Pipe et. al.'s (2002) assertion, that the use of toys and objects when interviewing children enhances their recall. Such a method was developed

in the current study, to interview children about play therapy, and is explained in full in chapter five.

In Brownlie's study one child recounted a detailed narrative of a role play he had engaged in during group play therapy. Brownlie sought the views of this child's therapist. The therapist did not recollect the precise enactment but confirmed the themes of conflict and confrontation which were evoked in the child's account were recognisable. Brownlie argues that this conveys the symbolic significance for the child rather than objective reality. However, further exploration of this issue is warranted. It is also possible that a bias toward adult memories over child memories is prevalent here. The therapist herself may not recall the episode. This does not mean that it did not happen. There is no indication that the therapist's recall was cross-referenced with the notes. Furthermore this child had forty-five sessions and it is highly likely that his therapist would not remember every play sequence, particularly in a group therapy format. However, based on the memory research reviewed above, the child himself is more likely to remember details of play sequences which were of particular significance.

In terms of the views expressed by children in the study Brownlie found that children generally had mixed feelings regarding the initial stages of play therapy and had limited information about what to expect. In contrast to Carroll's (2002) findings most of the children were aware of why they were referred to play therapy. Children juxtaposed play therapy as a fun place as opposed to school which meant work. Brownlie comments on the overall feeling that these children found it difficult to survive within their school world. Children appeared to emphasise getting away from stress and arguably described external processes occurring rather than internal shifts. Brownlie reports that they did not describe "painful material being processed in a conscious sense" (2006: 76). Similar to Axline's study, children emphasised the enjoyment of play and positive relationships with both the therapist and other group members. As noted above bias toward 'successful' cases was likely.

Themes regarding the play therapist included acceptance, warmth, being available and reliable, and being playful and helping. Some children commented on 'emotional caretaking'. Others focused on 'physical caretaking' of providing safety and fun. The three eldest children commented upon the therapist observing their behaviour, thoughts

and feelings and trying to help them manage this. This mirrors Carroll's findings of older children being aware of the processes involved in play therapy whereas the younger children focus on what they did there. However, this is in contrast to Axline's early findings of very young children being able to reflect on their behaviour and the process of change within the session itself. This is an area addressed in the findings of this thesis.

Interestingly, Brownlie also found a difference between those children who had experienced group play therapy and those who had received individual. In individual therapy children's comments focused on the relationship with the therapist and in group therapy their comments centred on the therapist managing the relationships between group members. With regard to changes, an inconsistent response emerged. Most found it difficult to answer this question. However, Brownlie neglects to acknowledge the fact that four of the children had not finished their therapy. Therefore, reflection upon outcomes would be more difficult.

Brownlie concluded that the Draw and Write Technique was a 'viable method to consult with children on their views of play therapy. She acknowledged that some children found it difficult to engage for the 'twenty-thirty minutes' it took to complete. The child's level of engagement with the task is an issue discussed at length in relation to the current study.

**Summary**

The emerging literature in this new field on children's views of child therapy has been presented. The main findings in the field include:

- The importance of play. Both the children's enjoyment of play within the play therapy literature and the need to integrate play and creative methods in the studies on family therapy and CAMHS interventions.

- The importance of the environment and the disruptive nature of interruptions.

- The important role of carers and important adults. Both in terms of supporting the work and their inclusion in sessions. A need to focus on the voices of children and adults was highlighted.

- The importance of the therapeutic relationship. Qualities of the therapist such as acceptance, warmth and reliability have been emphasised in the play therapy

literature. The need to build a relationship and go at the child's pace was identified across disciplines.

- The importance of confidentiality. However, this varied with the age of the child and felt more significant to older children and adolescents.

Within the play therapy literature there has been a bias toward 'successful' cases. Gatekeeping issues are particularly significant in the field of child therapy and have led to recruitment difficulties. The number of children recruited to studies range from 3 – 18, ages range from 3-14 years with many of the findings focused on the older age range. There has been an emphasis on the use of verbal semi-structured interviews. However, a few studies have emerged which have begun to utilise creative methods such as drawing (Brownlie, 2006, unpublished; Ross and Egan, 2004) or a variety of creative methods including play in focus groups (Day et. al. 2004) and one study which utilised video-playback (Strickland-Clark et. al. 2000). Limitations of these approaches have been highlighted. Within the play therapy literature in particular a need for methods which are individualised to the child's preferences is indicated. None of the studies utilised video recording of the interviews themselves, thus analysis of non-verbal communication has been extremely limited. Only a few studies briefly acknowledge the non-verbal communication within child interviews (Axline, 1950; Brownlie, 2006, unpublished). The importance of attending to children's non-verbal communication when ascertaining their views is an area addressed in the current study.

**Conclusion**

Outcome measures do not seen to be sufficiently sensitive to therapeutic change in young children, nor are children's views of therapy frequently sought. Developing and employing other, more child-centred methods of evaluation, with all children, particularly younger children, as this thesis does, therefore is an important task.

Although useful ideas can be drawn from research on attaining children's views in other fields, such as those mentioned above (e.g. MOSAIC approach; 'PhotoVoice'), the complex, sensitive, and confidential nature of therapy needs to be considered when designing research to ascertain children's views of therapy. Elsewhere it has been argued that qualitative methods of evaluation with young children will be most easily investigated using their own preferred means of communication, namely play-based expressive methods of evaluation (Jäger and Ryan, 2007). As reported in chapter one

(Jäger and Ryan, 2007) I piloted several expressive play methods of evaluation in my clinical practice within CAMHS and earlier within a schools' based, NSPCC therapeutic programme. Three play-based techniques, the 'Expert Show', 'Miniature Playroom' and the 'Puppet Interview' were piloted with 12 children of varying ages (5 ½ -10 years).   These techniques will be presented in full in chapter five. Further exploration of the rationale for the use of play and the implications and challenges of expressive play approaches for accessing children's views of therapy will be provided.

Before doing so I return to the argument, presented in the previous chapter, by Carroll (2000:15) that the 'quality' of the relationship between therapist and child is intangible. An essential aspect of any therapeutic encounter is the therapeutic relationship, discussed in the previous chapter as vital in NDPT. As can be seen from the research reviewed above, children's views on the *relationships* they have with adult professionals have been sought in a variety of settings. Children themselves emphasise the importance of this relationship. In the current study I also intend to present the child's perspective of the therapeutic relationship. Therefore further consideration of our current knowledge of 'therapeutic relationships' seems warranted; in particular what are thought to be facilitative and inhibitive ways of interacting.

Furthermore children, adults and infants, provide us with non-verbal cues to indicate their 'views' in interactions. As stated in chapter two, the literature on parent-child interactions (see Stern, 1985) and therapist-client interactions in the adult psychotherapy literature (see McCluskey, 2005) is useful to draw upon. These bodies of research have studied the non-verbal responses of infants (see Stern, 1977; 1985) and both the non-verbal and verbal responses of adults in therapeutic interactions in minute detail. However, there are no studies on children and adolescents in therapy. Both bodies of literature are located in the overarching framework of attachment theory. Whilst it is beyond the scope of this review to provide a comprehensive summary of the plethora of work in this area, a brief overview is provided and particular applications of attachment theory to therapeutic relationships in NDPT are given in the next chapter.

## CHAPTER FOUR

## THERAPEUTIC RELATIONSHIPS

**Introduction**

In this chapter I outline our current knowledge of 'therapeutic relationships' with a particular focus on facilitative and inhibitive ways of interacting. This study focuses on children's perspectives of play therapy, a central part of which is the relationship with the therapist. Therefore a review of the research in this area is needed. Furthermore this thesis explores the use of new play-based techniques administered *within* the therapeutic relationship. Thus a review of facilitative and inhibitive factors within therapeutic interactions is warranted.

First I briefly review the process research and theoretical literature on facilitative or inhibitive factors in the broader area of adult psychotherapy and then turn to children's views of 'helpful' adults before briefly returning to the limited work in this area in the play therapy literature[31]. As I highlighted in chapter two some researchers have turned to attachment theory and our knowledge of parent-child interactions along with the dynamics of attachment in relationships to  further our understanding of therapeutic interactions. Therefore I provide a brief overview of attachment theory and focus on the notion of 'affect attunement' and later 'narrative regulation' as indicators of responsive sensitive caregiving. I then turn to the theoretical proposition made by Ryan and Wilson (1996) that, in NDPT, therapists recreate optimal sensitive caregiving experienced by securely attached children. There follows a description of the 'dynamics of attachment model' (Heard and Lake, 1997), which has been applied to both adult psychotherapy interactions and NDPT child sessions. I provide a detailed description of McCluskey's (2005) comprehensive and thorough work on observed adult-adult interactions in the psychotherapy context, particularly her focus on facilitative/inhibitive factors which lead to an attuned/misattuned relationship. McCluskey applies the 'dynamics of attachment model' to aid our understanding of the interactions. This model has been applied in a broader sense to NDPT. I argue that application of this model, and careful observation of the verbal and non-verbal cues which indicate attunement, to NDPT sessions would be a useful contribution to the field. This would also contribute specifically to encounters which focus on facilitating a child's exploration of their views

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[31] A discussion I began in chapter two.

on sensitive topics, including their experience of therapy, the focus of this research project.

**Facilitative and Inhibitive Factors in Psychotherapy**

McCluskey (2005) provides an overview of the adult psychotherapy literature on 'successful/facilitative' and 'unsuccessful/inhibitive' factors in therapeutic relationships. She cites Rogers' annotated transcription of a counselling session (1942) highlighting that Rogers conceptualised the therapist's responses as either inhibiting or facilitating and therefore crucial to the interaction. Specifically Roger's defined four qualities that "characterise the most helpful counselling atmosphere":

1. a warmth and responsiveness on the part of the counsellor which makes rapport possible and which gradually develops into a deeper emotional  relationship
2. permissiveness in regard to expression of feeling – the client comes to feel that all feelings and attitudes may be expressed
3. a clear structure in terms of time boundaries and what types of actions are permitted during the session
4. freedom from any type of coercion or pressure

(Rogers, 1942:87-89, in McCluskey 2005:19)

Support for empathic understanding and acceptance of the client being related to successful outcomes has continued (Bozarth et. al. 2002; Sachse and Elliot, 2002)

McCluskey cites Fiedler (1953) who studied 16 cases sampling hours of therapy sessions at the beginning middle and end. Fielder observed that the 'patient' was very aware of the therapist's feelings towards him. He argued that "…in order to have a patient who expresses his feelings freely, one must be a therapist who had favourable attitudes towards his patient" (313). Carkhuff and Berenson, (1977:155) emphasise the importance of the *interaction* between therapist and client. They provide the following description of effectively responding in therapeutic encounters:

"…Responding is much more than a verbal exchange. Responding incorporates the complexities of attending: attending involves physical, emotional, and intellectual attending, observing and listening." (cited in McCluskey 2005)

The word 'process' in the context of therapeutic research can hold several different meanings. McCluskey (2005:17) clarifies that 'process' can refer to the interaction or the relationship, the verbal or non-verbal sequences of behaviour or both. She highlighted that much of the research into 'process' issues in psychotherapy has focused on the skill of the therapist. However, Carkhuff and Berenson observed that the therapist's *affect* would change in intensity in response to their clients, and this affected the level of subsequent exploration by the client.

I now turn to facilitative and inhibitive factors in child therapy. Truax and Mitchell's study (1971) included comparing therapeutic work in a variety of contexts, including individual and group work with children and/or families. Their findings indicated that regardless of the approach or techniques employed by the therapists, empathy, non-possessive warmth and genuineness was related to successful outcome.

Farnfield and Kaszap's (1998) study sought children and young people's (7-20 years) perceptions of what made a 'helpful' professional. Again they focused on a broad range of professionals with varying approaches including social workers, therapists, through to solicitors. Empathy and the ability to make things happen were the two most frequent themes cited by children as qualities that make up a 'helpful' grown up[32]. Whilst the authors themselves acknowledge it was difficult to disentangle therapeutic interventions from more practical help (1998:12) it is of interest that children themselves reflect qualities of understanding and responsiveness as facilitative in interactions with adults.

More specifically in the play therapy literature Winek et. al. (2003) set out to investigate the 'moments of movement' (as first referred to by Rogers, 1942) in filial play therapy sessions. The authors highlight that previous studies in psychotherapy on the 'good moments' in the therapy process had focused on the use of a behaviour coding scale developed by Mahler and Nadler (1986). These were largely based on the reduction of target symptoms and behaviours associated with outcome criteria. Winek et. al. (2003) chose to develop their own categories specific to *interactions* within filial play therapy interactions[33].

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[32] When asked about 'unhelpful' qualities in adults children tended to focus on parents/carers or teachers.

[33] The reader will remember from chapter two that filial play therapy is based on NDPT.

They analysed the interactions in a single case study reported to be 'successful'. Parents (therapeutic change agents in the case of filial therapy) were interviewed following each therapy session. The codes generated from these interviews were categorised into facilitative and inhibitive responses. These were then compared with independent observers' ratings of videotapes of the play sessions. This resulted in seven categories of facilitative responses from the parent, (including setting limits, accepting, narrating; encouraging; re-directing; joining in fantasy play; self-awareness) [34] and eight categories related to the child which were deemed to be facilitative (asking for help; following the rules, being independent; learning; awareness of competency; expressing emotions; engaging in fantasy play; exploring). There were three non-specific facilitative categories (initiating affection/intimacy; connection; calming). Nine inhibiting parenting responses were identified (directiveness; insulting; undermining/contradicting, anticipating child's next behaviour; threatening; non-enforcement of limits; 'guilting'; interpreting behaviour/feelings; insulting self). Inhibiting child categories included just two (being oppositional and not following the rules). Avoiding intimacy was identified as a non-specific inhibiting category.

Unfortunately, although the authors provide definitions for each of these categories, they do not describe the interactions observed in the case nor the variance in these categories over time. Presumably those highlighted as facilitative increased as progress was made over the course of time. This is not well detailed. The resulting categories are rather broad. However, they do encompass both verbal and non-verbal responses including play behaviour. Application of these categories to filial play therapy sessions to map 'successful' therapeutic interactions was suggested by the authors. Clearly a limitation of this study is that it is a single case study. Following this process with other cases before more general application of the categories seems indicated, in the first instance.

Having considered some of the studies in the psychotherapy literature, on tracking facilitative and inhibitive responses in therapist-client interactions, I now turn to the extensive research on infant-carer interactions. It is outside the scope of this study to review each area within this research base. However, an overview of attachment theory

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[34] Definitions for each of the categories are given in the article

with a focus on affect attunement and narrative regulation are provided. These two areas are particularly focused on due to their relevance to the current study: children's views, or narratives, of play therapy. Play therapy accesses both verbal and non-verbal modes of communication and the play-based techniques under study mirror this. The literature on affect attunement provides a window into the facilitative and inhibitive factors expressed, largely non-verbally, within interactions between mother and child. Arguably this literature can provide us with useful information which can be applied to interactions in psychotherapy (McCluskey, 2002). In child therapy non-verbal communication is even more prevalent, thus application of the findings in parent-infant interactions to child therapist and child interactions is likely to be fruitful. A convergence of the developmentalists' research of non-verbal interactions and psychoanalysts' research into narration and verbal communication was called for and pursued by Stern (1985). The studies Stern and others (Favez, 2003; Koren-Karie et. al. 2003) have conducted into pre-school children's co-construction of narratives with their mothers is the second area I focus upon. These studies have direct relevance to the interviews researched in this study where children co-construct a narrative about their experiences of play therapy with their own therapist.

**Attachment Theory**

Bowlby (1980) and Ainsworth's et. al. (1978) original works on Attachment Theory are the foundation of this literature. "Attachment Theory began to provide the conceptual tools that helped researchers to classify and make sense of the behaviours and interactional exchanges observed" in the parent-child relationship (Howe et. al. 1999:15). Bowlby described the bond which develops between mother and child. He focused on the separation in this relationship and formulated the concept of a goal-corrected behavioural careseeking system. That is, the child seeks care and protection from the carer when the child becomes distressed. If the goals of care and protection are met by the carer the child returns to a less distressed condition (see Bowlby, 1988).

A further key theoretical concept was developed by Bowlby: the internal working model. Bowlby asserted that individuals build a set of mental representations built on their experiences with caregivers which act as templates for future relationships (see Bretherton and Munholland, 1999 for a full discussion). A similar concept was proposed by Stern (1985) and termed "representations of interactions that become generalised" (RIGs). Heard and Lake (1997) have latterly described these as 'internal

working models of the experience of relationships' (IMERS) to reflect the possibility of having more than one template for the varying experiences humans have, even within the same relationship, which then act as guides for the future.

Ainsworth identified qualitatively different patterns in mother-child dyads when the careseeking system was activated through her well known 'strange situation' experiments. Ainsworth introduced the concept that the carer is a 'secure base' for the child, from which the child can explore. Ainsworth's 'strange situation' assessed the level of security infants experienced with their carers in a stressful environment. Ainsworth identified three attachment patterns: insecure-avoidant; secure; and insecure-ambivalent (Ainsworth, et. al. 1978). Main and Solomon (1986) later identified a fourth category: insecure-disorganised. An infant classified as secure within the novel environment of the 'strange situation' was able to use their caregiver as a 'secure or safe base' from which to explore. When separated from the caregiver the infant was observed to become distressed, but may be somewhat comforted by a stranger. The infant showed a preference for comfort from the caregiver upon return. Those with an avoidant classification were unlikely to show distress when the caregiver left and was indiscriminate between the stranger and carer. When the caregiver returned the infant often showed avoidant behaviour of ignoring or turning away. Those classified as ambivalent were unable to use their carer as a 'safe base' often seeking proximity with the caregiver, upon separation the infant was likely to be quite distressed and difficult to soothe by a stranger and sought proximity to the carergiver upon return. A 'disorganised' infant was likely to demonstrate conflicted or disorientated behaviours and does not follow one of the coherent patterns described above some of the time (Weinfield et. al. 1999).

Attachment styles have been shown to be relatively stable over time and a number of ways to measure the changing attachment behaviours over time have been developed (see Cassidy and Shaver eds. 1999, and Grossman et. al. eds. 2005 for comprehensive reviews of attachment research from childhood through to adult life and the clinical applications of attachment theory to therapeutic practice). Attachment Theory has developed and new areas have been explored. (e.g. Crittenden and Dallos, 2009). Of particular relevance to this study is research on the interaction within attachment relationships and the attachment dynamics evident between child and carer, which seems to mirror therapeutic relationships. Heard and Lake's (1997) work

extends the careseeking/caregiving goal-corrected system proposed by Bowlby. Their model considers the *dynamics* of the attachment relationship and incorporates five inter-related systems. Before considering this model I turn to the work on infant-parent interactions and the phenomenon termed 'affect attunement' which has been frequently observed in infants with sensitive caregivers. Ainsworth's studies (1967; 1978) had demonstrated that a key factor in the infant's sense of security was the level of responsiveness provided by the caregiver. This 'responsiveness' has been carefully observed. In pre-verbal infants it is known as 'affect attunement'.

**'Affect Attunement'**

Stern (1985:138) argues that "the sharing of affective states is the most pervasive and clinically germaine feature of intersubjective relatedness". Stern highlights that imitation of affective state is not enough to result in an intersubjective exchange. He asserts that the mother has to be able to first read the child's feeling state, second match this behaviour in a corresponding manner and third the infant has to be able to interpret this parental behaviour as a response to the infant's initial cues. Stern cites many investigators who have tracked such interactions. He highlights the work of Papoušek and Papoušek (1981) who describe detailed vocal interactions of affective attunement. Stern impresses that, when the infant is below 9 months, this begins with matches in the same 'mode' (or channel of communication e.g. vocalisation; facial expression; body movement). The mother matches an infant's vocalisations or facial expressions with her own it is not stereotypical but entails constant modifications. Stern later names this 'emotional resonance'. After the age of 9 months the mother expands this behaviour to what Stern terms *'affect attunement'*. Here the mother matches the child's affect 'cross-modally', meaning across communication channels. In other words: "affect attunement takes the experience of emotional resonance and automatically recasts that experience into another form of expression" (Stern 1985:145). For instance an infant's vocalisation might be matched cross-modally with a mother's body movement.

Stern provides five clear examples of 'affect attunement' (see Stern 1985:140 reproduced in appendix 3). Stern (1985:142) clarifies that attunements involve: some form of matching, which is often cross-modal, of an aspect of the other person's behaviour that *reflects the persons feeling state*. The infant's feeling state may be evident from their 'vitality affects'. Vitality affects are defined by Stern (1985:156) as "those dynamic, kinetic qualities of feeling that distinguish animate from inanimate and

67

that correspond to the momentary changes in feeling state". Kinetic terms such as 'surging' 'fading away' 'fleeting' 'explosive' 'crescendo' 'decrescendo' are used to illustrate the quality of feeling which Stern refers to as 'vitality affects'.

In recognition of the need to demonstrate the existence of such interactions, rather than simply see these as clinical intuition, Stern operationalised the types of behaviour that could be matched. He identified three main dimensions: intensity; timing and shape. He further divided these into six specific types of match. These are briefly summarised below:

1. *Absolute intensity*: the level of intensity of the mother's behaviour is the same as the child's.
2. *Intensity contour*: The changes of intensity over time are matched.
3. *Temporal beat*: A regular pulsation in time is matched.
4. *Rhythm*: A pattern of pulsations of unequal stress is matched.
5. *Duration*: The time span of the behaviour is matched.
6. *Shape*: Some spatial feature of the behaviour is matched.

(Stern, 1985:146)[35]

Stern applied these classifications to video-taped dyadic interactions between mothers and infants aged 8-12 months. Ten dyads were observed in free play sessions and the mothers were asked about their understanding of the attuned interactions. These interviews took place with joint viewing of the video tape between researcher and mother. The researcher paused the tape after every attuned interaction identified. Main findings included: the majority of attunements occurred *cross-modally* and matched in terms of *intensity*. The most frequently given reason by mothers for performing an attunement was 'to be with' or 'share' the infants experience. Furthermore '*purposeful misattunements*' were identified where the mother intentionally over- or under- matched the infant's behaviour these where identified as categorically separate from *'true misattunements'* where the mother incorrectly identified or was not able to match the child's feeling state.

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[35] See appendix 3 for a full reproduction of these definitions including examples.

Stern suggests that the parent-infant system and the therapist-patient system appear to have parallels. However, he cautions against conceptualising the affect attunement observed and described in parent-infant interactions as analogous with therapeutic empathy. He clarifies that affect attunement is a necessary precursor to therapeutic empathy. However: "attunement between mother and infant and empathy between therapist and patient are operating at different levels of complexity in different realms, and for ultimately different purposes" (Stern 1985: 220). Before considering this further, in relation to the research presented here, Stern's later work on pre-school children will be presented.

**'Narrative Regulation'**

Stern (1985) acknowledged that dealing with non-verbal communication has always been a familiar domain for developmentalists whereas psychoanalysts tended to focus on words, narration and interpretation. Stern asserts that his goal has been to bring the two to meet. He notes that the methods of analysis used by each discipline are necessarily different. Developmentalists have tended to conduct observational studies and undertaken micro-analysis of small behavioural units whereas psychotherapists have tended to focus on larger units which make sense as narrative units. Stern asserts that he has searched for clinical relevance by searching for implicit narrative-like meaning to the smaller behavioural patterns (1985:xiv). Stern's early work convinced him that the "narrative sense of self/selves was key to later clinical issues, and…the co-constructing process (is) crucial" (1985:xxxii) this led to work, together with Favez and others, on mothers with children aged 4-6 co-constructing narratives.

Favez (2003) explored affect regulation and dysregulation in mother-child interactions of pre-school age children during the co-construction of a narrative. As highlighted above the co-construction of narrative is particularly relevant to the current study. Favez (2003) highlights that 'narrative regulation' is another identified form of affect regulation. This is developed in the pre-school years of a child's life (Nelson, 1989; Stern, 1989 cited in Favez, 2003). Favez argues that narration "integrates the affect, cognition, and action related to an event; it brings order and differentiation according to characteristics inherent in the narrative structure" (2003:305).

The research team explored in what ways the mother regulates the child's behaviour in narrative interactions and whether or not similar patterns of interactions are observed as

those seen in non-verbal affect regulation. Favez (2003) hypothesised that an "optimal regulation pattern allows the affective core of the story to be mentioned, mainly the high point, whereas a dysfunctional regulation pattern hinders such a retelling after an experienced event" (2003: 307).

Forty-nine mother-child dyads, of children aged 3.6 years to 5.11 years (mean 4.5years) were studied. The researchers created an 'ad hoc' event (GEES: Geneva Emotion Eliciting Scenario). This was an 11-episode scenario played by actors in an experimental setting. The child actively participated in the scenario, thus creating a 'lived event'. The child then created a narrative about the event with their mother, immediately after the event and two weeks later. Half of the mother's were 'blind' to the actual event, equivalent to being an 'outsider' (as referred to in the participant researcher literature reviewed in the previous chapter) or viewed the event through a one way mirror, thus effectively an 'insider'.

Three different styles of negotiating the narrative reconstructions were identified: *optimal, over- and under-regulating* mothers. Cooperation and negotiation was enhanced by the *optimally regulating mothers*. These mothers pursued shared emotions and pleasure in telling using expressives and general assertives. They repeated and extended what the child said in a flexible way. These mothers seemed to prioritise a coherent account rather than an accurate account. In contrast performance and the conditions of the narrative were focused upon by the *overregulating mothers*. These mothers issued orders, requests and factual assertives. They were overinvolved in their child's discourse. *Underregulating mothers* provided only minimal support favouring passive following of the child's narrative. They spoke less than their child and asked few questions (Favez, 2003).

The researchers found that in interactions with 'informed mothers' (who had shared the experience with their child) the child's report was more accurate.  However informed mothers tended to be 'overregulated'. They were more demanding and corrected the child more frequently. They dismissed children's other concerns, such as being hungry, in favour of re-counting an accurate story. They relied on didactic rather than conversational styles. Interestingly they spent more time on the joyful event in the story than the affective core of the story, which included the feelings of fear and sadness. This was the least commented upon part of the story for all children. However, children with

optimal-regulating mothers more frequently mentioned the affective core of the story and elaborated more on this compared to other children (Gertsch-Bettens, et. al. 2003). Implications of these findings in relation to the current study will be discussed in chapter eight.

Favez (2003) asserts that these findings need to be confirmed through replication. A limitation of the study is the sole focus on the verbalisations in the interaction rather than inclusion of the non-verbal communication. In fact Favez notes the research teams surprise at the predominance of the overregulating mothers (45%) and suggest that measurement of facial expression maybe needed to assess true emotional level.

Koren-Karie et. al.'s (2003) study focused on the dialogues of slightly older children, 7 years, with their mothers. The team studied 120 dyads. They showed each dyad four feelings cards and asked them to remember a time the child had experienced this feeling. The dyads were asked to construct a story about the experience. Verbal transcripts, again non-verbal communication was not focused on, were subsequently coded. 'Juncture points' or challenges from the children to the mothers were analysed. These included the child being unresponsive; uncooperative; or talking about something the mother does not want to discuss. Four types of dyads were identified:

*Emotionally Matched: Task-oriented, engaged and cooperative* (43 of 120 28.3%): These dyads constructed a wide range of stories regarding all four feeling states. These included a mixture of full stories rich in detail, and brief narratives. However, all had a level of coherency with a clear and believable link. There were no exaggerations of extremes recorded. The mother frequently provided the structure to the story, by asking questions or suggesting a theme. They allowed 'space' for the child to tell the story as they remembered it, or make changes. The pace of the story was appropriate to the child. Mothers in this group responded to juncture points in calm not directive ways, they did not respond with hostility, anxiety, derogation or other negative acts. Patience and acceptance by both parties was witnessed. Interestingly "quite a few of the children brought up negative themes such as harsh discipline, mother being inattentive, or feelings of jealousy and rejection" (2003:341). However, importantly these themes were communicated openly and there was an absence of hostility, ignoring, dismissing or interrupting responses from the mother to the child. This is strikingly similar to Favez's

(2003) description of optimally regulated mothers exploring the affective core of the story which contained negative or difficult emotions.

*Emotionally Unmatched: Exaggerating, overreacting, and overwhelming* (57 of 120 47.5%) The stories from these dyads were often quite negative, extreme and dysregulated: emotionally charged stories. Confusion, repetition or mismatched to the feeling requested resulted in incoherence. Overdramatisation was often exhibited. Sometimes the mothers dominated the stories with their own emotions rather than the child's. A strong need to please or role reversal was sometimes evident. They were dismissive at juncture points. Parallels with Favez's (2003) description of over-regulated mothers, can be seen here.

*Emotionally Unmatched: Flat, Uninvolved and Using only Emotional Labels* (13 of 120 10.8%) Lack of dialogue was characteristic of these pairings. Emotions and linked events were named but the meaning was not developed. Stories were often short and the same event was frequently used to describe the different feelings. The mother quickly moved the child onto the next topic. Again similarities can be drawn with Favez's (2003) categories, here with under-regulated mothers.

*Emotionally Unmatched: Inconsistent Dyads (16 of 120 13.3%)* One of the partners was cooperative and consistent (sometimes the parent other times the child) whereas the other partner blocked the dialogue or engaged in a high degree of anger or hostility.

Koren-Karie et. al. (2003) argue that a mother's responsiveness and emotional availability is crucial in enabling a child to discuss a wide range of emotions. Where the mother is also able to contain negative emotions and maintain cooperation with a task the child is more likely to use the mother as a secure base from which to explore (Koren-Karie et. al. 2003).

However, similar to Favez (2003) they acknowledge the limitation of relying on the verbal transcriptions of dyads rather than video-tape where non-verbal communication could have been considered. The authors argue for the benefits of working from verbal transcripts alone. They suggest that focusing on one dimension, the voice, enabled them to identify the problematic nature of the communicative process focusing on the areas of critical importance: coherency, structure and organisation of the dialogue. Indeed it is

easy to see how coders may become overwhelmed by the amount of communication taking place in interactions. As Stern highlights:

"The embedding of attunements is so common and most often so subtle that unless one is looking for it, or asking why any behaviour is being performed exactly the way it is, the attunements will pass unnoticed…it is the embedded attunements that give much of the impression of the *quality of the relatio*nship" (1985:141).

However I would argue that attention to the verbal *and* non-verbal processes are necessary in understanding pre-school and school aged children's interactions. This is particularly so, given the findings of cross-modal communications. Whilst verbal communication becomes more dominant as the child develops non-verbal communication remains an important mode throughout human life. The addition of non-verbal information can completely change the meaning of a communication. A strength of McCluskey's (2005) work, within adult psychotherapy, is the detailed analysis of both verbal and non-verbal processes between adult dyads, to assess the level of emotional match or attunement. I return to this comprehensive study below. First I turn to the argument proposed by Ryan and Wilson (1996) that NDPT recreates optimal socialisation patterns and mirrors emotionally matched, or attuned caregiving relationships.

**<u>Non-Directive Play Sessions: An Optimal Environment</u>**

Kaufman (1989: cited in Schore, 1994: 445) argues that "psychotherapy must mirror development by actively engaging the identical processes that shape the self". Ryan and Wilson (1995) present a thorough and convincing argument demonstrating the parallels between NDPT sessions and normal infant socialisation with a sensitive carer. They outline the ways in which NDPT mirrors these processes, from a theoretical point of view. The authors draw upon one case study from clinical practice to illustrate their proposal.

It is argued that NDPT sessions create a non-threatening atmosphere where the child can engage at their own developmental level (Ryan and Wilson, 1996). The authors acknowledge that this is not unique to the non-directive approach alone and cite Bacal and Newman's (1990) exploration of the corrective functions of therapeutic

relationships. The shared properties between therapeutic encounters and optimal mother-child relationships are thought to include "emotional availability, dependability, empathic attunement, sensitivity to development needs" (Zeenah et. al. 1990 in Ryan and Wilson, 1995:30).

The authors apply these concepts directly to the therapeutic interactions and communications in NDPT. They argue that using a child-centred approach means that children are enabled to develop at their own pace and, similar to sensitive caregivers, NDPT therapists are flexible and responsive in their approach to children. Individualised treatment is at the core of NDPT (Ryan and Wilson, 1996). The enriched environment and facilitation of symbolic play enhances a child's development and ability to assimilate personal experiences freely (Wilson and Ryan, 2005). Therapeutic benefits arguably include a sense of independence and mastery; increased confidence and self-esteem; the ability for children to express themselves without fear of rejection and an increased sense of security, (Axline, 1989, see chapter two for a review of the efficacy of play therapy).

The authors argue that NDPT sessions provide children with security, by therapist's generalised attitude to the child that they are emotionally available and dependable. This is conveyed through the use of emotive verbal and non-verbal messages along with compatible motor actions in play sessions. They comment on play therapists promoting face to face interactions with children similar to those occurring in early infant-carer relationships which are responsive. They assert that the therapist adjusts these and the level of eye contact the child will tolerate in response to the child's individual needs. The authors provide examples of how therapists promote children's ability to move beyond child-adult, or child-object, only interactions to child-object-adult interactions, as has been observed in normal development studies. They argue that the play environment and responsiveness of the therapist heightens the child's interest in exploration and helps to foster a sense of personal competence. The combination of these conditions mirror those observed in optimal socialisation patterns between an infant and a sensitive carer during normal development (Ryan and Wilson, 1995).

Such an environment may have been lacking for the cohort of children who are referred to play therapy. Play therapy referrals include children who have been abused or neglected by their parent/carer(s). Alternatively the parent-child relationship may have

been a relatively secure and attuned relationship however a disruption in the attachment relationship may have occurred, for example due to a recent trauma, e.g. traumatic bereavement or extra-familial abuse may mean that the family would benefit from re-creating the enhanced environment usually provided during the child's early years. Ryan and Wilson (1995) suggest that children's innate predisposition to engaging in personally meaningful social interaction (Murray 1989) can be reactivated.

Since Ryan and Wilson's paper developments in attachment theory in terms of understanding the dynamics of relating in careseeker-caregiver interactions have taken place. I describe Heard and Lake's model which extends Bowlby's theory of careseeker-caregiver relationships before proceeding to describe the ways in which this has been applied in detail to adult psychotherapy and more broadly in the context of play therapy.

**Extended Attachment Theory:**
**'Dynamics of Attachment and Interest Sharing' Model**
Heard and Lake's (1997) aim was to encompass findings from more recent attachment related research and clinical findings of psychotherapists which were not explained by Attachment Theory. They hoped their extended theory could be used as a tool which would enhance therapists understanding of their clients.

Heard and Lake (1997) identified three specific areas where clients experienced difficulties, which were hitherto not fully explained. These were: i) peer relationships; ii) sexuality; and iii) how clients coped with unresponsive or rejecting care. These seemed to relate to, Bowlby's formulation of, instinctive goal corrected caregiving and careseeking systems, this led Heard and Lake to suggest that "…such patterns could be expressions of other systems of instinctive goal corrected behaviour", (Heard and Lake, 2001:2)

Bowlby argued that these goal-corrected systems were motivational, that they were activated by specific cues which would lead to behavioural outcomes rendering the system quiescent (Heard and Lake, 2001). Heard and Lake used this concept as a base, but moved away from the one-dimensional approach and formulated five interrelated behavioural systems which they have now termed 'The Dynamics of Attachment and

Interest Sharing' (Heard, 2002, cited in Ryan, 2005). This was based on their observations within the context of adult psychotherapy. The five systems are as follows:

1) The interpersonal **attachment or careseeking system** (as described by Bowlby)

2) The interpersonal **parenting system.** This includes Bowlby's **caregiving** component, where the adult provides protection from danger, but also includes physical care; comfort and soothing when in psychological distress, including emotional regulation. Further to this the parenting system encompasses a **growth and development component**, where the adult uses a 'supportive companiable' way of relating, to enable the child to be autonomous and exploratory and therefore promote the careseekers development. Heard and Lake assert that this system is "ultimately responsible for the harmonious functioning of all three interpersonal partnerships within the attachment dynamic" (Heard, 2001:8)

3) The **exploratory interest sharing system** with peers. This includes an interpersonal component, where understanding is enhanced and skills are developed whilst engaging in a mutual interest with peers. This system has an intrapersonal component where an individual experiences curiosity and creativity in a solitary activity. If the caregiving or careseeking system is activated this system is inhibited.

4) The **sexual/affectional system**. An interpersonal system developed with peers.

5) The **personal self-defence system**. This is an essentially intrapersonal system, its function being to minimise discomfort experienced from insufficient caregiving. It is activated when the individual experiences fear of abandonment, shaming and/or dismissive or angry care. (Heard and Lake, 1997, 2001).

Heard and Lake argue that when the goals of all five systems are reached a person is able to relate co-operatively, enabling satisfactory adaptation to change. They enable the person to achieve the optimal levels of vitality, well being and engagement with the world. However when the goals are not being met satisfactorily the functions of the systems change from promoting interpersonal well-being to seeking personal survival defensively (Heard and Lake, 2001). In particular if the careseeking or caregiving system is activated, the other systems are inhibited. If the personal defence system is highly activated, the exploratory system is inhibited.

As McCluskey (2005:241) clarifies Heard and Lake (2003) argue that the goal of careseeking is not to achieve proximity to the caregiver, as Bowlby had originally

proposed. Rather an effective response is required by the caregiver to assuage the careseeking of the careseeker and allow them to "get back on track and deal more competently with the world".

The interactions between and within the five goal corrected systems is discussed in detail by Heard and Lake (1997, 1999, 2001). Heard and Lake (1997), themselves psychotherapists state:

"…how to relate therapeutically to a client matches, in large measure, our understanding of companionable supportive caregiving." (136).

Research has begun on the ways in which the five systems interrelate in therapeutic encounters (e.g. Heard and Lake, 2001; McCluskey, et. al. 1999; McCluskey, 2005; Hunter 2003 unpublished[36], Ryan, 2004; and O'Sullivan and Ryan 2009). I review these below, providing a fuller account of McCluskey's work as this is the most comprehensive study. This study incorporates the research findings on infant-parent interactions, reviewed above, and Heard and Lake's attachment dynamic to a large number of cases.

**Application of the Dynamics of Attachment to Interactions in Adult Psychotherapy**
McCluskey and Duerden (1993: 26) felt that therapists could apply the techniques of micro-analysis used by Stern to therapeutic interactions. They concluded that capturing the detail of the process of communication in therapeutic interactions was necessary to further our understanding of facilitative therapeutic processes. Use of video-taped interactions which could be played back in slow motion appealed to them, as this would allow the 'ebb and flow' of the interactions to be captured. McCluskey's aims were to monitor the interaction pattern between therapist and client similar to the Grossmans' (1991) study on parents and infants in play interactions. However, rather than the 'third' element being play as it was for Grossmann, in the context of adult psychotherapy it was conceptualised as the discussion of emotional concerns.

McCluskey (2005) argues that psychotherapy provides an opportunity to effectively respond to the careseeking behaviours clients bring resulting in the acquiescence of the

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[36] The current author's MA dissertation on applying the attachment dynamic to interactions in filial play therapy: Hunter being the author's maiden name.

careseeking system and the promotion of the exploratory system. McCluskey (2005) recognised that, in the context of adult psychotherapy, this involved highly complex verbal and non-verbal interactions. She suggests that to successfully achieve acquiescence of the careseeking system and promotion of the exploratory system, in this context, the adult client has to experience empathy *in addition* to affect attunement (a pre-cursor to empathy). She states that empathy is a metacognitive capacity which requires:

> "the ability to have a sense of other minds, to see things from another's point of view, to understand their emotions, resonate with these emotions and convey in words one's appreciation of the other person's state in a way that is recognisable to them that you have understood them." (2005:243).

McCluskey further clarifies that affect attunement is expressed cross modally on a non-verbal level, and empathic attunement is expressed verbally: a verbal acknowledgement of the client's emotional state. Within this definition there is acknowledgement that to convey empathy affect attunement is present in addition to the words spoken. However, this definition does not wholly fit with Roger's (1951) description of empathy. He emphasises that conveying warmth and empathy is a pattern of behaviour including the words spoken, the person's facial expression and their gestures. McCluskey's definition suggests that to convey empathy one must *always* make a verbal statement in conjunction with attuned non-verbal behaviour. However, as Wilson and Ryan (2005) highlight, particularly in creative therapies, empathy can be expressed through non-verbal means. They assert that "therapists need to ensure that their verbal reflections do not detract from the power and creativity of the activities themselves" (2005:227). In the current study empathic attunement is understood as being expressed non-verbally with or without the addition of an explicit verbal reflection. Thus non-verbal communication can acquiesce the careseeking system and promote the exploratory system, particularly in the context of child therapy. The current study can be seen to take into account both play (akin to the Grossmans' study) and verbal discussion (akin to McCluskey's study) as the third element in child-therapist interaction.

Whilst all three of McCluskey's experiments are of interest and relevance to this study there is not space to adequately detail each of them here. The reader is directed to McCluskey's (2005) book for a thorough description of the processes undertaken. Here

I give a brief overview and focus on the procedures and findings which are of importance in relation to the current study.

McCluskey's (2005) first two experiments involved groups of novice and expert observers viewing 1.5 minute videoed extracts of interactions between therapists and clients in adult psychotherapy, from a range of theoretical orientations. This resulted in the crystallisation of 'empathic attunement' and specifically the need for raters to pay close attention to the *interaction*, rather than the behaviour of either the therapist or client in isolation.

The third experiment involved role plays in which professional actors played the clients (careseekers) and students took the role of therapist/social worker (caregivers). The students received a period of training following which a second role play was conducted. The role plays were videoed (creating 108 interactions). These were rated by the participants and measured by an external observer. The use of actors meant that ethical issues, regarding the use of live therapy sessions, were overcome. However, this clearly compromised the authenticity of the 'therapy sessions'.

Following the experiments McCluskey noticed that observing 1.5 minute segments often led to observers missing the 'repair' moments after the ruptures in attunement. This had sometimes led to discrepancies between the independent observers rating of the interaction and the careseeker and caregivers subjective ratings. This motivated McCluskey to gather further video tapes of real psychotherapy interactions (a total number of 22 video-taped clinical sessions were drawn upon). McCluskey (2005) also set up simulated sessions of 20 minutes between experienced clinicians, from a range of helping professions. This enabled use of two video cameras and full-length mirrors to fully capture the interaction. Arguably the video set-up negatively impacted upon the participants levels of comfort and interactions. However, this did enable McCluskey to capture and analyse the verbal and non-verbal communication in full. Whilst participants were asked to discuss a real issue the time frame was short and the authenticity of the interaction due to the setting was likely to have been somewhat compromised.

After a long process of initially failed attempts inter-rater reliability was confirmed. McCluskey asserted that the instinctive careseeking system would shut down when the

caregiver has effectively attuned to the careseekers affect and/or expressed empathy. This enables the careseekers exploratory system to become active. This was the theory of goal-corrected empathic attunement proposed by McCluskey (2005). Her findings suggested that this was an interactive process which required observation and judgement of the vitality affects and emotive messages of two people in interaction with each other. Attention to the mode of expression was needed, encompassing the voice, face, eyes, and posture, and the interaction was classified in terms of four levels of 'vitality state': low; medium; high and regulated. McCluskey (2005) provides detailed written exemplars illustrated with video stills of 'attuned responsive caregiving' which resulted in exploration and 'misattuned caregiving' which resulted in withdrawal or persistent careseeking. The video stills are taken from the simulated therapy sessions and enable the reader greater access to the material described. This is a new area of development in the presentation of the psychotherapy literature. Presenting findings in a visual form, without compromising anonymity when researching real psychotherapy sessions, are advanced in the current study and explained in chapter six.

McCluskey argues that in order for the careseeker to reach a state of exploration the caregiver needs to first manage the emotional arousal of the careseeker (affect regulation). Therefore the caregiver attunes herself to the 'vitality affects' of the careseeker by either 'tuning down' the careseekers affects so that the careseeker can think clearly within manageable levels. Alternatively the caregiver will 'tune up' the careseekers affect resulting in the careseeker being able to access their own affective experience. McCluskey has developed nine patterns of interaction associated with effective and ineffective caregiving in adult-adult interactions. Three of these patterns were categorised as effective, common to all three was the regulation of the careseekers affect. Application of these patterns, to the interactions observed in the current study, is provided in chapter eight.

**Application of the Dynamics of Attachment to Interactions in Play Therapy**

Ryan (2004, 2009); O'Sullivan and Ryan (2009), and myself (Hunter, 2003, unpublished) have applied the dynamics of attachment model to the interactions occurring in NDPT. Ryan (2004) applied the model, retrospectively, to further understand the processes in the systems around a child attending play therapy which had been particularly complex and resulted in the therapy intervention breaking down. The focus of Ryan's (2004) application is the ways in which the therapist communicated in a

non-defensive manner to encourage negotiation and cooperation within the system around this child with highly complex needs placed in short-term foster care. Theoretical application of the model arguably helped to clarify the interactions occurring between different parties (child, therapist, social worker, foster carers) at different points over the time of the intervention. Application of the model led Ryan to conclude that the therapist providing consultation to the existing system of adults around the child may have been more effective, due to the complex interplay of the attachment dynamics. Ryan (2009) has also applied the model in brief to a single case study where play therapy was thought to be successful.

In my own research (Hunter, 2003 unpublished) application of the model to the complex interactions, between child, parent/carer, and therapist, taking place in filial play therapy was applied to five case descriptions provided by therapists. A focus on both successful and unsuccessful cases was taken in this small study. Application of the model on a macro scale helped to track patterns of relating across the interventions as reported by the therapists. O'Sullivan and Ryan (2009) have drawn upon Heard and Lake's concepts to convey the containment provided to children through the use of therapeutic limit setting in NDPT. They highlight the importance of the caregiver's (therapist) self-defence system remaining quiescent during these times, in order to address the child's careseeking needs and promote the exploratory system. A limitation of the studies which apply this model to play therapy sessions is the lack of observational data to draw on. In chapter eight I apply this model to the observed interactions of four cases in the current study.

## **Conclusion**

In this chapter I have presented a broad range of theoretical, practice and empirically based research from the developmental, attachment, and psychotherapy literature. I have shown how the understanding of interactions between infants and carers, both from observational research and extension of theory, has been applied to psychotherapy. This has begun to develop our knowledge of facilitative and inhibitive interactions in therapeutic encounters, in particular the ways in which therapists (caregivers) can promote the exploratory system of their clients (careseekers). I have also argued that application of the research on the co-construction of narratives, between pre-school and school aged children and their mothers, to child therapy interactions is likely to be fruitful.

Application of the dynamics of attachment model to play therapy has begun. However, this has remained on the macro- level and theoretical application to clinical experience. Within play therapy the dynamics of attachment could usefully be applied to observed interactions. Furthermore application of the micro-analysis techniques employed by Stern and later adapted by McCluskey seems useful. Particular attention to the non-verbal and verbal processes is needed when analysing interactions in play therapy. In addition consideration of the developmental level of the child and focus of activity is needed. Therefore drawing on the range of techniques reviewed, from infant-carer non-verbal interactions, to mother-child interactions during co-construction of narratives to adult therapist-client interactions in psychotherapy is indicated. Of particular interest to this study is the therapist's ability to facilitate the child's access and maintenance of their exploratory system when constructing a narrative: specifically about their experience of play therapy.

This chapter completes the review of literature bases related to the current study. In the next section I turn to the development of the methodology employed. First I present the pilot study in chapter five; next I detail the methodology for the main study in chapter six.

**PART TWO:**

**METHODOLOGY**

# CHAPTER FIVE
## THE DEVELOPMENT OF PLAY-BASED EVALUATION TECHNIQUES:
## THE PILOT RESEARCH

### Introduction

In this chapter I first outline my initial purpose and related research questions at the piloting stage of this project and provide the reader with a preview of the final purpose and questions discussed in more detail in the next chapter. I elucidate further on the rationale for taking a play-based approach. I describe each of the Play-Based Evaluation (PBE[37] for short) techniques in full and present the findings of the pilot research. I focus on power and consent issues when undertaking evaluations with children, which parallel issues in the research literature on interviewing children. I explore the strengths and weaknesses of therapists undertaking evaluations with their own cases and address a central finding in the pilot research; namely the need to remain child-centred and flexible throughout the evaluation session.

### Initial Purpose

The gaps in the research, and methodology applied to, gaining children's views of child therapy were presented in chapter three. It was argued that current outcome measures do not seem to be sufficiently sensitive to therapeutic change in young children. A need to develop and employ other, more child-centred methods of evaluation with all children, particularly younger children, was proposed. Thus my initial purpose, in the pilot study, was to develop child-centred methods which would enable exploration of the complex, sensitive and confidential nature of therapy. In particular the central focus was on developing play-based methods which would match the play therapy intervention received. A further aim was to develop a method which could both be utilised in research, but also incorporated into practitioners' everyday practice.

### Research Questions

My main research question at this stage was:

- Can existing play-based therapeutic and assessment techniques usefully be adapted to elicit children's views of play therapy?

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[37] PBE will be used for ease from this point forward.

More specifically I was interested in two techniques and posed the following two sub-questions:

- Can 'Broadcast News[38]' be adapted to elicit children's views of play therapy?
- Can Story Stems[39] be adapted to elicit children's views of play therapy?

## Play-Based Evaluation Methods

As stated above, existing outcome measures, or even 'child-friendly' questionnaires,[40] appear incongruous to the intervention itself. This issue has also been raised in the context of adult clients' views of psychotherapy. Macran et. al (1999) assert that objective measures and questionnaires do not truly seek clients' perspectives, particularly as they are shaped by researchers' agendas rather than allowing participants to share what is important to them. They stress the importance of remembering that psychotherapy is very much a subjective interpersonal experience and argue that research designs need to reflect this.

In other modes of therapy, e.g. CBT[41], worksheets may form a part of the intervention itself and therefore a paper-based questionnaire for children at the end of therapy may be an appropriate choice. However, even in this context, arguably much important information is lost particularly due to the constraints of the structure imposed by a quantitative measure. Clearly more research is needed to establish the effectiveness of paper-based measures and other evaluation methods in gaining children and young people's views of different modes of therapy. One clear advantage of paper-based questionnaires is the ease of administration and the fact that low level time implications enable study of a greater number of participants. Day et. al (2006), reviewed in chapter three, proposed to use the findings gathered from a variety of creative methods implemented in semi-structured focus groups to act as the framework for a paper-based questionnaire. This will enable the researchers to use an instrument, informed by

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[38] A cognitive behavioural play-therapy technique (Kaduson, 2001) described in detail below.

[39] A projective play-based assessment technique (for a review of variations see Woolgar 1999)

[40] These are often developed within small therapeutic teams as part of a package of evaluation incorporating service-user satisfaction e.g. NSPCC or national projects see BAPT, play therapy specific evaluation questionnaire and for child therapy in CAMHS the national outcomes research consortium (CORC) have produced the CHI Commission for Health Improvement service satisfaction surveys including one questionnaire aimed at 9-12 year olds which includes feeling faces.

[41] CBT is an acronym for cognitive behavioural therapy, see Friedburg and McLure, 2002 for an overview of this approach.

qualitative research, with a much larger sample. It will be interesting to compare the findings of their original study with the proposed study using questionnaires when this study is complete.

In play therapy, where play is the main focus, it follows that a play-based evaluation would be the most fitting option. Some researchers have used play simply as a way to build rapport with a child or as an activity to initiate talking (Thomas and O'Kane, 1998). In the child witness research the incorporation of play materials has been used to try to enhance children's abilities in communicating what has happened. However, the effect this has on the accuracy of what is reported has revealed mixed results (Pipe et. al., 2002, see chapter three). In the field of sociology James and Prout (1995) assert that concrete aids and play enhance children's ability to verbally communicate. A central tenet of play therapy, as discussed in chapter two, is that play is the child's natural method of communication. Verbal communication is not privileged over the non-verbal, rather *both* modes of communication are seen as equally important means of expression and windows into the child's inner world (Wilson and Ryan, 2005 Ch3).  Play therapy techniques emphasising non-verbal means of communication seem highly adaptable to interviewing children in a child-centred and effective way (Jäger and Ryan, 2007).

Allowing the child choice within a play context is the emphasis of NDPT. Therefore developing a range of techniques would incorporate some level of flexibility and choice into the evaluation stage. The evaluation measures would also need to be suitably complex to try and access children's varying thoughts and emotions about a complex experience. Thus appropriate methods used with young children in other contexts - cited in chapter three, e.g. the MOSAIC approach (Clark and Stratham, 2005) - did not seem suitable either.

As previously described, in chapter two, NDPT is highly child-centred; encouraging children to lead the play towards emotional issues of their own choosing (Wilson and Ryan, 2005).  Therefore children already have developed a relationship with their therapist that is non-judgmental, child-led and respectful of children's capacities to effect changes in their own lives when provided with optimal conditions for emotional change. Mental defences are not challenged or confronted directly by therapists. Rather, play with imaginative toys allows children to distance themselves and explore

issues without undermining their defences against emotionally difficult topics. All of these features were needed in an evaluation method suitable for NDPT

Four different PBE's were developed. The first technique 'The Expert Show' was adapted from a directive play therapy technique sometimes used during therapy interventions, described below. The second technique was inspired by Story Stems, a play based assessment technique (see Woolgar, 1999 for a full description). The third technique was inspired by a child's play therapy sessions in my clinical practice and a desire to provide a fitting evaluation method. The fourth technique 'Large Dolls' was developed in consultation with my supervisor[42], to address developmental needs of young/developmentally delayed children. These latter two techniques have since been combined. The process and rationale for this adaptation will be described below. First a full description of each technique is provided.

**'The Expert Show' – a Role-Playing Technique**

*Background*

This technique is an adaptation of a directive play therapy technique, 'Broadcast News', developed by Kaduson (2001). In the original technique a child is invited to be the expert on a news show and the therapist pretends to be child callers ringing in to ask advice regarding common childhood problems. The therapist asks about a range of issues which become progressively more similar to the child's own issues. Used in this way it is primarily a problem-solving technique based on CBT principles.

*Description*

In the adaptation of this technique, for this study, the child remains an expert on a TV chat show. However, the therapist invites the child to talk about his/her *experiences of play therapy*. The therapist herself acts as the presenter on the show and pretends to be various children and parents who ring in. Rather than asking the 'expert' for advice on solving their problems the callers ask for the 'expert's' opinion on various aspects of play therapy. This comprises the first phase of the evaluation; the *call-in phase*. Later children are invited to talk more directly about their own experiences in the *chat-show phase*.

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[42] Dr. Virginia Ryan, who is also a qualified Play Therapist, in addition to being a chartered clinical psychologist.

A real video camera is used to record the evaluation and a 'TV script' is followed. Kline (1993) notes that over half of the 200 6-8 year olds in his study incorporated television characters or scripts into their play. He states that the dialogue children used in and around their role play games highlighted that children use TV as a "source of ideas which give structure and rationale to their play" (1993: 329). This technique draws on children's familiarity with media and technology (see Jensen Arnett, 2007 for a recent and comprehensive overview of 'children, adolescents and the media'). The use of role play is highly accessible for a wide range of children and adolescents as Forrester (2000:242) states "the techniques of role-playing…are simple and easy to understand, socially accepted and culturally sensitive".

*Call-in Phase*

The therapist first helps the child to get into role and to prepare for going on the TV show. Before beginning each evaluation it is explained to children that there are no right or wrong answers. As advocated by Westcott and Littleton (2005) ground rules are agreed with children before the interview starts. The child is invited to name the show, badges are made, and the therapist pretends to count in the cameraman before introducing the show. The therapist follows a semi-structured interview schedule/TV script, asking the child open-ended questions about their general experience of play therapy. The therapist then guides the child through the process of the play therapy intervention beginning with questions about what it will be like when a child first starts therapy, the progress meeting(s) held with parents during the therapy, and what it will be like at the end of therapy.

The 'Expert Show' technique therefore allows the therapist to respond flexibly to children's answers. Different avenues can be explored more thoroughly as they arise by changing the callers and questions as required during the call-in phase, in a similar way to conducting semi-structured interviews using verbal responses alone. Hill (1997) suggests that children's enjoyment of acting may enable children to more accurately and vividly represent their experiences rather than simply reporting them in an interview. He acknowledges others' scepticism about the validity of role plays in research. However, he asserts that this is less of a problem if participants are able to de-brief and the relevance of the role play can be discussed with them; something the second phase of the 'Expert Show' method, the chat-show, provides an opportunity for.

*Chat-Show Phase*

After several telephone calls the therapist, in role as the presenter, invites the child to join her in the chat show format of the 'Expert Show' by sitting in another area of the room. The therapist/interviewer asks about the child's *own* experience of play therapy. The therapist asks how the advice given to callers paralleled their own experiences of therapy. In this way the therapist maintains the role play of being on a TV show, but allows children to talk more directly about their own experiences. This phase seems important because it is possible that, during the call-in part of the evaluation, children may feel they have to give favourable advice to the 'child' callers to prevent them from worrying. This chat show part of the evaluation allows the therapist to explore this possibility with the children, in addition to gathering further information. This phase also serves as a step along the journey from 'dramatic reality' back to ordinary reality (Pendzik, 2006). Here the therapist and child sit facing each other (at a 45° angle) discussing aspects of the role they played as the expert. Finally the therapist and child say goodbye to the audience and the therapist facilitates a complete de-roling by using the child's real name and asking the child for comments on the whole process (see Pendzik 2006:277).

## 'The Miniature Play Room' – a Projective Narrative Technique

*Background*

'The Miniature Play Room' technique was inspired by a well researched projective play assessment technique, Story Stems and Doll's House Play (see Emde, et. al. eds. 2003 and Woolgar, 1999). In the assessment technique the researcher uses Play Mobil and animal figures to act as child protagonists and family figures and some dolls house furniture as props to enact the beginning of a set of stories. The child is asked to complete the 'stem' given by the researcher. There are a number of variations of story stem batteries, but all aim to present the child with an emotional dilemma and elicit the child's experiences of the world and their expectations of others. Emde (2003: 6) argues that "narratives exemplify a vital process of meaning-making in everyday life". Using children's natural interest in play and stories proved to be a fruitful way to engage them in and gain "access to their representational worlds". The range of studies reported in Emde, et. al.'s (2003) edited book certainly provides support for this view. It also highlights the relatively recent and intense interest in children's narratives which have been studied for a variety of reasons across disciplines (Engel, 2005). Engel (2005) asserts that "children's stories help them to organize and articulate their experience"

(2005:208). Engel suggests that children's narratives are a window into their thoughts and feelings. It is beyond the scope of this thesis to provide a comprehensive review of this area. However, relevant findings which were taken into consideration during the development of this PBE technique are briefly summarised.

Engel (2005) reports that children, between the ages of 18-28 months, begin co-constructing narratives with adults, by adding single words to adults' accounts. By 3 years old they are able to add complete sentences and by 4 they are able to tell an interested listener their own story. Engel (2005) names play as an underlying foundation to the development of narrative. She highlights the narrative aspects which accompany symbolic play. She asserts that "early on the language is sporadic and amplifies or augments the play" (2005:204). Thus a PBE incorporating story telling and symbolic play where children can 'play out' the story is desirable. Bearing in mind that the cohort of children referred to play therapy includes children who have experienced some form of cognitive or emotional developmental delay, due to traumatic experiences, a technique which is accessible to young children was desirable. Engel asserts that children tell stories for a range of different purposes and these are likely to change dependent on who the 'listener' is. These range from solving emotional and cognitive problems, to establishing and maintaining intimacy, to constructing and communicating a sense of self, to retell experiences and participate in the culture (2005:206). She states that "researchers have begun to appreciate how closely tied the form of a story is to the function it is serving" (2005:206). Engel calls for more research in this area to discover more about the influence of context on children's narratives. This is an issue I return to when reflecting upon the findings of both this pilot study and the main study in chapter nine.

*Description*

In the 'Miniature Play Room' PBE technique the child is provided with Play Mobil figures with which to choose a child protagonist and adult figures to represent the therapist and any other adult they choose, e.g. a parent waiting for the child during play therapy. Similar to the 'doll's house' assessments, a miniature building is provided. In this case instead of a doll's house a miniature playroom is used. Doll's house furniture and miniature toys are provided. Although an exact replica of the real playroom and equipment is not offered, the usual toys of a play therapy room are represented (e.g. sand and water tray; clay; pens and paper; dolls; animals; cars; ball; costumes). It was

hoped that the toys would help to reinstate the environmental context and provide external concrete cues for the children (Pipe et. al. 2002).

*Part One – Unstructured*

In part one the interviewer asks the child to tell them and show them what happens in special play times using the 'Miniature Playroom'. This is a relatively unstructured part of the evaluation. Although the interviewer uses general prompts about the child's story, she does not suggest that it is any particular session or guide the story in any way. The first use of this technique included part one only. However, the results of this (detailed below) indicated the need to develop a series of stems similar to the story-stem batteries. However, in order to facilitate children's unprompted memories and experiences of play therapy, this less structured part has remained part of the schedule.

*Part Two –Structured Story Stems*

In the second half of the evaluation a more structured approach is taken, similar to Story Stems or Dolls House Play, in which the interviewer begins several different stories and asks the child to finish the story (see Woolgar, 1999). However, in contrast to the story stem assessment, children are not presented with emotional dilemmas nor generalized stems. Rather, stems which reflect the child's actual experience of play therapy are depicted, similar to Ross and Egan's (2006) picture completion task reviewed in chapter three.

Engel (2005) argues that children from the age of two years are helped to share their experiences if 'tags' are used at the beginning of sentences. She gives examples such as "remember when…" In the ' technique the interviewer starts a story with the child and parents at home and provides the 'tag' or 'stem' of the therapist knocking on the door and introducing themselves saying 'I've come to talk to you about Sam coming to play therapy' and gives the child the concrete cue that it is the first time the child has ever met the therapist. The therapist/interviewer then asks the child to show them and tell them what happens next. Similar to 'The Expert Show' the therapist/interviewer guides the child through the process of the therapy intervention beginning with stories about the initial meeting, the first play therapy session, and so on.

**'Puppet Interview' Technique**
*Background*

From experience in my clinical practice I realized that some children may find it difficult to engage in the aforementioned techniques, particularly since the 'Expert Show' relies heavily on verbal communication and the 'Miniature Playroom' relies on manipulating small figures. One child in particular with whom I was working had used puppets exclusively in his sessions. Therefore using the above two techniques seemed incongruous with this child. However, it seemed clear that the interview style of the 'Expert Show' could be adapted to using puppets.

*Description: Acts One and Two*

When using puppets, children are asked to take part in a play consisting of two acts. In Act One children are invited to tell their story of what happens in play therapy sessions using a range of puppets. This is relatively unstructured similar to part one of the 'Miniature Playroom' technique. Following this open-ended part of the evaluation, the therapist/interviewer invites the child to take part in Act Two. Here the therapist/interviewer invites the child to choose a puppet to represent someone going to special play sessions for the first time. In much the same way as the other techniques outlined above, the therapist/interviewer uses different puppets to ask questions about what therapy will be like, taking the child through the process from the beginning to the end.

The 'Large Dolls' techniques will be presented below as it was an outcome of the initial pilot study. First the issues which arose during this pilot study and the findings are presented.

**Findings from the Pilot Study**

The three aforementioned PBE techniques, the 'Expert show', the 'Miniature Playroom', and the 'Puppet Interview', were piloted in my clinical practice[43] with 12 children of varying ages (5 ½ -10 years), as table 2 below shows. With the exception of Chris and Adam, all of the children received short term individual play therapy ranging from 8-16 sessions. Both Chris and Adam received a 6 month filial therapy intervention. The table also details the developing rationale for using a particular technique with each of the children in turn.

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[43] 7 of the children were drawn from my practice as a play therapist in a school setting and 5 from in a CAMHs setting.

Table 2: Participants in Play-Based Evaluation Pilot Study

| Child[44] | Age | Technique | Rationale for choosing technique |
|---|---|---|---|
| Will | 10 | Expert Show | Will had used role play as the main way to communicate in his play therapy sessions. He was also highly articulate and enjoyed chatting in his sessions |
| Lucy | 9 | Expert Show | Lucy used role play frequently and enjoyed a sense of drama in her sessions. |
| Sharon | 8 | Expert Show | Although Sharon had not used role play she liked to talk during her play sessions. |
| Carla[45] | 10 | Expert Show | Again Carla had not used role play but liked to have 'chats' at the beginning of every play session. |
| Liam | 6 | Expert Show | Liam had not used role play in his sessions and had spent most of his sessions engaged in symbolic play with figures. However, he was very articulate and during his sessions he had worked on building up his confidence. Therefore having him be in the role of 'the expert' would match his therapeutic needs. |
| Molly | 10 | Expert Show and Miniature Playroom | Molly was given a choice of all three techniques. She chose to incorporate the miniature playroom with the Expert Show. She set the toy playroom up to be on the pretend TV set and expressed her views using the 'Miniature Playroom' during 'breaks' on the 'Expert Show'. |
| Justin | 5 ½ | Expert Show and Miniature Playroom | Due to Justin's young age and his use of figures and symbolic play in his sessions, we began the evaluation with the 'Miniature Playroom'. However, due to Justin getting distracted easily and becoming bored with the 'Miniature Playroom', we used 'the Expert Show' also. |
| Chris | 6 | Expert Show and Miniature Playroom | Chris began with the 'Expert Show'. However, due to Chris' level of understanding of the questions (Chris had speech and language difficulties and mild learning difficulties) and his preference for largely non-verbal communication, we used the 'Miniature Playroom' also. |
| Adam | 6 | Miniature Playroom | Adam was offered three choices. He chose to use the 'Miniature Playroom' throughout the evaluation. Adam had mild learning difficulties. |
| Henry | 7 | Puppet Interview | Henry had used puppets exclusively in his sessions. Therefore using them in the evaluation seemed the most appropriate way to meet his individual needs. |
| Sam | 8 | Puppet Interview | Sam had used puppets and role play extensively in his sessions. He was given the choice of using puppets or being on the Expert Show. |
| Simon | 10 | Puppet Interview | Simon had been almost silent throughout his; he had used some art and mainly symbolic play with soldiers. He was offered a choice and chose to use the puppets. |

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[44] Pseudonyms have been used to protect the anonymity of the participants.
[45] This therapy ended prematurely due to Carla's foster placement breaking down. Carla was the only looked after child in this study, all the other children lived with their birth mother or parents.

Table 2 shows an evolutionary process, from the first child, Will being offered and taking part in the 'Expert Show', to Simon, who was offered a choice and chose the puppet evaluation. These three different techniques evolved over the pilot time and offering children choice has now become a standard part of the evaluation procedure.

**Children's Expressed Views**

The pilot research indicated that children were able to share a wide range of views regarding play therapy. Importantly they were able to share both positive and negative experiences (see Jäger and Ryan, 2007 for examples). As Westcott and Littleton (2005) suggest it seemed that the props provided a joint referent which was helpful in the process of joint meaning-making within the evaluation session. As the props were the focal point, further safety appeared to be afforded to the children. Arguably it is easier to share negative views if you do not have to maintain eye contact. They were also able to express thoughts about the therapy which neither I, as the child's therapist, nor the child's parents, had thought of as being important. This highlighted the importance of actively seeking and asking the child for their view, rather than relying purely on recording views they share during the process as I had previously done.

One interesting finding was that children occasionally recalled specific details which I had not remembered in such detail. However, on cross-referencing the notes I discovered the child was accurate. This mirrors Brownlie's finding, commented upon in the previous chapter. This demonstrates that children's memories can be different to adults' and emotionally important moments in the therapy can be particularly salient in their recall. This finding highlights the importance of listening to children and hearing their story from their perspective. Overall the children were highly engaged in the PBE techniques and appeared to enjoy the playful aspect of the approach. The reader is directed to Jäger and Ryan, (2007, included as an appendix to this thesis, appendix 4) for illustrations of this technique and a summary of the views expressed by the children. Here the process issues and changes indicated to the use of PBEs are focused upon.

**Power Issues**

*Reducing the Power Imbalance*

In all adult-child interactions there is an inherent power imbalance. Several measures were built into the techniques to help minimize this. First, the use of play, the child's preferred method of communication (Axline, 1989), arguably reduces the power held by

the adult. The children's comments during interviews in the pilot phase seemed to support the suggestion that the power dynamic between adult and child is reduced. For instance Carla said: "I feel like a grown up doing this!" (10 years). Liam puffed out his chest as he answered the phone, providing the caller with his name while looking down at the name badge on his chest and stating that he was the 'expert' (6 years old).

Second, in 'The Expert Show' the therapist always pretends to be a child younger than the child being interviewed to maintain the 'expert' status of the interviewee. Similarly in the 'Miniature Playroom' and the 'Puppet Interview' the child protagonist is introduced as being younger than the child being interviewed. This perhaps goes some way to emulate the effects of children being interviewed by other children where, as already mentioned in chapter three, suggestibility is reduced (Saywitz, 2002).

In addition, the 'distance' and safety from over-exposure of self that is provided with role play and play materials (see Wilson and Ryan, 2005) allows children to share views which they may find more difficult to express if they were asked directly. With pretend telephones neither the children nor the therapist have to look directly at one another, thus making it easier for children to explore the things they do not like. Similarly with the miniature playroom the figures and props provide a focus point for both child and therapist.

*Informed Consent*

 The pilot research highlighted that the 'Expert Show' technique, in particular, appeared to enable children to use creative ways to inform the therapist of how much or how little they wished to participate.

As the interviewer/therapist I bore in mind Westcott and Littleton's observation regarding ground rules: "…no-where do we see children and interviewers actively involved in co-constructing ground rules as a shared discursive framework for the interview" (2005:150). I explored different ways of passing on questions with children before the evaluation started. A signal for when the child needs a break or wants to stop was also agreed upon. Sometimes children immediately had ideas about how they would do this; other times I offered some of my ideas to provide the child with a framework while allowing them choice. During the evaluation itself I asked the children, in my role as the 'presenter' of the show, if they wanted to take the call right

away or have me find out what the caller's question was first. This appeared to be effective in the pilot research as children could choose to reject certain calls or re-direct the caller to the helpline.

The importance of supplying children with instructions for how and when they can apply such strategies is advocated in the child witness research, see Saywitz (2002). It is suggested that giving children permission not to know, or indeed to re-phrase a question optimizes the accuracy of children's accounts and has shown to improve their comprehension and memory (Saywitz, 2002). In this pilot study these instructions seemed to prompt some children to draw on their own creative methods to reject calls e.g. choosing to ask the caller to ring back at a later time so that they could have a break. This permissiveness also appeared to enable children to use the evaluation to impress on the interviewer the importance of certain points. For example, one child pretended to call back a previous caller and told the caller information the child 'forgot' to tell them earlier. In fact this was a re-emphasis of a point the child had made earlier on. This suggested the salience of this point to that child. This process appeared to be empowering for children and suggests that children are provided with effective mechanisms in PBE's to ascertain their consent during the process. Thus informed consent from children truly is seen as an ongoing-process (Mahon et. al. 1996).

As children were able to use these mechanisms so effectively in the 'Expert Show', further thought into how this could be promoted in the other techniques was needed. Emphasis on their being no 'right or wrong' stories was built into the introduction of these techniques as was the fact that it was OK to pass on a story if the child did not want to partake.

*Importance of De-Briefing*

A further finding was the usefulness of the 'chat show phase' in the 'Expert Show'. This seemed valuable, not only due to facilitating further, more personal, information from children about their own experiences, but also in helping them to de-role, as described above. Most often children reported that the information they had given to the callers was the same as their own experience. This indicated that children were able to use the role-play format to share their own experiences rather than those imagined. However, it seemed that it may be helpful to emphasise in the 'presenter's script' that sometimes children and young people give different advice to the callers compared to

their own experience, to ensure that children feel it is permissible to have done this. This was incorporated halfway through the pilot study.

**Environment**

*Timing and Place of the Evaluation*

The pilot research highlighted that children found it difficult to engage in the evaluation if it took place only one week after their therapy sessions and in the same room. One child was clearly distressed that the playroom did not look the same and found it difficult to make the shift from NDPT sessions to this more directive play therapy evaluation session in such a short space of time. Therefore a recommendation for evaluations to take place two weeks after the end of therapy sessions was indicated; helping to distinguish that it is different to the therapeutic intervention yet being close enough to the intervention to aid children's memories. In addition, emphasis on undertaking the evaluation in a separate room from the playroom, and making it explicit to children that the evaluation session is different to their other play therapy times, was also indicated and incorporated in the training for therapist participants in the main study, described in the next chapter.

*Use of Space*

The pilot research highlighted that both the 'Expert Show' and the 'Miniature Playroom' techniques required the children to be relatively static. This may be a big change for some children who have been far more active within their actual play therapy sessions. Therefore the need to build in breaks and emphasising that this is permissible to children was highlighted. Furthermore if children appear to be restricted or finding these techniques difficult this may be one possible reason indicating that a more active technique, such as the puppets, should be offered. These suggestions were included in the training.

**Non-Verbal Communication**

For some of the children, who were not perhaps as verbally articulate as those involved fully in the 'Expert Show', the 'Miniature Playroom' and the 'Puppet Interview' techniques seemed useful for children to communicate in largely non-verbal ways. As stated above the techniques were improved upon throughout the process of the pilot research. Initially children were provided with the 'Miniature Playroom' and asked to

show and tell about their experiences of play therapy. Where this was used, without the second phase of using structured stems, children seemed to engage in the task of telling a story about play therapy sessions to a limited degree. As described above, this led to the inclusion of specific stems which seemed to enable the children to share much more about their experiences of different parts of the play therapy process. This is in concordance with the developmental research on children's memory. Saywitz (2002) highlights that children's narratives, in contrast to adults, tend to begin with fairly skeletal descriptions. She emphasizes the child's difficulty in understanding the listener's perspective and therefore their expectations. Subsequently young children particularly need adults to provide a structure for their narrative. When developing the stems I took into consideration Wade's (2006) findings from her research using vignettes to ascertain children's views of parental separation and divorce. She found that children were less responsive if a vignette was short, bland and too simple. Children were far more engaged if concrete cues were given to add texture and a sense of reality to the vignette. She suggests a balance is important; the story needs to appear plausible and real with enough information provided about the situation while still being vague enough for children to add their own thoughts and interpretations.

**Flexibility: Responding to Children's Individual Differences**
The pilot research highlighted the importance of remaining flexible and responding to children's individual needs. For example, in both the 'Miniature Playroom' and the 'Puppet Interview' technique, children are asked to choose the child and the therapist who will be having play therapy sessions together. They are offered a wide range of figures/puppets, including both child and adult figures of both genders and figures with different skin tones. Toy wheelchairs, hearing aids, glasses, crutches in the kits are also provided for children to express their experiences.

It seemed that for some children in the 'Miniature Playroom' technique the objects they may have needed to tell their story were not available. Therefore different coloured plasticine for the children to mould anything additional which they need to represent was indicated as a useful addition. Furthermore, particular salient features of a room, such as a microphone hanging from the ceiling or fixed cameras may prove to be helpful cues to children. It was hoped that this addition would enhance this technique given Pipe et. al.'s (2002) assertion that one of the difficulties with the use of scale

models and toys is the low level of similarity between the toys offered and the real event.

One child in the pilot research chose to use a female child figure and a male therapist figure; the opposite of his own experience. Another child chose to use animal figures rather than human figures. I would suggest that these adaptations afforded the children extra 'distance' enabling them to feel safe to express their views (see Landreth, 1993: 49 for a discussion on symbolic expression in play and Hodges, et. al. 2003:245 on the use of displacement in story stems through animal figures). It seemed highly useful to allow children this flexibility, if *they* chose this.

Another explanation for the child's use of a male therapist may be a way of communicating a preference for a male therapist rather than the female therapist he had in reality. This highlighted the issue of gender and the need to focus on this as a potential issue in the evaluations. Therefore a question on gender of the therapist and what children think to having a male or female therapist is now incorporated. The names of the protagonists in the calls and stories are gender neutral e.g. Sam; Jamie.

A further adaptation which was employed with one child in the pilot study included switching to 'e-mail' instead of using the phone. This seemed important in responding to her need to write things down as we continued the interview. Importantly this had the effect of slowing the pace of the interview down and the number of questions and prompts used was reduced. This allowed the child to take more control during the interview process. I suggest that this flexibility is likely to enable a greater number of children to access these evaluation techniques, for example, d/Deaf[46] children who use written and visual modes of communication, e-mail, webcam, fax and text, rather than the phone.

This pilot research also highlighted that interviewers may need to have more than one technique available during the evaluation, and need to be flexible about changing

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[46] The convention of using d/Deaf is adhered to here in acknowledgement of current use of terminology related to deafness. This convention reflects inclusion of both those children who consider themselves as 'Deaf' with a capital D, in other words a group which share a sign language and culture, rather than identifying with an 'impairment/disability' definition. The lower case 'deaf' is used in reference to: 1) the absence of or reduction in response to sound in the audiological sense. 2) People who are deaf but do not consider themselves to be members of the signing Deaf community. (Meadow-Orlans and Erting, 2000:3)

techniques half-way through the evaluation procedure. Some children may find it difficult to concentrate for long periods of time or are easily distracted (see Chris and Justin in table 2 above for examples). Therefore introducing a second technique may help to keep their interest. Some children may be able to express only certain aspects of their experience using one technique, and more data is collected when a second is offered (see Molly in table 2).

**'Large Doll Narrative' technique - A Fourth Technique**

As indicated above, a fourth technique was developed following this pilot research. This was due to a desire to meet the needs of younger children who may struggle with the above techniques. Most of the children interviewed for the pilot study were articulate and able to make use of verbal communication and/or manipulate the small figures to tell their story. For the youngest children a technique using large dolls that are closer to children's own experiences than the other techniques was developed in discussion during supervision. In the 'Large Doll Narrative', it was planned that children would be invited to select large dolls to represent themselves, the therapist and their parent in the children's actual therapy room with the toys laid out as they had been used in therapy. Nesbitt (2000) in *Researching Children's Perspectives* argues that some of the best insights into children's perspectives come unexpectedly when they are stimulated by a visual cue or some other question. It was hoped that this set-up would further aid children's recall. Again it was planned that the therapist/interviewer would guide young children through the process of the therapy sessions.

**<u>Further Piloting of the Techniques</u>**

I chose to undertake further piloting of the interviews with children. My rationale being that this is an underdeveloped area in the research and I wanted to refine the methods I used with children to maximise the potential data I could collect. Furthermore, as stated in the introduction to this thesis, my intention had been to utilize these techniques in two other research projects. These enabled me to experience administering the techniques as an 'outsider'. The sample of children was not drawn from those who had experienced individual play therapy; rather they were drawn from children who had experienced two other interventions which were the focus of these separate research studies. Below I detail the benefits and changes made as a result of these further pilots.

I piloted the techniques with two children who had undertaken individual filial play therapy (see VanFleet, 1999 for a description), two children whose parents had attended a filial play therapy group following a modified version of the Landreth ten week model (see Landreth and Bratton 2006 for a description) and four children whose parents had attended the Incredible Years Webster Stratton group parenting programme (see Webster-Stratton and Reid, 2003, for a description and review) and had been engaging in 'special play times' as part of the home work task.

**Combining the 'Large Doll Narrative' and the 'Puppet Interview' Techniques**

Although the large doll narrative technique was not piloted in the initial pilot study, described above, I had an opportunity to pilot it with two children in these later pilots with one four year old girl and one seven year old girl. Following their use and consultation with other play therapists, this technique was adjusted. A different room to the real play room and a selection of the toys from the playroom itself was indicated. This was due to a consensus that young children may be overwhelmed by the 'real' playroom. They may find it difficult to differentiate the evaluation session from an actual play therapy session. However, it also seems important to provide real 'props' to the children, rather than forgo the benefits of using concrete external cues which other research has shown are useful for young children's retrieval processes (see Pipe et. al. 2002). Therefore, it was planned that therapists would purposefully select both toys which the child has played with extensively during the therapy sessions, and those that the child has either seemingly ignored or played with very little.

In recognition of practical considerations, the puppet and large doll narrative techniques have been combined. A benefit of the 'Miniature Playroom' and the 'Expert Show' is that they are not reliant on expensive resources or props. However, a set of large dolls which are not used in the child's play therapy sessions is an expensive commodity to expect play therapists to have. Therefore the format of the large dolls narrative is followed, with familiar toys in a different room, but using hand puppets as the characters for the children to show and tell their story. This has the added advantage of using simple hand puppets which are inexpensive. Therefore it is possible to offer the child a wider range to choose from. The puppets are easy to decorate with a range of facial expressions and can be made from a range of different colour fabrics to represent different skin tones. This provides a more culturally sensitive set of characters with which children can express their views. In the main study this combined technique

comprised the third option taught to therapist participants on the training day. However, it was not used by any of the therapists in the main study.

**Insider or Outsider**

*Evaluator Bias or Not?*

These interviewing techniques, to ascertain children's perspectives of their therapy, were developed in the context of evaluating play therapy sessions for which I was the therapist. However, this additional piloting enabled me to experience administering the techniques as an 'outsider'. There are advantages and disadvantages in both positions; that of a practitioner researcher, or 'insider', and that of an independent, or 'outsider', position. Indeed, some of the biases are experienced in both positions and, as White (2001) highlights, there are many different positions along a continuum, including being 'inside' out and 'outside' in. I discuss the advantages and disadvantages here with regard to enhancing children's accounts, sharing negative views, and children's desire to please. These considerations motivated the main research design reported in the next chapter.

*Enhancing Children's Accounts*

The child's own therapist as evaluator, an 'insider', has a thorough understanding of the *process* of the therapy intervention. This understanding enables therapists to tailor questions and add concrete cues when needed, e.g. the venue for the first meeting (see Jäger and Ryan, 2007). As noted in chapter three, the developmental research pertaining to child witnesses indicates that such cues have proved facilitative in helping children to recollect their experiences (Westcott and Littleton, 2005).

As an 'outsider' I found that I was unable to add concrete cues to help scaffold children's responses when an open-ended inquiry was not sufficient. This was despite my thorough theoretical and practical knowledge of individual filial therapy[47]; one of the interventions under study. I also found it more difficult to follow potentially helpful lines of inquiry within the interview the further removed I was from the intervention itself. Although my theoretical understanding of the group filial therapy programme is good, my practical experience is limited. I have no practical experience of the implementation of the Incredible Years Programme and my theoretical understanding of

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[47] I am a trained and practising filial play therapist and have undertaken previous research in this area, see Hunter, 2003 (maiden name) and Rye and Jäger, 2007.

this programme is less advanced. This meant that my understanding of the finer details of what the children may have experienced was reduced and this seemed to have an impact on my ability to facilitate the child's exploration. This supports Pettit et. al. (2002) findings (as noted in chapter three) that fully informed interviewers facilitated more accurate accounts from 3-4 year olds.

Perhaps more importantly, I found it more difficult to assess, interpret and understand the child's communication within the interview itself as I had limited understanding of the child's unique ways of communicating. Although I am experienced in quickly gaining rapport with children in my play therapy practice, the children I interviewed were much less at ease, because of being with a stranger, compared to children I already had formed a child-centred relationship with. For instance I was sometimes unsure when a child's agitation, or quiet withdrawal, was due to their energy levels and natural way of communicating, *or* their discomfort with the question, task *or* with me. I was more cautious in my approach and my ability to facilitate the children's views, whilst arguably adequate, was less successful than with my own cases.

Engel (2005:206) highlights, that children are not likely to tell the same kind of story to a strange researcher that they tell an intimate friend: "The child's sensitivity to context raises major questions about how typical the narrative elicited by a researcher can be". With my own cases children had already experienced playing with me, and sharing intimate thoughts and feelings with me. As PBE's are aimed at exploring a therapeutic intervention in which children have explored difficult emotional experiences, it seemed that there were significant advantages to having an established therapeutic relationship[48].

Engel (2005) asserts that it is important to consider the function of the story being told as well as the content. As an 'outsider' some of the prominent functions[49], for the children, appeared to be about 'establishing a connection' with me, 'making friends' and 'impressing me'. In addition there was an element of children seemingly trying to 'solve a puzzle'. The puzzle being who I was, what my aims were, and what the right answers might be. Whilst there was some emphasis on 'ordering and sharing

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[48] The reader is also directed to Davis, 1998:329 for a discussion on reducing social distance between adults and children by taking on the 'least adult role'.
[49] These are drawn from Engel's (2005:214) suggested functions and applied to my own experiences of conducting the interviews.

experiences' these were far more pronounced when I was an 'insider'. In these cases a further function, from the child's perspective, seemed to be 'making upsetting things safer'. Whilst these children also seemed to be 'solving a puzzle', about how this time was different and what my aim was, it appeared to me that fewer of their resources were being used in this way. Furthermore, I seemed to be more adept at addressing these concerns and subsequently facilitating a space where the main function for the child was ordering and sharing their experiences. However, it could also be argued that a function for children who had experienced a therapeutic relationship with me was to prolong the therapy and our relationship.

*Children's Desire to Please*

Concerns about children feeling they need to please adults have been highlighted in the literature (Mahon et. al., 1996) and have been seen traditionally as disallowing well-known adults as interviewers of children. Saywitz (2002), in the context of the child witness research, highlights the gap in the literature providing guidance on optimal levels of rapport development with children to minimize the effect of suggestibility. She presents the dilemma that 'unfamiliar' or independent adults are faced with when interviewing children. Too little rapport with a child heightens suggestibility due to the adult's power in the relationship, and yet too much arguably creates a "desire to please the new friend" (2002:16). As referred to above, the initial pilot research presented here, indicated that children are able to share both positive and negative views of their experiences of play therapy when the therapist is the evaluator. Arguably, given the knowledge the child's own therapist has of the child's emotional world, the therapist is at least likely to know whether a desire or need to please adults is particularly pronounced for individual children. If so, then arguably therapist evaluators could take this into account during the interview itself, by emphasizing messages about it being permissible to share things which were unhelpful about their therapy as well as things that were helpful. Furthermore therapists could reflect on this in the analysis of the child's evaluation.

*Sharing Negative Views*

It could be argued that children may be more able to express any negative views, about the therapist and the experience as a whole, if an independent person interviewed the child. Curle et. al. (2005) asked both children and parents about their preferences for having their own therapist or an independent interviewer asking them about the service

they had received. The findings revealed mixed views. Whilst one child hypothesised that children "might not tell the truth", parents acknowledged that this was equally valid with regard to independent researchers.

My experience as an 'insider' suggested that children *can* share negative views about their experience of play therapy *and* their therapist, to their own therapist. In NDPT an underlying principle is to create a permissible atmosphere and the message that all thoughts and feelings are acceptable in the therapy room is conveyed by therapists. This is a different relationship to the kinds of relationships children may have with their teachers, for instance, where it is clear that some things are not permissible to say. Although the aim of play therapy is to create such a non-judgmental atmosphere it cannot be known whether the children experience it this way without further research. Moreover, I cannot know whether the children I interviewed would have shared more if they had been interviewed by an independent researcher. Bond (1995) highlights that children can find it difficult to share negative views of staff and services even when interviewed by an independent person. As an 'outsider' she was aware that children may not say anything negative because they may perceive this as being a betrayal of the trust built into their relationships with their workers.

The 'insider/outsider' debate and the rigour of 'practitioner research' is an area of considerable debate (see Shaw and Gould, 2001 Ch10 for a thorough discussion). White (2001:105) highlights the arguments against practitioner research as under theorised, frequently lacking critical engagement with the phenomena in question. In relation to psychotherapy research, particularly Stancombe and White (1997) argue that clinician-researchers often report findings which they anticipated at the beginning of the inquiry, due to their desire to prove that therapy is effective. I agree that if the purpose of undertaking practitioner research and evaluation is driven by a need to justify practice and provide 'evidence' to 'prove what works' within the framework of evidence-base practice, (see Shaw and Faulkner, 2006 and Gilroy, 2006) a strong bias may be evident in practitioner research. However, if the purpose of the research or evaluation is a genuine desire to understand processes, improve practice and learn from children, then more critical engagement may be seen. I suggest that the findings of the pilot research indicate my own genuine interest and engagement with all aspects of the process, both in terms of the development of PBEs and what children's views of the therapy they

received really are. Arguably such engagement leads practitioners to actively respond to the findings of research and make improvements to their practice (Gilroy, 2006).

White (2001) argues that critical or analytic positions to one's own professional practice can be achieved, partly through seeing the limitations of one's own 'favoured' theories and extended knowledge of other analytical frameworks outside of one's own discipline. I have been fortunate enough to work in a multi-disciplinary CAMHs setting where sharing of theoretical frameworks is encouraged, alongside receiving supervision and teaching in research methods from academics, both within and outside of play therapy. This has increased my curiosity in a wide range of theoretical approaches and arguably increased my reflexivity. Davis (1998) highlights the need to take a reflexive stance regarding one's own culture and how this interacts with participants' varying cultures when researching children. He asserts the need to ensure space for the variety of differing views when presenting the 'voice' of the child. I return to these arguments in the next chapter and again in chapter nine when I reflect on the findings of the main study.

**Summary**

From the pilot research I had found the 'insider' role within this context to be advantageous for a number of reasons. I was better able to understand the process as it was occurring and add concrete cues to facilitate the child's exploration. I already had an established child-centred relationship with the children which enabled me to read the child's non-verbal and verbal cues more easily. Arguably I was more adept at responding to their cues, particularly regarding their engagement with the task and their potential need to please me. In addition it appeared fewer of the child's resources were consumed by establishing a connection with me and making friends. Instead they seemed able to focus primarily on organising and sharing their experiences. When I was an 'insider' some of the children were able to share negative experiences. However, I was also aware of how vulnerable or defensive that may make some therapists feel and the importance of being able to remain accepting of the child's personal comments. Furthermore I was aware of the potential danger of wanting the child to say positive things to 'prove that play therapy worked'. I was motivated to acknowledge these issues in the training of other therapists, and to stress the importance of drawing on existing therapy skills of acceptance when a child is rejecting. It must also be borne in mind that this was a small sample and other researchers or therapists may have different

experiences. However, these experiences and application of other research informed the rationale for the methodology in the main study, described next in chapter six.

**<u>Re-defined Aims</u>**

Westcott and Littleton (2005) assert that we should move away from trying to *elicit a response* from children to a position where we attempt to empower children to share their experiences. Exploration of these positions over the course of the pilot study resulted in a crystallisation of the aims and purpose of play-based evaluation techniques. In NDPT play is not used to 'elicit' verbally from children their problems. Rather, play is used to enable children to explore their experiences. Likewise, in PBEs it became clear that play should be used to facilitate the child's expression of their views, rather than 'elicit' a response. The Concise Oxford Dictionary's (2002) definitions of these terms help to convey the different connotations implied. The definition of 'elicit' is 'to evoke or draw out a response'. The origin of the word comes from the Latin elicere which means 'to draw out by trickery'. In contrast facilitate means 'make easy or easier' and express means 'to convey a thought or feeling in words or by gestures and conduct'. I set out the aims and purpose of the main study in further detail in the next chapter.

**Development of Semi-Structured Interview Schedules**

A general loose framework which allowed data to be co-produced had been employed in the pilot research. It was recognised that wider spread use of PBE's would require a tighter framework for therapists to follow. Key areas of interest were highlighted by children in the pilot study. Consultation with children after the interviews enabled me to develop specific questions to address these areas of importance.

The phrasing of questions was seen as particularly important to help guard against therapists using leading or double-barrelled questions. Guiding therapists to cover key areas would enable some comparison across cases and a baseline standardisation. Therefore drawing on the literature on developing interview schedules with children, my own experiences of questions which had worked well and those which were more difficult or of little interest during the pilot phase, and the children's own ideas, was the next stage of the process.

Saywitz (2002) highlights that a balance between providing children with enough structure and input to 'elicit' further information and maintaining a neutral stance is

needed. Within the forensic context this is, of course, essential. Arguably, in the context of evaluation research, more emphasis should be put on helping children to share their views more fully, rather than focusing too heavily on credibility. However, drawing on the research from the forensic arena is undoubtedly fruitful in the quest to support a child's account in the least biased and leading way possible.

Saywitz (2002) emphasizes the use of open-ended questions, before narrowing questions on more specific areas. She asserts that open-ended questions make it easier for the child to reply 'I don't know'. Kvale's (1996) guidelines on the use of a variety of question types in the interview schedules, along with consulting my PhD supervisor and two other therapist colleagues, helped to solidify the questions to be used in the schedules. It became apparent that I would need to provide detailed descriptions and prompts to enable other therapists to employ the techniques in similar ways. For instance, the introduction to the evaluation session itself; the setting up of ground rules; the introduction of the TV show (in the Expert Show) and comments made during transitions from one call or story to another. The resulting schedules are included in appendix 5 and were distributed at a training day for qualified play therapists. The recruitment of therapists to these training days is described in the next chapter on the methodology of the main study.

## **Conclusion**

In this pilot research the play-based techniques, particularly when delivered by therapists themselves, appeared to be a useful way of facilitating children's views. Children's abilities to produce meaningful views seemed to be enhanced by using play as a central aspect of the evaluation interview. Children were able to use the variety of techniques offered to them to express their opinions in their own unique ways. As Kellet and Ding argue:

"…children can and do provide reliable responses if questioned in a manner they can understand and about events that are meaningful to them. The challenge is to find appropriate techniques that neither exclude nor patronise children." (2004:165).

The outcome of the pilot study was formalisation of semi-structured interview schedules for use by qualified play therapists in their own clinical practice.

## CHAPTER SIX

## METHODOLOGY: MAIN STUDY

### Introduction

In the previous chapter the pilot study and findings were described. In this chapter I set out the purpose, structure and rationale of the research design. I describe the training of other therapists in using PBEs in order to produce a cohort of participants for study. I outline the methods I employed to research the subsequent use of these techniques. These included pre- and post-evaluation session questionnaires for the therapists to complete and indirect observation of the play-based evaluation session via video-tape. The methodological and ethical dilemmas I faced during this process are presented. I then detail the sampling and recruitment stages of data collection. I outline this process in diagrammatic form.

Two separate but interlinked lines of inquiry were followed. First, an inquiry into the content of *what* children expressed about play therapy. Second, the process issues arising in PBE sessions. A description of the processes I employed to analyse these two areas are briefly described. These will be returned to and discussed in depth in the relevant chapters on the findings and discussion. The data analysis phase was varied and complex, therefore an overview of the data analysis methods is provided in tabular form. During the data collection and analysis process I recognised the changing and overlapping roles I held. These included: therapist; developer; trainer; researcher; colleague and more. A reflexive account of my role in the process is provided at points throughout this chapter and the remaining chapters of the thesis.

### Research Design

**Purpose and Structure**

The overall purpose of this study was two fold:  to record the children's views of play therapy and to explore the use of PBE's as new methods to gain children's views. The main aim was to test the hypothesis that children are able to express a range of views about their experience of play therapy when interviewed using PBE's by their own therapist.

**Rationale for Methodology**

Qualitative inquiry seemed best suited to studying PBEs which are new to the field of child therapy. Miles and Huberman (1994) advocate qualitative designs as the best strategy for discovering and developing hypotheses. Conducting exploratory research seemed a useful contribution. Flick (2007) asserts that qualitative research approaches the 'world out there' and strives to explain social phenomena 'from the inside' by accessing experiences and interactions in their 'natural context'. I was specifically interested in accessing children's experiences of play therapy; therapists' experiences of PBEs and the interaction between children and therapists during a PBE session. I was aware that this would entail multi-layered complex processes and I was keen to utilise the strengths of qualitative data to explore these:

> "Another feature of qualitative data is their *richness and holism*. With strong potential for revealing complexity; such data provide 'thick descriptions' that are vivid, nested in a real context, and have a ring of truth that has a strong impact on the reader' (Miles and Huberman, 1994:10).

Criticisms of qualitative studies have included an opaque approach to reporting how the design took shape, through to what was actually done and how the analysis developed (Miles and Huberman, 1994). To counter this potential difficulty I strive to be transparent, and yet succinct, in this chapter by providing a thorough procedural and reflexive account of the development of the research design through to the analysis.

*The Context: A Cross-Sectional Design*

Play therapy sessions with children experiencing emotional and behavioural problems are highly sensitive and are undertaken as largely confidential. I had experienced significant recruitment difficulties with previous projects on aspects of child therapy where a longitudinal design employing a comprehensive selection of research interventions had been experienced, by stakeholders, as potentially intrusive or practically unviable. Thus the 'natural context' I was interested in accessing was difficult to enter. Therefore a cross-sectional or 'snapshot' (Flick 2007) methodology which was low in intrusiveness and low in terms of practical demands was developed.

*A Multiple-Case Study Design*

This cross-sectional design would incorporate multiple cases. Multiple-case designs assist the researcher in theory building and identifying new concepts relevant to emerging theories (Bryman, 2001). As Yin describes, "…case study method allows investigators to retain the holistic and meaningful characteristics of real-life events – such as individual life cycles" (2003:2). This seemed essential when researching the children's views of an intervention in which the child was likely to have explored emotionally important events in their individual life cycle.

An often stated weakness of multiple case-study designs is that they provide little basis for scientific generalization. However, Yin (2003) argues that case studies *are* generalisable to theoretical propositions (analytic generalisation) but not to populations or universes (statistical generalisation). Fook usefully conceptualises this issue as a matter of 'transferability' she states the purpose is to develop an understanding of expert practice "which might be *transferable* to other situations, in that it might help provide meaning in other contexts" (2001:125-6).

As I had developed PBEs and based the pilot study on my own cases I would need to find a way to increase the practice base of PBE techniques. This would necessarily entail me training other play therapists in delivering PBEs. As a sole trainer, and a cohort of 258 BAPT[50] registered Play Therapists to draw from, it was expectable that only a limited sample would be available for study. Therefore a design where analytic generalisation could be achieved was attractive.

Yin (2003) argues that multiple-case designs can produce compelling robust evidence. Despite this Yin (2003) argues that some of the criticisms of case study designs are well founded. Yin (2003) details three main areas where one can ensure greater rigour in case study research. These are: 1) Using multiple sources of evidence as this allows the researcher to develop *converging lines of inquiry,* in other words, a process of methodological triangulation. I planned to use both video observation and a number of questionnaires to provide me with multiple sources of evidence from both the children's and therapists' perspectives; 2) Creating a case study database; and 3) Maintaining a chain of events. I systematically dated and organised all documentation. I maintained a

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[50] British Association of Play Therapists

research diary and utilised Atlas-ti's (CAQDAS[51] software) memo function. This process would allow an outsider to follow the derivation of any evidence from the initial research questions to ultimate case study conclusions (Yin, 2003).

Further criticisms of multiple case-study designs have centred on the approach drawing the researcher's attention away from the specific context and focusing on the ways in which the cases can be contrasted (Wilkins, 1991; cited in Bryman, 2001). It was hoped that undertaking within-case and cross-case analyses of the data would counteract this tendency.

**Original Research Questions**

The research questions at this planning stage of the research were:

1. What are children's views of play therapy?
2. What are the children's important memories of their play therapy sessions?
3. Are PBEs effective ways of ascertaining children's views?
4. Are Play Therapists views of the play therapy process influenced by the children's views expressed in PBEs?

These research questions were revised during the planning and development of the project. This process is detailed in the section below on gaining ethical approval.

<u>**Data Collection**</u>

**Research Methods**

*Gaining Observational Material and the Children's Views Via Video-Observation*

Video observation allows the researcher to observe the interaction between therapist and child and reduce the intrusion on the therapeutic process. Observing the final evaluation session reduces this further, by this stage children have reached the end of their therapy and are arguably less vulnerable than during, or at the beginning of therapy sessions. The video tapes I planned to collect would provide me with data to address the first three aforementioned research questions. They would allow me access to the children's views of play therapy, whilst also enabling me direct observational access of the PBEs being delivered. This would allow me to analyse the experiences children had of play therapy and to analyse the interaction and communications in the making (Flick, 2007).

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[51] Computer assisted qualitative data analysis software.

Particular advantages of video-taped observation included the possibility of repeatedly analysing the data and in particular capturing the non-verbal communication occurring within the interaction (Banks, 2007). As Goodwin asserts:

> "Videotape records are frequently most useful because of the way in which they preserve limited but crucial aspects of the spatial and environmental factors of a setting, the temporal unfolding organisation of talk, the visible displays of participants' bodies and changes in relevant phenomena in the setting as relevant courses of action unfold"(2001: 179).

A potential weakness would be the quality of the video recording. As noted in chapter four other studies, in adult psychotherapy, have employed more than one camera and mirrors to capture interactions (e.g. McCluskey, 2003) others have employed a camera for each participant and an overview camera, (de Roten, et.al. 1999) and have advocated capturing the participants from head to toe, due to the importance of the relationship between body posture and positioning and the therapeutic alliance (Davis, 1998). However, my own field of study is with children, who do not tend to be as static as adults in their therapy sessions, particularly an active intervention such as NDPT. I wanted the research methods to capture the 'natural context' and be as unobtrusive as possible. This would mean relying on the therapists' one angle recording of the session. I instructed therapists to check the camera angle before beginning the session to ensure the best recording possible. I also emphasised the priority was their delivery of the session rather than being distracted by adjusting the camera angle. Some of the quality issues with regard to video tapes were reduced by excluding the poorest tapes. This process is detailed below.

*Gaining Contextual Information and the Therapists' Views via Questionnaires*

To establish therapists' views of the sessions, and the impact children's views have on their practice, a second measure was needed. Piloting both questionnaires and telephone interviews was planned to establish the most effective method of gathering this data. These methods were chosen, over face to face interviews, as they are more manageable in terms of therapists' and researcher's time. However, following consultation with potential participants telephone interviews were excluded as inhibitive for therapists' engagement with the research.

A limitation of the cross-sectional design would be the lack of observational data from different points of time over the intervention. Whilst this would limit my ability to assess whether or not the observations were characteristic of the usual interactions between therapist and child, the planned questionnaires would gather the therapists' views of this issue. This would allow triangulation of the data. Furthermore I was most interested in the evaluation session itself and planned to undertake detailed analysis of this session in particular, therefore the cross-sectional design seemed best suited to my aims.

However, I did plan to establish three different data points by providing therapists' with two questionnaires and request that they complete questionnaire one *before* they undertook the PBE and questionnaire two *after* the session (see appendix 6). The aim of this two phase approach was to gain the therapists' views both before and after they had heard the child's views. The pre-evaluation questionnaire would also provide me with contextual information about the child, demographics and presenting problems, length of intervention and so on. Furthermore I wanted to analyse the potential similarities and differences between the therapists' views and those expressed by the child. I was interested to see if the therapists' views of the intervention were altered by the child's expression. In addition the two-phase questionnaires would enable me to gain insight into the *therapists' interpretation* of both the views expressed by the child and the process of the session.

Using paper based questionnaires provided a further advantage. I would be able to keep the questionnaires, with the therapists' views, sealed and separate from the video-tapes, with the child's views. This would allow me to remain blind to the therapists' views and information regarding the child, such as presenting problems, until completion of analysing the observational material. This would enable me to reach my own views and interpretations as an observer before being influenced by the therapists' perspective. Whilst this process relied on trusting the therapists to follow this procedure without my control, it was the only workable way of accessing this information.

May (2001) argues that self-completion questionnaires can reduce bias in responses compared to face-to-face interviews. This was a significant consideration as it was likely that the therapists may have a tendency to provide responses which they thought

would please me as the developer of the techniques and their trainer. Clearly this potential bias would not be eradicated by use of questionnaires but was likely to be reduced.

I piloted the use of these questionnaires with five therapists during the training phase and made adjustments to the questions to reduce ambiguity. I also verbally explained the purpose of the questionnaires during the explanation of the research on the training days. The potential for ambiguity of the questions and the inability to probe therapists beyond their written answers remained a limitation (May, 2001). However, I later incorporated two follow-up e-mail questionnaires (see appendix 7) which allowed some further probing. An obvious limitation of this additional method was the time span between the e-mail questionnaires being sent (after my own analysis) and the therapists' conducting the evaluation session (varying from 3-18 months).

The triangulation of these different sources, (children's views, my own views and therapists views), and methods (observation and questionnaires), with their own unique strengths and biases, were complementary and therefore increase the validity of my findings (Miles and Huberman, 1994).

**The Process of Ethical Approval**

Before embarking on data collection a thorough research proposal with full supporting documentation (e.g. participant letters and leaflets, see appendix 8 for a comprehensive list of documents) and completion of the NHS multi-site research ethics application was submitted and reviewed Autumn 2006. This was necessary as several of the potential therapist participants were employed by the NHS and would need the project to be approved through this process in order to take part in the research. For those working in other settings the rigorous NHS ethical procedures and requirements were likely to be adequate to meet any other agencies requirements. Furthermore this provided an opportunity for the project to be reviewed and very careful consideration of ethical issues given to it by myself, my supervisor and the ethics committee. First the major ethical considerations related to the research design are summarised below. There follows a description of the process of ethical approval. The subsequent refinements and additional considerations which resulted are detailed below.

**Ethical Considerations**

The existing broad guidelines provided by Alderson, (1995); MRC (1991); and the NCB (1993) were applied to this research. Unfortunately the specific ethical guidelines in relation to research in the field of play therapy are not well developed in Britain or America[52]. Hill (1997b) states that many questions arise when we address ethical issues and these do not necessarily, have neat solutions. This is particularly the case when the research involves child participants. Following Hill's lead I explore the dilemmas faced in this study which informed my decisions. For some part the aforementioned guidelines helped to shape the decisions I made about these dilemmas. However, some issues were not dealt with sufficiently in the guidance and required my further careful consideration. As Daniel-McKeigue (2007) points out the existing ethical codes exist to guide and inform the researcher but ultimately it is the integrity of the individual which ensures research in child therapy is carried out in an ethical manner. She highlights that whilst there has been a political advancement in children's rights generally, the ethical basis of a number of research studies have been called into question (see Daniel-McKeigue, 2007:241). Referring to other research and the arguments presented helped me to clarify my standpoint, as discussed further below.

*Impact on Children*

Hill (1997) contends that the ethical considerations for children are much the same as those for adults. However, he acknowledges that due to children's vulnerability, and sometimes their more limited understanding, ethical dilemmas are heightened when children participate in research. As the methods I planned to use involved no direct contact with the researcher or any additional interventions, the impact on children was greatly reduced. However, indirect contact posed its own challenges, particularly in gaining the children's and parents consent to take part in the research.

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[52] BAPT provide brief principles for research as part of their general code of ethics and the American association APT do not have specific guidelines, both associations guide researchers to relevant ethical committees.

*Informed Consent*

There is much debate in the literature regarding children's ability to give their informed consent (see, Mahon, et.al., 1996). There is concern that children either won't understand what is being asked of them, or they will view the researcher as an authority figure and therefore acquiesce. Following Mahon et.al.'s., (1996) suggestions I ensured that children were given full and honest information about the research and gave guidance to therapists about obtaining children's assent and ensuring they provided children with a number of opportunities to decline. I developed child-friendly assent forms, augmenting writing with pictures and using developmentally appropriate language. Whilst such measures are advocated by other researchers (such as Grimshaw and McGuire, 1998 and Lindeke, et.al. 2000:103) somewhat surprisingly rather bland forms without pictures nor 'appealing fonts' are presented as being 'model examples'. Some use of pictures and photos of the researchers are used in other projects (e.g. Beresford, 2008:180). Photos and pictures with age appropriate language were used for both child and adult participants in this study. Arguably visual cues make information leaflets more accessible and understandable for all[53], not just children and are frequently used as a means of communication in everyday life in the 21st century (see Jewitt, 2008). Further details regarding the letters of invitation, information leaflets and agreement forms developed for children are described below (see appendices 4-6).

I was mainly reliant on therapists' adequately assessing the child's assent to take part and this was a disadvantage of this methodology. I sought written consent from the person with parental responsibility for the child and assent from the child themselves (see Daniel-McKeigue, 2007 and Lindeke et. al. 2000 for an overview of the debate on consent vs. assent issues). The informed consent of therapists was also sought for their own participation in the research.

*Power Issues*

Children may feel they have to take part in the research due to a desire to please adults, and particularly their therapist who they are likely to see as directly connected to the research. However, the nature of NDPT is permissive and it was hoped that this would help to reduce the power imbalance inherent in adult-child relationships. Morrow and

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[53] This includes, but not exclusively, those with disabilities and English as a second language. Provision was also made for leaflets to be made available in alternative formats, including large print and other languages.

Richards (1996) suggest that the use of non-invasive; non-confrontational and participatory methods help to reduce the ethical problems of imbalanced power relationships between researchers and child participants. Methods such as videos, stories, play materials and drawings provide the child with a sense of distance, which enables children to express their emotional worlds in a more manageable way (Wilson, and Ryan, 2005). As discussed in chapter five these play-based methods were to be employed in this research.

*Confidentiality and Anonymity*

Hill (1997) makes a useful differentiation between 'public confidentiality' and 'network confidentiality'. By public confidentiality Hill means the way in which the research is presented in the public arena, for example anonymising identifying information in reports. Hill acknowledges that dilemmas arise if a child wants to be identified in the presentation of the findings. He highlights that with young children particularly this may be problematic as they may not consider the consequences of this happening and may for example be embarrassed by the report as they grow older. For this project it was decided that identifying information would be removed, however children's participation in this process was encouraged. All of the participants were assured of anonymity both verbally via their therapists and within their information packs. To help children understand this concept a method adopted from Carroll's (2002) research was adopted: the children were invited to choose a pseudonym in the PBE itself, this was then used in the write-up of the project[54].

With regard to 'network confidentiality' Hill is referring to maintaining confidentiality during the data collection process. I had to be mindful of this when meeting therapist participants in other contexts. Confidentiality and anonymity in a relatively small network of professionals was particularly important given the potential 'harm' therapist participants may experience when the final report of the research is disseminated. As Miles and Huberman (1994:292) assert "harm or risk to participants can take many forms from 'blows to one's self-esteem' or 'looking bad' to others, to threats to one's interests, position, or advancement in the organisation". I was asking therapists to share both successful and unsuccessful cases. Furthermore, they were employing a technique which was new to them, and therefore their skill level could potentially be relatively

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[54] If children did not chose their own pseudonym one was assigned to them on receipt of the tape.

low, I was mindful of how exposing the research could be and ensured strict confidentiality and respect toward all participants through my own conduct and sensitivity in write-up (Flick, 2007).

*Child Protection Issues*

The NCB[55] (1993) provide guidance on procedures to be followed by researchers if a child, during the research, discloses information which makes the researcher concerned for their well-being. The guidance is clear that it is the duty of the researcher to pass on information to a professional who is able to take the necessary steps to protect the child. As my only contact with the children was through observation of a PBE session it was deemed unlikely that child protection issues would arise in this way. Therapists themselves would remain professionally responsible for reporting any child protection concerns. However, I could not overlook the questions posed by Miles and Huberman (1994) regarding intervention and advocacy when observing other's harmful, illegal, or wrongful behaviour. I was aware that I had an ethical responsibility as another professional observing a child's session and any child protection issues or observations of conduct which contravened BAPT's ethical guidelines or the specific agreed procedures, by the NHS MREC[56], for this study would be reported. All therapist participants received a copy of the MREC documentation.

**Application for Ethical Approval**

Initial approval of the project from the NHS MREC was rejected due to the following main concerns (for full details of concerns see appendix 9):

1. There was only one child information leaflet spanning the 5-13 age range.

2. Concerns regarding sending video-tapes in the post.

3. Concerns regarding the proposed number of children to be recruited

I addressed these concerns by developing two leaflets for children, one aimed at older children with more sophisticated language and more detailed information and one aimed at younger children which contained more pictures. Therapists were asked to decide which leaflet was most appropriate for the child participant based on their individualised knowledge of the child and their development, rather than relying on

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[55] National Children's Bureau
[56] National Health Service Multi-site Research Ethics Committee

chronological age alone. This seemed an important consideration given the cohort of children I was studying.

I adjusted the procedure to ensure that any video material would be sent by recorded delivery. Other methods of collection were impractical and whilst this incurred a cost for the therapists it felt important given the sensitive nature of the data being posted.

Lastly I provided justification for my plan to recruit a large number of children I had aimed for a more representative sample. However, I reduced this significantly over time. Interestingly, over the data collection period I adjusted my position toward the data realising that the data was incredibly rich and plentiful from a small number of cases because of the methods of analysis I developed. In fact large numbers of participants in the study began to feel inhibiting and there was a realisation that this would likely result in an analysis which would 'skim the surface' and abstract the data rather than revealing the complexities which I was aiming for. Thus the actual sample of twenty (detailed below) was a self-selecting one and unlikely to be representative of the population of children and young people accessing play therapy in the UK. However, as Mason (1996) notes the necessity of large numbers to construct a representative sample precludes the intensive study aimed for in qualitative designs.

Following further communications and minor adjustments over a five month period, ethical approval was obtained. Due to therapists being based in several different sites across the UK a further application to each local NHS research and development committee was necessary along with applying for an honorary contract with each Trust where a therapist was based[57]. This led to further queries about the research procedure proposed and several communications to provide clarity. One key issue which was raised was the lack of acknowledgement of equality issues. This was a particularly glaring error on my part and whilst equality issues were at the forefront of my mind when I developed PBEs I had not communicated my understanding of equality issues and the relation to my study in the proposal. A thorough response to the committees concerns was provided and an additional research question regarding the accessibility of PBEs was added:

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[57] In total four NHS research and development committees and one Social Services Quality and Performance Review Committee reviewed my proposed study.

'Are PBE methods accessible to all children? (focusing on age; disability; gender; culture)'

This process of secondary approval took a further three months. This ran alongside the recruitment phase. Due to the need to train therapists this process only resulted in delays with three therapists. However all three of these therapists did not take part in the study and it is possible that this delay resulted in their motivation to take part in the study declining. Details of recruitment and the final sample are given below.

This thorough reviewing process promoted reflection upon my research questions. It helped me to crystallise the research questions into three main areas (detailed below). Importantly my understanding shifted from a perspective of seeking out whether or not PBEs were *effective* to a more modest position of exploring their use. This was in recognition of the necessarily exploratory nature of this new field of study and the limitations of this initial research project.

**<u>Modified Research Questions</u>**
The modified research questions following this process were as follows:

*Children's views*
- What are children's views of play therapy?
- What are children's important memories of their play therapy sessions?

*Play Therapist's views*
- Are Play Therapists' views of the play therapy process influenced by the children's views expressed in the play-based interviews?
- Do Play Therapists' views differ from children's views of play therapy?

*The Techniques*
- Are play-based evaluation techniques useful ways of ascertaining children's views?
- Are play-based evaluation methods accessible to all children? (Focusing on age; disability; gender; culture)

*Ethical Dilemmas: An Ongoing Process*

Morrow and Richards, (1996) highlight that ethical dilemmas can arise at any point in the research process. The consideration of ethics did not cease at the point of obtaining ethical approval. Ethical issues were regularly recorded in my research diary and discussed at supervisions. Further ethical dilemmas did arise during the process and these are described to the reader at various points throughout this thesis. However, I now turn to the recruitment of participants and the resulting sample.

## **Recruitment**

The recruitment process involved four phases:

1) Initial training day in PBEs – open to qualified play therapists
2) Submission of a PBE training tape to complete the training phase – open to therapists who had completed the one day training.
3) Recruitment of therapists (who had completed phase 1 and 2) to the research project
4) Recruiting child participants via therapists discussing research to parents/carers/professionals and children, using my invitation letters and leaflets.

Each of these phases are described in detail below and illustrated in figure 1.

*Phase One:*
*Training*
*therapists*

Attended Training day in PBE's Therapists N=32

*Phase Two:*
*Completion*
*of therapist*
*training*

Completed training tape Therapists N=15

Did not complete training tape Therapists N=17

*Phase Three:*
*Recruitment of*
*therapists to*
*study*

Did not return written consent Therapists N=1

Consented to take part in research Therapists N=12

Declined participation Therapists N=2

Provided provisional consent to take part in research Therapists N=4

Declined participation (managerial decision) Therapists N=3

Did not return written consent form Therapists N=7

Did not respond Therapists N=3

*Phase Four:*
*Recruitment*
*of children to*
*study*

Child's participation declined Child N=7 (from 5 different therapists)

**Participants included in final cohort Therapists N=7 Children N=20**

Participants excluded in final cohort due to poor camerawork Therapists N=2 (not represented in any of the other tapes) Children N= 7 (from 4 different therapists)
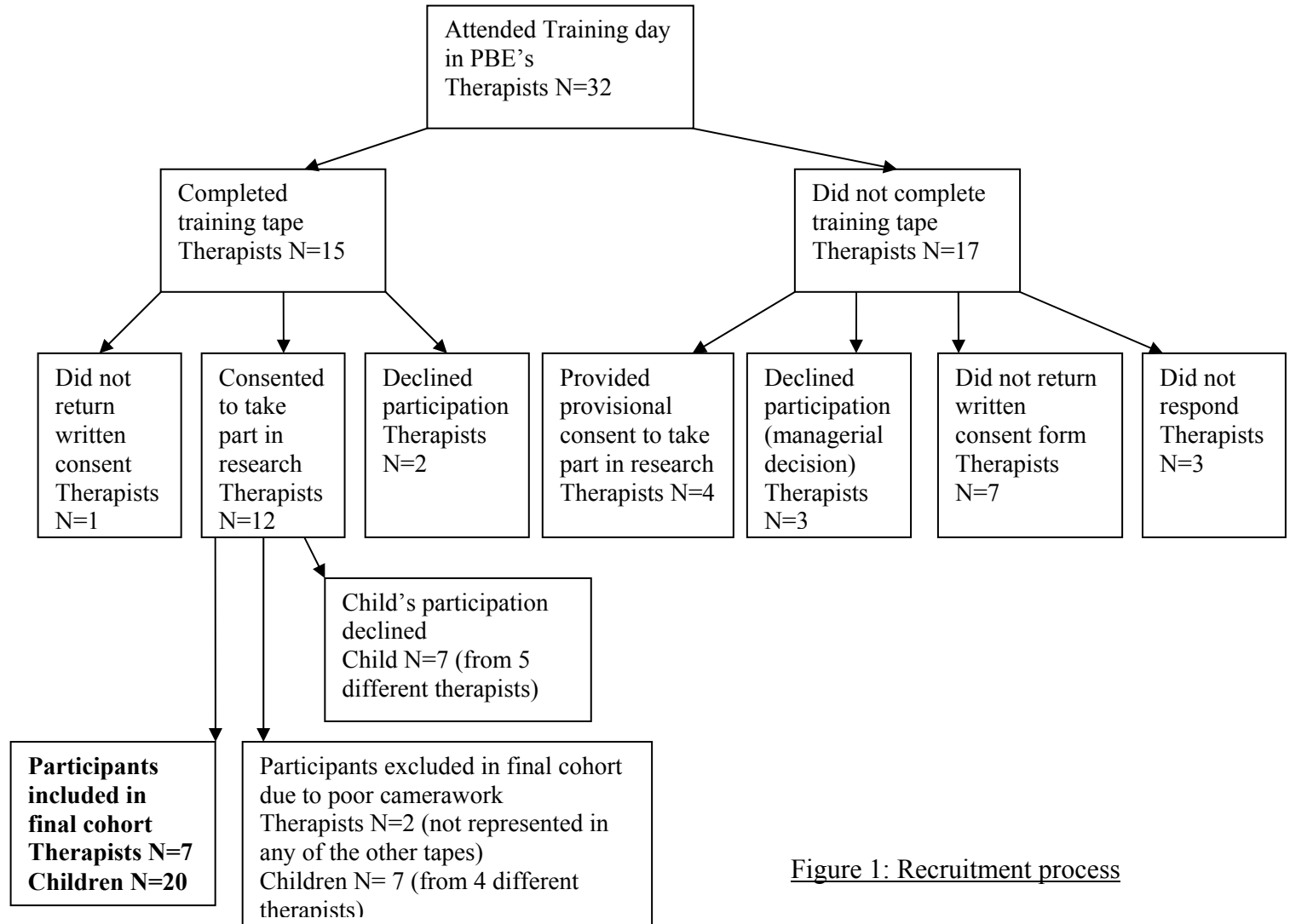
Figure 1: Recruitment process

123

**Phase One: Recruitment of Therapists to Training Days**

I advertised a one day free training event via e-mail to play therapy graduates from the University of York who had two years post-qualification experience, using the University of York play therapy graduate database. The aim of including University of York graduates only was to obtain as homogeneous group as possible with regard to practice of individual NDPT. This first event was well attended (15 therapists).

However, it was apparent from feedback, regarding the number of children on therapists' caseloads, that this number of therapists would not be enough to recruit the target number of child participants at phase four. Therefore further training days were offered and the inclusion criteria was widened to all BAPT qualified play therapists[58] with at least one year post-qualification experience, undertaking individual NDPT in their practice. These graduates were contacted via e-mail using the four institutions graduate contact lists. I held three further one day training events, two in the North of England and one in the South. A minimal administration charge was made for these subsequent trainings.

The advertisement (see appendix 10) provided information about the training and about the research. This detailed benefits and expectations of therapists in terms of the PBE research. The training was open to Play Therapists who were open to the possibility of taking part in the research and had their managers' initial approval. This inclusion criteria was checked at the point of therapists contacting me to book onto the training event. At this stage five play therapists declined involvement in the project, due to their managers disagreeing with their potential involvement with the research.

At the training events I provided thorough information about the research. I gave a half hour presentation on the proposed research and provided therapists with a recruitment pack (see appendices 4-6). The purpose of the research and questions posed was therefore transparent to participants. I allowed time for discussion and questions about the research. I requested feedback regarding potential gate-keeping issues therapists envisaged in their area and discussed potential solutions. The recruitment pack included a covering letter to therapists, an information booklet for therapists and consent form

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[58] This included all four BAPT approved training institutions across the UK: The University of York; Liverpool Hope University College; Notre Dame Centre, University of Strathclyde; Roehampton University.

along with example covering letters, information booklets (see appendix 11-13). And consent forms for parents, children, and GP's[59].

Due to gate-keeping difficulties with social work managers and therapists' professional line managers[60] I developed and sent out[61] an information leaflet aimed at social work managers (see appendix 12d). The aim of this leaflet was to address some of the gate-keeping issues known to concern managers when providing consent for Looked After Children (see Murray, 2005). I was keen to guard against convenience sampling and ensure that it was not just those therapists and gatekeepers who had fewest concerns who were included in the study (see Flick, 2007). I made it clear that I was happy to talk directly to these concerned parties and actively encouraged therapists to facilitate such connections. However this was not acted upon by any of the therapists.

Thirty-two therapists completed phase one over a period of 12 months[62] through the delivery of four training days.

**Phase Two: Completion of Training**

Phase two and three overlapped. Over a fifteen month period[63] training tapes were received from therapists. Fifteen therapists provided one video-taped PBE with a child in their own clinical practice. Individualised training feedback was sent to each therapist (for an example see appendix 14). This completed the training stage for these therapists. Thus fifteen therapists met the inclusion criteria to take part in the research.

**Phase Three: Recruitment to Research Component**

Of the fifteen fully trained therapists twelve consented to taking part in the research. One therapist, whilst expressing an interest and verbally agreeing to the research, did not provide written consent. Two therapists declined participation as they were no longer delivering individual play therapy[64].

Four therapists, who had not completed phase two, returned written consent to take part in the research. However, they did not send a training tape therefore their eligibility to

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[59] For NHS participants as required by the NHS MREC.
[60] Reported by therapist participants, who were currently at phase four of the recruitment process.
[61] August 2007
[62] November 2006-2007
[63] January 2007- May 2008
[64] Due to one changing professional roles and the other retiring

take part in the research remained pending throughout the lifetime of the project. Three declined participation due to their manager not consenting. Seven expressed an interest but did not return their forms and the remaining three therapists did not respond following phase one.

This left twelve participating therapists.

**Phase Four: Recruitment of Child Participants**

Therapists were asked to give children and parents' information leaflets and letters inviting them to take part in the research. Therapists were asked to verbally explain the research to children and parents. This method of indirect recruitment was chosen for both practical and ethical reasons. The evaluation sessions would be taking place at the therapists' workplaces. These covered a wide geographical area, many of which would entail a day of travelling from my base.

In addition timescales for organising a mutually convenient time would be difficult particularly as I hold my own clinical commitments three days a week and potentially more than one therapist would be undertaking a session in any one week. Therapists were encouraged to invite children to take part in PBE's and the research at the same time. This was usually at the final progress meeting (approximately 3-4 weeks before the session took place). Attending this meeting as an 'outsider' had ethical implications and setting up a meeting after this point but before the evaluation session took place was impracticable.

The evaluation sessions were being delivered by these therapists as an integrated part of their clinical practice. The research aspect was indirect observation via video tape. Thus indirect recruitment also felt appropriate. This meant that children did not have to make a new relationship with a stranger who they were going to have no other contact with. However, it did feel important that the children and parents knew who I was and could contact me on their own terms if wanted. Therefore a photo of me was included in the information leaflets and a variety of ways of contacting me were suggested: telephone; text; e-mail or via the therapist.

I was reliant on therapists to invite *all* children with whom they were undertaking a PBE to take part in the research. It was not possible to strictly monitor this procedure.

However, therapists were repeatedly encouraged to tell me about children who declined participation and to send me evaluation sessions which, in their opinion, had been successful as well as those they deemed unsuccessful. Whilst some therapists informed me of children who declined to participate and some sent in evaluations where they felt the therapy had not been entirely successful, or the evaluation session itself had been difficult, it is not possible to know whether this reflects all instances of this. Thus the sampling process was self-selecting both in terms of the families' agreement and the children therapists chose to ask. Indeed feedback from some therapists throughout the process indicated a level of anxiety regarding exposing their practice. This may account for some therapists' choosing not to take part and may also have had an unknown impact on the children therapists chose to invite participation. I tried to counteract this by acknowledging, via e-mail communication and up-date reports, the exposing nature of the research, reassuring therapists that I would maintain confidentiality and anonymity; and re-iterating the usefulness of receiving successful and unsuccessful sessions.

Twenty-seven children were recruited to this study. Six of whom were not included in the analysis due to poor recording[65] or significant known chunks of missing data. One child was excluded due to a third person being present in the PBE. It was decided that this had a significant impact on the session and many non-verbal cues could not be understood as the third person was off shot for most of the session. Thus the final cohort of children participating in this study was twenty.

Participation of seven further children was declined. For three children, whilst their parents provided consent, they themselves declined participation in the research. It is difficult to separate the reasons for non-participation and whether these were solely related to the research component or to PBEs per se. In two cases the therapist did not offer the PBE without the research component so it is not possible to know whether it was the PBE per se, which the child did not want to engage with, or the research. In the other case the child engaged in the PBE session. Although the child's parents continued to provide consent for his tape to be used in the research and children's assent only was being sought it was decided to respect this child's view. He was eleven years old and

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[65] This included a close-up of the child only resulting in the therapist being off shot for most of the session in three tapes, this rendered analysis of the interaction and non-verbal communication untenable. Two tapes were poor recordings from CCTV cameras not allowing enough detail. In one case difficulties with recording led to over 30 minutes of the session not being recorded.

was ambivalent about taking part in the PBE session itself. However, when his therapist asked him about sending me the tape for research purposes he clearly stated 'no this is only for you'. Given his age and very clear message that he did not want his tape shared I decided to inform the therapist and destroy the tape before watching it.

One social worker and four parents did not provide their consent for their child to take part in the research. In three of these cases the child was looked after with the local authority and the birth parents holding joint responsibility for the child. In two of these three cases the birth parents did not complete the consent forms and the Social work managers would not override this. In the two remaining cases no reason was given. Unfortunately in all of these cases the therapists did not offer the PBE without the research component attached. As stated above, it was intended that therapists would undertake PBEs as an integrated part of their practice and the research was an additional component to seek consent for. Whilst therapists' involved in the project have since reported that they have and will continue to use PBE's beyond the lifetime of the project, it seems that during the project they had not conceptualised them as separate processes.

**Final Sample**

The recruitment phase was lengthy and complicated. Over a two year period twenty-seven children were recruited by nine, of the twelve participating play therapists. Following the exclusion criteria a final sample of twenty-children and seven therapists were included[66]. By way of summarising the above process the sampling criteria employed is outlined here:

*Sampling Criteria*

*Therapists:* Qualified BAPT registered play therapists who:
- practice NDPT
- have at least one year post-qualifying experience
- have completed a one day training in PBE's
- have submitted a PBE training tape

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[66] Six of these therapists were trained at The University of York, thus all but one of the therapists had undertaken the same training which focuses on an NDPT model.

*Children:* Children who have received, *mainly*, individual NDPT and:

- were 5-13 years of age

*Exclusion Criteria*

- Tapes which exclude sight of one of more participant for over 25% of the time
- Tapes which cut out over 25% of the session.

Due to the high number of play therapists who now involve parents or carers in therapy interventions it was necessary to include children who had received individual NDPT with some modifications. This occurred in four cases. For one child this involved the therapist working in partnership with his mother who observed for half an hour, and sometimes took part (six out of nine sessions). For a second child his mother observed the last two sessions. In two cases the children were ending individual play therapy but transferring to another form of play therapy: filial therapy (see Van Fleet, 1999) with the same therapist. This entailed their parents observing one or two of their individual NDPT sessions. The PBE had taken place after these observed sessions, but prior to filial therapy sessions starting. The information regarding the intervention undertaken is detailed in Table 6 below.

First the demographic information gathered on child participants is presented in Table 3. The children are listed in age order. There were 9 girls and 11 boys. The age range was 5-13 years. There was one 5 yr old, one 6 yr old, nine 8 yr olds, three 9 yr olds, three 10 yr olds, two eleven year olds and one 13 yr old. I have used the terms employed by the therapists rather than adhering to a particular convention of detailing demographic information. Fifteen of the children were White British, the other five were recorded as follows: mixed race, Italian/Brazilian, Algerian, Black, and Black African/Jamaican. Five children had a statement of educational/learning or emotional and behavioural difficulties and one child had a diagnosis of ADHD. Each child has been given a pseudonym, either using the name they assigned for themselves during the evaluation session or in the absence of this a name I have assigned to them. Some of the names children assigned to themselves are unusual and may prove distracting to the reader. However, I have respected the children's choices and use their pseudonym throughout the thesis. A limitation of the data collected is information regarding the child's home circumstances.

Table 3: Demographic data of child participants

| Child | Age | Disability | Gender | Religion | Ethnicity |
|-------|-----|------------|--------|----------|-----------|
| Susie | 5.6 | None stated | Female | C of E | White British |
| Jack | 6.1 | Statement of emotional & behavioural difficulties | Male | None stated | White British |
| Rob | 8 | None stated | Male | None stated | White British |
| Marble | 8.5 | Special needs record of action | Female | None stated | White British |
| Hannah | 8.5 | None stated | Female | None stated | White British |
| Bradley | 8.5 | None stated | Male | None stated | Mixed race |
| Lee | 8.7 | ADHD | Male | C of E | White British |
| Elizabeth | 8.7 | None stated | Female | Roman Catholic | Italian/ Brazilian |
| Gabriella | 8.9 | Statement of emotional and behavioural difficulties | Female | None stated | White British |
| Herbert | 8.11 | None stated | Male | None stated | White British |
| Emma | 8.11 | None stated | Female | None stated | White British |
| Leanne | 9 | None stated | Female | Muslim | Algerian |
| Cathy | 9.1 | None stated | Female | C of E | Black |
| Eddie | 9.3 | None stated | Male | None stated | White British |
| Charlie | 10.1 | low level learning difficulty (unassessed) | Male | Mormon | White British |
| Billy | 10.9 | None stated | Male | None stated | White British Traveller |
| L-man | 10.10 | None stated | Male | Christian | Black African/ Jamaican |
| Martin | 11.1 | Statement of special needs | Male | None stated | White British |
| Sarah | 11.6 | None stated | Female | None stated | White British |
| Bob | 13.9 | None stated | Male | None stated | White British Traveller |

I detail the reasons provided by therapists at the point of referral in Table 4 below. Those highlighted as a primary issue are represented in bold text, for secondary issues standard text is used. The main five areas of presenting problems used in the collection of this data (see appendix 6a) is listed at the top of Table 4, with each specific issue listed below. The child's age is re-stated under their name.

Table 4: Presenting problems at referral

| CHILD | Primary referral issues/Secondary referral issues | | | | | |
| | Abuse | Personal/ Self | Health | Racial/ Cultural/ Identity | Relationships | Behaviour |
|---|---|---|---|---|---|---|
| Susie 5.6 yrs | **Emotional Sexual Witness Domestic Violence** | Anxiety/ Stress Anger | Sleeping Difficulties | | | Behaviour Problems at home |
| Jack 6.1 yrs | | **Anger Conduct Problems** | | | **Poor peer relationships** | **Behaviour Problems at school Exclusion Academic** |
| Rob 8 yrs | | **Anxiety/ Stress** | | | **Bullying Others** | **Behaviour Problems at home & school** |
| Hannah 8.5 yrs | | **Anxiety/ Stress** | Nightmares | | **Attachment Difficulties** Multiple Bereavement | Behaviour problems at home & school Academic |
| Marble 8.5 yrs | **Sexual (infancy-6yrs)** | **Withdrawn** | | | Bereavement (baby brother) | Academic |
| Bradley 8.5 yrs | **Emotional Neglect Witness Domestic Violence** | **Anxiety/ Stress Anger Conduct Problems** Self-esteem Trauma | | | Poor peer relationships Attachment difficulties | Behaviour problems at home |
| Lee 8.7 yrs | | **Suicidal** | **ADHD** | Identity in family | Bereavement | **Behaviour problems at home** |
| Elizabeth 8.7 yrs | **Emotional Neglect Physical Witness Domestic violence** | Anxiety/ stress | | | Poor peer relationships Attachment difficulties | Behaviour problems at home & school |
| Gabriella 8.9 yrs | **Neglect** | **Anxiety/ Stress Anger Conduct Problems Self-esteem** | Phobias | | Poor peer relationships Attachment Difficulties Early loss (foster care -> adoption) | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Herbert 8.11 yrs | Witness domestic violence | **Anxiety/ Stress Anger** | | | **Loss of father through separation** | |
| Emma 8.11 yrs | | **Anger** Suicidal | **Eating Difficulties** Sleeping Difficulties | | **Attachment difficulties Poor sibling relationships** | |
| Leanne 9 yrs | **Emotional Sexual** | Anxiety/ Stress Anger Trauma | **Eating difficulties Sleeping difficulties** | Identity – religious/ cultural | Attachment difficulties | **Behaviour problems at home** |
| Cathy 9.1 yrs | **Neglect Witness domestic Violence** | Anxiety/ Stress Self-esteem | Sleeping difficulties Nightmares | Discrim- intation | **Attachment difficulties** | |
| Eddie 9.3 yrs | | **Anxiety/ Stress Anger Self-harm** Self-esteem | **Sleeping Difficulties** | | **Attachment difficulties** Parental acrimony Lots of transitions | **Behaviour problems at home & school** |
| Charlie 10.1 yrs | **Witness domestic violence** | **Suicidal** Trauma | | | **Attachment Difficulties** Academic | |
| Billy 10.9 yrs | **Witness domestic violence** | **Anxiety/ Stress** Self-esteem | | | | Behaviour problems at home & school school refusal academic |
| L-man 10.10 yrs | **Physical Witness domestic violence** | | | **Identity – religious/ cultural** | **Bereavement** Poor peer relationships Bullying Attachment difficulties | Behaviour problems at home & school |
| Martin 11.1 yrs | **Emotional Neglect Witness domestic violence** | **Anxiety Stress Anger Conduct Problems** | Eating difficulties | | Parentified child Attachment difficulties | Behaviour problems at home & school |
| Sarah 11.6 yrs | **Neglect Witness domestic violence** | Anger | | | **Bullying** | Behaviour problems at home & school |
| Bob 13.9 yrs | **Emotional Neglect Physical Sexual** | Self-esteem Withdrawn | | | | Behaviour problems at school Academic |

The main characteristics of the therapists are detailed in Table 5. I have been mindful of the need to protect the anonymity of therapists from such a small community. I have assigned random pseudonyms rather than following a convention of using the same first initial. I debated whether to include the gender of the therapists as there was only one male participant in this study. However, there are a number of male play therapists practising in the UK and specific location or service is not revealed therefore gender is specified in brackets after the therapists' name. The qualifying institution is presented and it is worthy of note that all but one participant was drawn from the University of York graduates. Therefore the resulting cohort was fairly homogenous. The amount of post-qualifying experience is grouped to ensure therapists cannot be easily identified. Presenting the data in this way also conveys the amount of *actual* experience each therapist has had. Thus the number of full-time equivalent years the therapist has been employed as a play therapist is recorded. The time between attending the training day and submitting a first training tape and subsequent research tape varied for each therapist. This data is documented in the fourth and fifth columns. It is important to note that the number of video-taped sessions provided by therapists in this study varied from one to nine. This was not planned. However, such a spread enabled comparison across therapists and comparison of children who undertook an evaluation session with the same therapist. Three of the participants attended an additional half-day seminar on PBE's where further video material was shared and a review of the techniques and process was given.

Table 5: Details of therapist participants

| Therapist name & gender | Judy (F) | Emily (F) | Polly (F) | Rachel (F) | Nick (M) | Lucy (F) | Sonia (F) |
|---|---|---|---|---|---|---|---|
| **Institution training undertaken** | York | Roeh-ampton | York | York | York | York | York |
| **No. of yrs experience (FT equivalent)** | 8.5 | 8 | 4 | 3.5 | 2.5 | 2.5 | 0.5 |
| **No. of months between PBE training & 1st training tape** | 1.5 | 4.5 | 2 | 4 | 5 | 5.5 | 4 |
| **No. of months between training tape &1st research tape** | 0 (1 wk) | 4 | 4 | 2 | 0 (2wks) | 5 | 6 |
| **No. of research tapes[67]** | 9 | 2 | 3 | 1 | 3 | 4 | 1 |
| **Attended extra half day** | yes | no | no | yes | no | yes | no |

In Table 6 I bring together information about the child and therapist participants providing details of the intervention. I detail who the therapist was in each case. In the second column I detail how many research tapes the therapist had submitted at the point of undertaking the PBE with each case (e.g. 1 of 3; 2 of 9). As detailed above, four children experienced more active involvement of their parents and carers in their interventions. Observations of their individual sessions took place either as part of the transfer to filial play therapy or as an addition to their individual play therapy intervention. I highlight this in Table 6 below. I document the length of the intervention which ranged from 8-40 sessions. A limitation of the data is that some therapists documented both the number of sessions the child received and the length of time in months and some recorded only one of these. I document whether or not the intervention was complete or in the process of transferring to Filial Play therapy or ending prematurely for other reasons. Lastly, I document the type of PBE used with each child. Only two of the three techniques were utilised by therapists in this study: 'The Expert Show' in 13 cases and 'The Miniature Playroom' in 2 cases a combination of both of these techniques was used in the remaining 5 cases.

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[67] Some of these tapes were excluded in the final sample due to poor recording (described above).

Table 6: Research dyads: details of intervention

| Thera pist | Tape no | Child | Age | Length of intervention | Premature/ unresolved ending | Type of PBE |
|---|---|---|---|---|---|---|
| Judy | 1 of 9 | Charlie | 10.1 | 12 months | Returning for visits | Expert Show |
| Judy | 2 of 9 | Lee | 8.7 | 15 months 34 sessions | Returning for visits | Miniature Playroom |
| Judy | 3 of 9 | Emma | 8.11 | 13 months | Completed | Miniature Playroom & Expert Show |
| Judy | 4 of 9 | Rob | 8 | 5 months 14 sessions | Premature/ unresolved (mother observed last 2 sessions) | Miniature Playroom & Expert Show |
| Rachel | 1 of 1 | Eddie | 9.3 | 8 sessions | Premature/ unresolved | Miniature Playroom & Expert Show |
| Nick | 1 of 1 | Martin | 11.1 | 18 months 30 sessions | Premature/ unresolved | Expert Show |
| Judy | 5 of 9 | Billy | 10.9 | 10 months | Completed | Expert Show |
| Judy | 6 of 9 | Marble | 8.5 | 15 months 40 sessions | Completed | Miniature Playroom & Expert Show |
| Lucy | 1 of 4 | Leanne | 9 | 36 sessions | Premature/ unresolved | Expert Show |
| Lucy | 2 of 4 | Susie | 5.6 | 9 sessions | Premature/ unresolved | Miniature Playroom |
| Judy | 7 of 9 | Hannah | 8.5 | 4 months | Transferring to filial therapy | Expert Show |
| Polly | 1 of 3 | Gabriella | 8.9 | 20 sessions | Transferring to filial therapy | Expert Show |
| Judy | 8 of 9 | Bob | 13.9 | 11 months 32 sessions | Returning for visits | Expert Show |
| Judy | 9 of 9 | Elizabeth | 8.7 | 5 months 17 sessions | Returning for visits | Expert Show & Miniature Playroom |
| Polly | 2 of 3 | Jack | 6.1 | 31 sessions | Completed | Expert Show |
| Emily | 1 of 1 | Bradley | 8.5 | 9 months 28 sessions | Premature/ unresolved | Expert Show |
| Lucy | 3 of 4 | Sarah | 11.6 | 10 sessions | Completed | Expert Show |
| Lucy | 4 of 4 | Cathy | 9.1 | 10 sessions | Completed | Expert Show |
| Sonia | 1 of 1 | L-man | 10.10 | 24 sessions | Completed | Expert Show |
| Polly | 3 of 3 | Herbert | 8.11 | 9 sessions | Completed (inc. mother observing ½ hr 6 out of 9) | Expert Show |

**<u>Influence of My Role</u>**

As Scourfield (2001) highlights the researcher's own biography, values and beliefs and personal conduct are intrinsically bound to the progress of data collection and analysis. As a play therapist myself and particularly as the developer of the techniques under study I was very aware of both the advantages and disadvantages of my position. Yin (1994) and Flyvberg (2004) highlight the dangers of researcher bias when the research subject is particularly valued by the researcher. Several writers (e.g. McLeod, 1994 Marshall and Rossman 1995) highlight the importance of self-reflexivity being aware of how one's own values and experiences influence both the subject matter and style of proposed research. Consultation with a wide range of professionals outside of the field of play therapy assisted me in considering the use of PBEs from different perspectives and highlighting my own assumptions This included the multi-disciplinary CAMHs team[68] in which I work and academics[69] within my University setting.

Due to the necessity of building a cohort of play therapists who could deliver the PBEs I had created a dual role with the therapist participants of both researcher and trainer. I was also a fellow play-therapist and founder of PBEs. I was aware that this was likely to have an impact on the therapist participants, and in turn their behaviour may lead to biased misinterpretation on my part as researcher (Miles and Huberman, 1994). I was particularly aware of the tendency for the therapists to see me as the 'expert' and as someone to please. This was two fold. In terms of my role as their trainer therapists were likely to have concerns about administering the techniques 'correctly'. In terms of my role as one of the few researchers of play therapy in the UK, therapists were likely to have concerns about being scrutinised and providing me with 'good data' particularly in a climate of 'evidence based' practice being key to the standing of our joint profession. I tried to make a distinction between the time period in which I was the therapists' trainer (up to and including their individual training tape and feedback) and when I stepped into the role of researcher. I was explicit to participants about this change in role and acknowledged that I

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[68] Professionals consulted included art therapists; child psychotherapists; clinical nurse specialists; participation workers; psychiatrists; psychologists; and social workers.
[69] These included academics in the social policy and social work department and the music therapy department.

would no longer be able to be consulted for advice regarding how to administer the techniques. I advised them to use their usual channels of support and reflection: clinical supervision and other therapists trained in the techniques. It is also important to mention that I held additional roles with some of the participants. I was known to four of the therapists from previous training, seminars, and research projects as a peer, trainer, lecturer, or researcher. In addition to bringing my work related roles to the research I brought personal attributes. I am a white, middle class, young female. I am married with no children.

Having a specific interest in the research topic and a detailed understanding of the research context is also recognised as a strength in assisting researchers' analysis (Bannister, et.al. 1994). It is worthy of note that the continued communication between myself and the therapist participants via e-mail and verbal discussion at events seemed to help maintain both my own enthusiasm for the project and their commitment in taking part. It was at times frustrating not to share the findings as they emerged, so as to reduce possible bias. However, I very much valued their interest in the more practical reporting of the progress I was making (see appendix 15 for progress reports sent to participants) which helped to reduce the isolation of my role. Furthermore therapists' continued commitment to the project also enabled me to consult them regarding my analysis which I refer to below. Throughout the remainder of this thesis I periodically return to the influence of my role on participants in the study and on the analysis process.

**<u>Data Analysis</u>**

Following Miles and Huberman's (1994) advice I was keen to establish systematic, credible and replicable methods for analysing the wealth of data I had collected. They assert that "the strengths of qualitative data rest very centrally on the competence with which their analysis is carried out" (1994:10). In order to enhance the validity of my conclusions I was keen to ensure I analysed the data from different angles, and put systems in place to protect against 'self-delusion' and 'data overload' which lone researchers are particularly prone to (Miles and Huberman, 1994). A key issue for me was to remain close to the data. My interest in the meaning and complexity of the children's views necessitated immersion in the data and insurance against the data being abstracted and separated from context.

Furthermore my growing interest in the interaction between the therapist and the child during the PBE session also required close analysis of not only the words spoken and play enacted but the non-verbal communication and the overall 'feel' of the session. I felt it was important that I did not drift too far away from these subtleties nor simply analyse text as talk.

I ensured that I drew on a range of well established and more contemporary methods throughout the data analysis process to enable me to hold together these different levels from the data. This included reviewing the source data numerous times and at all stages of data analysis. I was motivated to make use of the advantages of CAQDAS[70] packages alongside visual methods and more traditional paper-based methods. As Flick (2007) points out the use of the software was not a method in itself, but rather a technical device to support my analysis.

The analysis followed three different strands which are interwoven. The first line of inquiry was the children's views of their play therapy intervention, essentially a thematic content analysis. The second major line of inquiry was the therapists' use and the child's response to PBE's. It became clear as I began to analyse the data that to thoroughly explore one of my main research questions 'Are PBE's useful ways of ascertaining children's views?' I would need to closely attend to the interaction taking place between the therapist and child during the evaluation session itself. This developed into two strands of analysis: first the process observed and reported during the evaluation session across all cases and second an in-depth exploration of the interaction between child and therapist in four different cases.

This enhanced attention to 'process' issues was not entirely envisaged at the outset of the study and it resulted in new research questions being raised and a shift in focus away from exploring the therapists' views in depth. It was clear that there was less data on the two research questions related to the therapist's views (stated above) to draw upon. Therefore, some analysis of the therapists' views was undertaken and interwoven into the presentation of findings in chapters 7-9. However, it seemed likely that focusing on the interactional issues would be more illuminating. The research in this area has already been reviewed in

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[70] Computer assisted qualitative data analysis software

chapter four. The main research question posed regarding the interaction, at this later stage of analysis was:

> 'Does the level of attunement between therapist and child have an impact on the use of PBEs?'

Several different analysis processes were completed all of which contributed in varying degrees to these three strands of inquiry. An account of the analysis methods utilised is presented below.

**Initial Reflection Sheet**

An essential first stage of the analysis involved watching each video tape from beginning to end and 'experiencing' the session. I used an adaptation of Miles and Huberman's (1994) contact sheet to record my first impressions (see appendix 16). I recorded key words to describe the session; any questions each particular video raised for me; any data related to each of my research questions; and the feelings evoked in the session, how I had felt watching it and how I thought the child and the therapist felt. This helped me to notice when my role as developer of the techniques or as trainer affected my position toward, and interpretation of, the data. It also enabled me to retain a record of those initial feelings and reactions which only occur when you first witness an event. I returned to these sheets many times over the analysis process to see how my views and feelings toward the sessions changed over time. This process is similar within play therapy itself and my previous training on recognising my own and others feelings assisted my analysis. The recording helped me to keep in mind salient points I had noticed at this first viewing. My research diary was also an important place for reflection throughout the analysis process. This housed new ideas and concepts and importantly how I was interacting with the data. I recorded external influences and the ways in which these were shaping my thinking as I proceeded.

**Transcribing Video-tapes**

The tapes were then viewed a second time and verbally transcribed. A third and fourth viewing of the tapes was undertaken and corrections made to the verbal transcription and transcription conventions were inserted to reflect the sub-verbal content, for example whispering; inflections; pauses (see appendix 17a for full transcription conventions followed, adapted from Heath and Hindmarsh, 2002[71]).

I was keen to ensure I did not lose the entire context of the communication beyond the verbal and sub-verbal. I was interested in exploring a method of obtaining children's views which put as much emphasis on the child's non-verbal communication (facial communications, gestures and body language and their play and actions with the toys) as their verbal communication. Therefore it seemed essential to capture this information as thoroughly as possible. The tapes were viewed a fifth time in slow motion, at times frame by frame, to add the non-verbal data included head nods, smiles eye gaze direction and 'performance directions' for example picking up the phone, manipulating a figure (see appendix 17b for non-verbal transcription conventions used and exemplar).

The tapes were viewed a sixth time to attend to any errors in the verbal or non-verbal transcript. It is important to note that while transcription conventions for the texture of talk-in interaction are well developed Goodwin (2001) argues that transcription of visual phenomena is in its infancy. Whilst I considered different conventions in use by Heath and Hindmarsh (2002), I found that these were not workable on such a large volume of data and would become unusable when uploading the transcripts to Atlas-ti. Therefore I chose to use abbreviated codes for non-verbal communication and utilise the conventions used in transcribing verbal data to reflect intensity and duration. I used abbreviations which I could later easily replace[72] to be read in full in the text at a later stage.

Initially, due to the labour intensive time-consuming nature of the task, I aimed to complete this in-depth level of transcription for a small sample of the tapes. However, I was struck that this immersion in the data seemed to particularly enhance my ability to 'hear the

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[71] I had considered various forms and levels of transcription having followed Antaki (2002) online tutorial.
[72] With the find and replace function in Microsoft Word.

child's voice'. It seemed that so much of the child's communication was on the non-verbal level that nothing less than full attention to this process would truly convey their views. As this was a central aim of my study the additional time needed seemed justified, therefore I undertook this rigorous process with all twenty video-taped sessions.

Further benefits of this process included a greater understanding of the interaction between therapist and child. Whilst I accept that transcriptions are never 'perfect' (Bryman, 2001) as Silverman argues transcription which is informed by or emulates the detail achieved in conversational analysis "represents a more objective, comprehensive and therefore more reliable recording of the data" (2006: 288). This level of familiarity with the data also enabled me to remain in touch with the context of the session when I began coding, and subsequently the overall feel or potential meanings of a statement. Goodwin (2001:158) outlines examples where reading the verbal transcript alone leads to a different interpretation to reading the verbal transcript with eye gaze added. This small convincing example highlighted that the thorough inclusion of non-verbal information would allow me to maintain my qualitative understanding of therapists', and particularly children's utterances when undertaking a thematic analysis. This enhanced the quality of my thematic analysis and particularly the coding analysis of the therapists' and child's process during PBE's, described below.

**Thematic Coding**

As suggested by Miles and Huberman (1994) I began with a provisional list of codes. These were derived from the pilot research (concept-driven codes, Gibbs 2007), the initial themes arising from the initial reflections sheets and transcription of the first cohort of video-taped sessions (data-driven codes, Gibbs, 2007). Due to the data being collected over a two year period thematic coding of early tapes began before all the data was collected. Thus a range of analysis activity was occurring simultaneously at times. This helped to reduce the tedium of such detailed transcription, and consequently the number of potential errors. It also maintained my motivation levels which was essential during this isolating period as a lone researcher. This iterative process informed the development of codes over time, new tapes necessarily involved new codes being developed, and subsequent systematic checking of earlier transcripts to identify any occurrences of the new codes.

Three separate coding lists were devised. This reflected my interest in exploring the data in two distinct, and yet inter-related ways. It enabled me to focus on only those codes relevant to one line of inquiry at a time. As previously stated these were: the children's views and the process issues. I first coded the children's views. I chose to separately attend to the therapists' process, for instance showing acceptance of the child's views and choices or curtailing the child's expressions, and then the child's process, for instance when they became distracted or when they took the lead in the interaction (see appendix 18a, b and c for code lists with full descriptions).

The rationale for attending to these processes separately was to ensure I did not become overloaded and did not favour one participant's part in the interaction over the other. However, it was important to remain mindful that the meaning of one participant's process was influenced by the interaction with the other. The filtering facility in Atlas-ti was an advantage here. Whilst I was able to focus on only the child's or only the therapist's process when assigning codes I could display any combination of the three separate coding processes (e.g. child's process and therapist's process; child's views and child's process). This was a significant advantage of utilising CAQDAS and enabled me to assess the influence of the process on the views the child expressed. I was able to draw on this facility when writing up thereby giving the reader greater access to the process issues during the session when presenting the child's views. Furthermore, rather than creating distance and experiencing a feeling of de-contextualisation (a criticism of early CAQDAS packages, see Gibb, 2007), utilising Atlas-ti's functionality of displaying quotations in context was a real strength. This was of particular importance given the lengthy time span from initial coding to write-up (20 months). The memo function also assisted in maintaining a link to contextual issues as I was coding and enabled me to track the development of my thinking over time in relation to the study as a whole, but specifically certain segments of tape or particular dyads. I followed Lewins and Silver's (2007:14) advice of "coming out of the software" by printing memos, sections of coded transcripts, code reports and coding frequency tables on a regular basis, and utilising traditional pen and paper methods.

A significant limitation of this stage of the process was a lack of inter-rater reliability of the codes, it was not possible for me to find a volunteer who did not have involvement in the

project already and would be willing to spend a considerable amount of time familiarising themselves with the data and coding conventions. However, coding checks were utilised throughout the process to increase internal validity (see Miles and Huberman, 1994). Re-reading the coding definition list for the area I was analysing (children's views; therapists process of child's process) each time I began a coding session helped to reduce definitional drift, thereby increasing reliability (Gibbs, 2007). Furthermore, quotation reports of individual codes were undertaken and each quotation checked for adherence to the coding definitions before final conclusions were drawn. Any quotes which did not fit the coding definition or were better suited to a code developed later in the analysis were moved. Although the number of quotes subsequently moved was not systematically quantified this was a low number. The use of Atlas-ti's auto coding facility was also employed to identify any quotes which may fit each code and were missed. Again the number of quotes identified in this way was low but was not systematically recorded which is recognised as a limitation[73].

This process, of checking each quotation assigned to each code, enabled a second layer of analysis to occur. For instance in the children's views coding all of the quotes assigned to the code BEG (beginning) were reviewed and further categorised using codes such as: familiarisation; preparation; the unknown. Whilst I intended to use this thematic coding to present quotations verbatim I was also able to undertake a quantitative analysis utilising Atlas-ti's functionality. This helped to identify patterns in the data. In terms of the children's views I first listed the children from low to high, based on my own subjective opinion following the in-depth qualitative analysis. I then quantified the data by creating a code frequency table of the number of quotes coded as a child expressing their views. This matched the outcome of my subjective analysis in all but two cases. I had rated Billy a little too highly, possibly a reflection of his high level of engagement in the task. However, the quantification revealed that he hadn't actually shared as many views about play therapy as some other children. I had rated Gabriella a little too low, perhaps an indicator of my judgement being influenced by her challenging nature in the actual session. Clearly my subjective judgement might also have been influenced by the actual quality and depth of the

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[73] Due to the dating functions and numerous saved versions of the hermeneutic unit in Atlas-ti this could be tracked through an auditing procedure if necessary.

children's remarks which would have been missed by the quantitative analysis. I was also aware that the quantitative data was somewhat skewed due to some quotes being coded twice as they related to two separate themes. Therefore I grouped the children into five groups rather than individually rank them. The range of quotes coded as the child expressing their view was 16-157. The groupings were as follows: low (16-30) low-mid (31-40) mid (41-50) mid-high (51-60) high (61-70) and very high (70+). These groupings will be referred to in the presentation of the findings in chapters 7-9.

**Data Displays**

Miles and Huberman (1994) argue that data displays are a central way to increase the validity of qualitative studies. They assert that displays enable researchers to organise information into digestible chunks and help to guard against overloading human information-processing capabilities when continually reviewing extended pieces of text. I utilised various different data displays during the analysis. Following the code-checking, network displays were used to further develop the analysis and assist in writing up the varying views and experiences children talked and played about. For other analyses matrices seemed more helpful, for example representing the children's range of feelings regarding different parts of the play therapy process (see appendix 19).

**Case-Analysis Meetings**

To compensate for working alone I used my supervisor, who has both research and clinical experience in the field of play therapy to act as 'critical friend' (Miles and Huberman, 1994). This was not only through reviewing transcripts and discussing data conclusions as they emerged but holding more structured 'case analysis meetings' (Miles and Huberman, 1994). In preparation for these meetings my supervisor read the transcript of the case to be discussed (three in total). In the subsequent meeting I utilised a guide (see appendix 20) to explore my supervisors independent impressions of the data discuss explanations and hypotheses and discuss alternative interpretations to the data. This process was critical in crystallising my thinking, making me aware of blind spots and potential biases and ensuring that I communicated my position in a clear and understandable manner to others.

With multiple cases there is a danger of voices becoming lost or merged. The case analysis meetings guarded against this. I had found that there were two cases in particular which I merged. There were characteristics of these cases which were similar so this 'merging' was of interest. However, it was equally important that I maintained an understanding of each individual case and the meetings assisted me in this.

**A Coherent Overview**

Whilst separating out different strands of analysis was necessary, particularly in preventing overload and creating a concrete baseline from which to explore the data in greater depth, there was a constant need to maintain a coherent overview of the different processes, both within and across cases. There were a number of methods I utilised to achieve this.

*Time Frame Analysis*

Whilst the PBE sessions follow the chronological process of a play therapy intervention children's play and comments did not always follow this chorological sequence. I wanted to be able to obtain an overall sense of each child's experience of play therapy from the beginning process right through to the evaluation process. This included the child's expressed views in the observed evaluation session the reasons for referral (detailed in therapist questionnaires) and the therapists' views of the therapy intervention. Therefore I utilised an 'event listing' or 'time frame' adapted from Miles and Huberman's (1994), to document salient points regarding the child's experience of the play therapy intervention over time. These began with the child's views only, as I remained blind to the therapists' completed questionnaires until the transcription, thematic analysis and initial write-up of the children's views was complete. Data from the therapists' questionnaires was later added. These time frame analyses were recorded on a 'FoldedSheet' visual mapping document (Choules and Jackson 2004 www.chaletalpine.wordpress.com). These are effectively blank ordnance survey style maps which enable the researcher to view one pane at a time, several panes or the whole 'map'. This device was an attractive way to display the data enabling me to focus on one case (displayed on one pane) or the entire dataset (displayed on the map, see appendix 21).

*Case Summaries*

Producing a one page summary of the information drawn from all the different analyses for each case was a further strategy for maintaining an overview and tool in writing up. These detailed key factual information about the case, significant themes arising from the thematic analysis and a brief summary of the engagement. Information from the therapists' questionnaires was added later in a different font colour (see appendix 22 for an exemplar).

*Development of Additional Questionnaires*

Analysing the therapists' questionnaires provided a large amount of contextual data and helped to identify the most likely interpretations of the data I had been exploring in my analysis. However, there were also a number of unanswered questions which I felt the therapists were likely to have helpful information on. It was also clear that consulting the therapists on sections of my analysis, particularly sections which were complex was likely to be fruitful. Furthermore I wanted to make use of these therapists' expertise. They had been using PBEs with a number of children and were likely to have further ideas about their development and use, particularly areas of improvement. Therefore I devised two additional e-mail questionnaires for therapists to complete. One was a generic follow up questionnaire and the second was an individualised questionnaire specific to their cases included in the research (see appendix 7a & b).

**Analysis of the Process**

To further analyse the process issues evident in the PBE session the process codes assigned during the thematic analysis were reviewed and quantified. As Miles and Huberman (1994:254) assert "doing qualitative analysis of all data with the aid of numbers is a good way of testing for possible bias, and seeing how robust our insights are". During this phase I was less interested in finding a way to present *what* was said/communicated and more interested in the relationship between *how* the therapist approached the task and *how* the child responded. Therefore analysing the frequency of therapist process codes, for instance how many times they made an accepting statement or a curtailing statement, and the child's process codes; for instance how many times they disengaged from the task, was likely to be helpful.

Such an approach has been criticised for de-contextualising the information (Flick, 2007). However, this quantitative analysis was intended to support and complement the qualitative analyses undertaken. The context of each quotation had been considered during the content analysis and the findings are presented alongside my qualitative interpretations. Utilising Atlas-ti's query tool and grouping together codes into inhibitive factors and facilitative factors proved fruitful. Making use of quantitative computations with regard to these process codes was illuminating. Quotation code frequency tables were used to display the number of times a particular code occurred. Groupings of codes were broken down into smaller tables and displayed on a 'folded writing sheet' (Choules and Jackson 2004) enabling viewing of therapists codes alongside child codes or facilitative codes against inhibitive codes (see appendix 23 for an exemplar).

The therapist inhibitive responses were subtracted from the facilitative responses (see appendix 24 for a list of codes grouped into inhibitive and facilitative) to provide an 'overall score' for each evaluation. In recognition of the fact that some quotes maybe coded more than once under separate codes and to avoid suggesting that each therapist could be given a precise score for their overall skill level each dyad was grouped into five different levels by placing all the dyads within a 40 point range together. For example a therapist who made 100 facilitative responses and 10 inhibitive responses would have an overall 'score' of 90 therefore they would be placed in the high level (80-120 range). Two therapists made more inhibitive responses than facilitative responses therefore they received a negative overall 'score' and were placed in the low level (-40-0 range). The findings for all dyads are presented in Table ii appendix 25. Due to space restrictions and the exploratory nature of this part of the analysis, discussion of this analysis is confined to comments regarding the therapists' overall skill level in the four dyads presented in chapter eight.

*Engagement Analysis*

An area which I found was relative weak, when using CAQDAS, was pattern searching (Gibbs, 2007). My data was complex and the interactions between therapists' comments and children's responses and vice versa needed more careful attention than the capabilities of proximity and co-occurrence searches available in Atlas-ti. Therefore further in-depth

analysis was indicated to analyse the therapist-child interactions. First, I colour coded each transcript in terms of the child's engagement with the therapist (high, mid or low) and the task (high, mid, or low). The definitions for each of the engagement codes are detailed in appendix 26a. The colour coding of the transcripts could be viewed in Atlas-ti enabling cross-referencing of the thematic coding and the engagement process. I printed out the colour coded transcripts in a micro format which allowed me to paste the transcript onto a strip of paper (approx. 1 metre, see appendix 26b) and assess changes and patterns in the engagement process over time. Whilst this provided a relatively basic overview of the child's engagement with the therapists and task it proved to be an important initial step and enabled me to identify cases to explore in greater depth. I arranged these strips in various groupings to assess similarities and differences. Reviewing these along with other documents (including: initial reflection sheet, process code frequency tables, time frame analysis and the case summaries) resulted in four dyads being chosen for micro-analysis. These reflected 'extreme cases' and those which illuminated 'surprising' or 'negative evidence'. Further analysis of such cases is advocated by Miles and Huberman, (1994) to increase analysis validity.

*Micro-Analysis of Four Dyads*

Micro-analysis of four sections of the video-taped interaction for each of the four dyads was undertaken (the first 5 minutes, two 2 minute mid sections and the last 5 minutes). The transcripts for these segments were printed and reviewed. This allowed me access to the colour-coded engagement analysis and all the thematic codes assigned to that section of the transcript (displayed in the margin: see appendix 27 for a sample). This allowed pattern searching for small manageable segments of data. After review of these documents the video segment corresponding to each section of transcript was reviewed, once at full speed and then in slow motion. Specific attention to the attunement between the therapist and child was given and video-stills or 'frame grabs' were taken at salient points.

I drew on the analytic techniques utilised in an ethnomethodological study by Heath and Hindmarsh (2002). They analysed doctor/patient interactions using an expanded form of conversation analysis attending to body language and gestures. A second major influence for this analysis was the work on infant-carer and adult-adult interactions in psychotherapy

contexts reviewed in chapter four, particularly McCluskey's (2005) study analysing video-taped interactions between adult therapist volunteers in quasi-experimental conditions, Koren-Karie et. al.'s (2003) work on co-construction of narratives between seven year old children and their mothers and applying Heard and Lake's (1997) attachment dynamic to small segments of tape. The process of this analysis, findings and discussion are discussed further in chapter eight.

**Visual Representations**

Whilst further detail regarding the analysis processes will be provided in context for the reader it is worthy of note here that advances in the field of visual analysis were drawn upon and applied to all three strands of analysis. The use of visual representations in qualitative research is increasing[74]. Goodwin (2001:179) outlines four significant areas where visual phenomena have received particular interest in qualitative analysis, two of which were of particular interest in this study:

1. The body as a visible locus for displays of intentional orientation through both gaze and posture.
2. The body as a locus for a variety of different kinds of gesture, from iconic elaboration on what is being said in the stream of speech, to pointing, to the hand as an agent engaged with the world around it.

Given my interest in exploring the non-verbal communication of the participants representing the data in formats other than text was desirable. This would allow the reader greater access and enhance the reliability of my analysis (Silverman, 2006). As Goodwin (2001: 161) argues the complexity of the phenomena, of human interaction, necessitates multiple methods to represent the work and render relevant distinctions. As noted in chapter four, researchers have previously used video stills in conjunction with quotes in the presentation of their work to further illustrate their analysis (e.g. McCluskey, 2005; Goodwin, 2001). However, there are ethical considerations of using such material.

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[74] The first international visual methods conference was held in September 2009 which was the result of a three year project called 'Building Capacity in Visual Methods' funded by the ESRC (Economic and Social Research Council) under its 'Researcher Development Initiative' (Prosser, 2009).

McCluskey's (2005) study involved filming therapist volunteers in a quasi-experimental setting. Whilst there were ethical considerations in using identifying stills the experimental nature of the set-up and use of adult volunteers significantly reduced these concerns. Other researchers have used line drawings to replicate scenes (e.g. Iedema, 2001 in television documentary analysis). However, I did not think this would provide sufficient detail to convey the non-verbal communication evident in the interaction.

Therefore exploration of new 3-D modelling software (Poser 7: Weinberg, 2008) was undertaken. Poser 7 allowed me to create virtual models which I could position in the appropriate 'pose' to match my visual stills. Sophisticated advances in modelling enabled me to make minute changes to the models facial expressions[75], direction of eye gaze, body positioning etc. to re-create a close enough fit to the real visual still without compromising participant anonymity. The backdrop for the figures were re-created in a simplified posterised form from video-stills of the real environment the evaluations took place. Identifying features of the rooms were changed in Photoshop CS4. Creation of these scenes is time-consuming therefore their use is sparing throughout the thesis. However, a few scenes where non-verbal information was central in the analysis are replicated in chapter seven on children's views. There main use is seen in chapter eight. Here I have included several representations which help to convey the cross modal attunement I refer to in my analysis of the therapist and child participants interaction.

Table 7 below provides an overview of the data analysis methods employed in this study.

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[75] Pre-designed models can be loaded and several parameters, for instance ethnicity, can be adjusted to create a unique model. Clothing and hairstyles can be adapted. This enabled me to create models which matched the child or therapists ethnicity without replicating their unique identifiable facial features, hairstyles or style of clothing.

Table 7: Overview of Data Analysis Methods

| Analysis Method | Description |
|---|---|
| General Analysis Stage | |
| Initial Reflection Sheet | Watching video noting down reactions |
| Verbal transcription | Second, third and fourth viewing of each tape to record the verbal and sub-verbal content |

| Verbal transcription | Second, third and fourth viewing of each tape to record the verbal and sub-verbal content |
|---|---|
| Non-verbal transcription | Fifth and sixth viewing of each tape in slow motion to record non-verbal data including body language, eye gaze, and performance directions |
| Thematic Coding | Coding of children's views; in Atlas-ti |
| Subjective analysis | Listed children from low – high number of views |
| Quantification of children's views | Output report from Atlas-ti listed children from low-high number of times a children's views code was coded |
| Data Displays | Included Matrix of the range of feelings children expressed and network displays of how the thematic codes interlinked |
| Case Analysis Meetings | Structured meetings with 'critical friend' to discuss alternative explanations and hypotheses on selected cases |
| Time Frame Analysis | Chronological diagram of child's experience of play therapy from referral through to evaluation. Inc. child's views. Therapist's views, information about the child & intervention was added later. |
| Case Summaries | Summary including key factual information; themes arising; brief summary of the engagement. Therapists' views on these areas were later added. |
| Analysis of the Process | |
| Thematic Coding | Coding of children's process; therapists' process in Atlas-ti |
| Quantification of therapists' process | Grouping of facilitative and inhibitive factor codes provided overall skill level – grouped into five groups. |
| Engagement Analysis | Colour coding each transcript in terms of child's engagement with therapist and child's engagement with the task. |
| Review of analysis | Review of engagement analysis; intial reflection sheet; process code frequency tables; time frame analysis and case summaries enabled identification of four dyads for further analysis. |
| Micro-analysis of four dyads | Sections of transcript including engagement analysis and process codes printed out for 4 sections of tape ($1^{st}$ 5 min; two 2 min mid sections & last 5 mins) |
| Creation of video stills | Video reviewed for each of these sections once at full speed then slow motion. Video stills of attuned and misattuned moments were taken. |
| Application of attachment dynamic | Heard and Lake's (1997) attachment dynamic model was applied to the interaction. |

**Consultation**

Before concluding this chapter it seems important to summarise the consultation processes, with research participants and concerned communities, which have taken place throughout the lifetime of this project. It has been argued, in the research methods literature, that participants themselves will identify their own unique interpretation of the data (Holstein and Gubrium, 1995) Miles and Huberman (1994:275) assert that "one of the most logical sources of corroboration is the people you have talked with and watched." Therapist participants were consulted regarding the design of the study, how to gain consent, and making interpretations of the data during the analysis stage[76]. They were asked to provide their own initial interpretations of the evaluation session in the post-evaluation questionnaire and were consulted again during the data analysis phase via two e-mail questionnaires asking for their further interpretation of the data and my analysis, this enabled me to achieve a good level of 'communicative validation' (see Flick, 2007)[77]. At the analysis stage my description and exploration of other interpretations of the data was very detailed. The process of checking with therapist participants enabled me to reduce the data with more confidence in the validity of the interpretations put forward.

As stated above, consultation with children began at the initial stages of developing the techniques in the pilot study. Children were also consulted about the information leaflets and assent forms and the design of the final report. Hogan (1997) proposes a model of research where the child is a research partner. This is gaining increasing attention from researchers and practitioners. Whilst it was not practically possible to *fully* involve the children in this study as 'research partners' the techniques themselves arguably met the children as partners rather than subjects. As James asserts: "Talking with children about the meanings they themselves attribute to their paintings or asking them to write a story…allows children to engage more productively with our research questions using the

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[76] As stated above, members consulted included my PhD supervisor, who is a practising play therapist, and two academic staff members on my thesis advisory panel, play therapists at training events (both those who participated and those who declined participation), other professionals within a CAMHs team were consulted about the methods used, children and young people in the pilot study and those in my own clinical practice along with a convenience sample of children drawn from a non-clinical population.
[77] Particularly as I received a 100% response rate

talents which they, as children, possess" (James, 1995, cited in Morrow and Richards, 1996:100).

## **Conclusion**

This chapter has detailed the development of a qualitative research design developed to overcome several methodological dilemmas. The strengths and weaknesses of the design have been reviewed and relevant literature on research methods and ethical issues has been presented. In the next section of this thesis I present and discuss the findings of this main study.

**PART THREE:**

**FINDINGS**

# CHAPTER SEVEN
## CHILDREN'S VIEWS OF NON-DIRECTIVE PLAY THERAPY
## EXPRESSED USING PLAY-BASED TECHNIQUES

## Introduction

In this chapter I outline the children's views of play therapy, as expressed in PBE's. I follow the process of play therapy detailing the children's views of beginning play therapy, the middle phase and the end of the play therapy process. I record views from all of the children in the study in brief[78], except Bradley. The process of Bradley's evaluation session suggested that the few views he expressed were significantly affected by the process. Therefore his evaluation session is discussed in depth in the following two chapters on process issues. There is a slight emphasis on two children in particular: Herbert (8.11yrs) and Eddie (9.3yrs). This is due to the high number of detailed views they shared[79] and the breadth of issues they covered. Most, although not all, of the detailed verbatim quotes are drawn from their transcripts. It is hoped that this will also enable the reader to track the process of the entire evaluation session for these two children, the case summaries of both of these children are included as exemplars in appendix 22a &b.

As previously described, the interview schedules followed in the evaluation sessions explore the play therapy intervention in chronological order. However, there were times when children referred to issues related to the first stages of play therapy at the end of the evaluation session and vice versa. I have chosen to present my analysis of the findings following the description of each section of the play therapy process. Presenting the data and analysis in this format allows the reader to negotiate the large amount of data and detail presented more easily. Throughout the presentation of the children's views I interweave the therapists' views gained from the questionnaires administered. This provides the reader with contextual information and also highlights occasions when therapists' views corroborate or are in contrast to the children's views[80].

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[78] Whilst full quotes are provided for some of the examples given it has not been possible to provide full details on all the views expressed by the children due to word count constraints.

[79] They were both in the group of four children who shared the highest number of views, based on the number of quotes coded as an expression of the child's view, as detailed in chapter six.

[80] I have not sought corroboration on every view expressed by the children, where there is a known discrepancy or significant corroboration I detail this, however issues of space do not allow full elaboration.

Throughout this chapter I refer to the child's 'communications' when making general reference to the views they expressed via verbal comment, non-verbal communication or through play demonstration. Line numbers of the verbatim transcripts along with reminders of the transcription conventions are detailed in the footnotes. Whilst consideration of deleting the transcription conventions was given, to increase the ease of reading I have chosen to include these to allow the interested reader access to the intonations and sub-verbal information. The non-verbal communication codes have been transcribed in full and are presented in parenthesis in grey font for ease of reading. The first time I refer to a child in the study their age is detailed in brackets. The reader is referred back to Table 3 in chapter six (pg 130) for further reference. When the non-verbal content was particularly significant I include visual illustrations to enable the reader greater access to the child's expressed view. These illustrations are computer generated reconstructions of video still images[81].

In the first section: 'The Beginning', I present children's communications about the initial stages of play therapy. I consider their views on the reason they were referred to play therapy and their first impressions. Their follows a discussion of these views: relating the findings to current literature. I have chosen this format due to the volume of data presented in order to help the reader think about this data in context, rather than waiting until the next chapter. In the next section: 'The Middle' I describe the play therapy environment and atmosphere children and young people reportedly experience. I dedicate a large section to the expressed views on the role of play therapists before turning to the role of parents and extended family. Again a discussion is presented before proceeding to the final part of the play therapy process. I present children's communications about the outcomes of play therapy and the progress, or lack of progress, they feel they made. I detail children's recommendations for changes to the play therapy process before concluding with a discussion relating the findings to the literature and highlighting the implications of the children's expressed views.

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[81] As described in chapter six the visual images were re-constructed by the author in the 3-D computer package 'Poser7' and 'Photoshop CS4'.

## Play Therapy: The Beginning

There were forty-five references made by the nineteen children presented in this analysis regarding 'beginnings' in play therapy. First I consider why children were referred to play therapy, from their perspective. I then turn to their first impressions of play therapy. Themes associated with home visits[82] undertaken by play therapists and the first play therapy session being a positive experience included: being given information about what to expect, having support from family and knowing that children can choose what to do in play therapy. Difficult experiences or feelings in the initial stages were linked to play therapy being something unfamiliar. However, there was one child who conveyed excitement regarding the 'unknown'. A process of familiarisation, moving from the 'unknown' to the 'known' was described by eight children. Therapists creating a feeling of permissiveness and a sense of security were highlighted by the children as important factors in creating an overall positive initial engagement with children.

### Reason for Referral

Only a few therapists asked children *why* they went to play therapy[83]. Therefore data regarding the child's views of why they were referred is limited. However, there were comments and play demonstrations from six children, which explicitly addressed or alluded to the reasons children think they or other children are referred to play therapy. Herbert's views are detailed in full and the five other participants are all briefly presented here.

Herbert, named anger, along with worry, due to loss and separation issues, as the reason children might go for play therapy:

> **Herbert:** …  if::: you're:::↓ (.) {looks downward}  dad→ or→ your→ mum split up::↓ and the:::n you got↑ dead↓ an↑gry: for stuff {leans back in seat rest head back looks upward} er::: (.) it ca::n (.) it can worry y- it can you angry or

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[82] It is important to note that whilst there is an explicit story regarding the home visit in the miniature playroom this is not explicitly cued for in the Expert Show. It is unknown how many children actually received home visits by their therapists.

[83] This is despite there being a direct question in the Expert Show interview schedule during the 'sofa area' section. Eight children were not invited to join the therapist on the sofa area, thus this whole section was not covered for these children. There is no direct question relating to reasons for referral in the miniature playroom schedule.

worry you[84]

Herbert was explicit in linking his anger and worry to parental separation and subsequent referral to play therapy. He later described difficulties between him and his mum. Similar to the above quote, this was named as a separation. It is possible that he meant the separation between his parents, particularly because he used the word 'they' as opposed to 'we' when referring to this separation. However, it is also possible he was referring to difficulties in the relationship he had directly with his mum:

> **Herbert:** Well::: {puts one hand behind head leans back in seat} me→ and→me→mum::: actually they split up:: and (.) {taps side of face with hand, arm wrapped around back of head} er::: {looks downward} (.) {eyebrows raised}I mean I→ got→a→bit→ an↑gry:: act↑ually::: (.) so::: (.) then me mum didn't have:: (.) me→ mum→ had enough {releases arm from behind head sits forward looks at camera turns body to face Polly rests elbow on back of chair rests head in hand} so she wanted me to be a bit ca:::lmer:: so:::
>
> **Polly (therapist):** Right::
>
> **Herbert:** yer:: so {takes arm away from head} then {taps cushion with hand eye contact::: eyebrows raised} she took me to these special play sessions::[85]

Herbert names his mum's exasperation with his angry behaviour as the reason he went to play therapy. However, earlier in the evaluation Herbert stated that *children* have to cope with 'all sorts of stuff'. He said play therapists should be nice because the children who attend play therapy are:

> **Herbert:**…*chil*dren {looks to right of room slightly upward} who→ aren't→ nice probably {looks downward toward Polly} who are getting all sorts of

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[84] (653:654)
::: = elongated speech
→ = fast paced speech in comparison to usual pace
↑ = upward intonation
↓ = downward intonation
(.) = pause
[85] (908:915)

*stuff*[86]

Thus Herbert appeared to highlight two-way relationship issues as the reasons for referral, rather than the issues being purely located within him, the child. Herbert's stated views were corroborated upon reading the therapist's views. She reported in the pre-evaluation questionnaire that the primary reasons for referral were: loss of father through separation; anger and anxiety. Interestingly, in response to what the therapist felt had changed for the child she referred to Herbert having been able to 'share some worries that she (mum) might leave him like dad; Herbert even drew up a contract on the computer for mum to sign'. The therapist elaborated on the location of Herbert's anger: within the mother-child relationship. A number of Herbert's comments about play therapy centred on his mother (see section below on 'the role of parents').

Having detailed Herbert's views I now turn to briefly describe the views expressed by other children in the study related to the reason they were referred: Billy (10.9yrs) was not explicitly asked why he went to play therapy. However, he asked one of the child callers what their 'problem' was. He went on to say that he used to have a problem with anger when he was seeing his dad. The fact that this statement was in the past tense pointed to there being loss and separation issues also. The therapist's pre-evaluation questionnaire stated that domestic violence and subsequent separation from his father were issues for Billy. Anxiety rather than anger was highlighted as a presenting problem. However, in the post-evaluation questionnaire the therapist highlighted that Billy had explored the anger he felt toward his father in his therapy sessions.

Sarah (11.6yrs) named anger, specifically shouting and smashing things up, as a problem she had before coming to play therapy. She did not provide any specific information about why she was angry. However, when she provided advice to a child caller about releasing anger in play therapy she suggested imagining the 'man you're angry at'. This raised the possibility that Sarah's anger was directed at a particular male figure, therapist information revealed Sarah had witnessed domestic violence.

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[86] (241:242)

In response to being asked if she remembered anything special or important about her play therapy times, Cathy (9.1yrs) explicitly identified her worries, particularly her fear of needles. For Leanne (9yrs), bullying or abuse from a peer was suggested in her account as a reason children would go to a play therapist. Leanne did not relate her statement to herself directly, but appeared uncomfortable based on her non-verbal communication, as she shared that something might happen to you: like a boy or girl doing something bad to you. The therapists' follow-up information revealed that Leanne had been sexually abused by a male adult *and* an older teenage boy.

Martin (11.1yrs) initially presented a positive view of his childhood. However he was later able to acknowledge some difficulties; specifically his granddad dying. It may be that this was the most significant emotional issue for Martin. However, Martin also alluded to other difficulties in his 'childhood', namely his expressed fear and underlying anger at social workers taking children into care. He sent out a caring message toward children who are 'in danger' who might be watching the show and a strong message to parents who have 'kids who are in danger' to 'treat them with respect'[87]. These references give us further indications for the reasons Martin may have been referred to play therapy: anger, loss and separation issues, and possibly abuse or neglect from his parents, were highlighted from Martin's own account. These issues were corroborated in the therapist's pre- and post-evaluation questionnaires who reported that Martin had experienced emotional abuse, neglect and witnessed domestic violence: Anger was also highlighted as a presenting problem.

Lastly, Jack (6.1yrs) simply stated that he did not know why he had been to play therapy. There were no other comments or play demonstrations from this child which pointed to the reason for referral.

This section on reasons for referral will be discussed below. Now I present the findings on children's first impressions of play therapy.

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[87] See section in chapter nine on role reversal for full quote.

**First Impressions: Positive Descriptions**

Six children made direct 'positive only' comments about the first session in the playroom. These children did not share any difficult or negative feelings about the start of play therapy. In the process of analysis, two codes were found to be directly associated with positive experiences of the first session. These were: 'support from family', and 'the importance of choice'. These will be explored below.

Martin interjected a positive comment about play therapy being 'great' during the 'Expert Show' before the therapist had even had chance to pose any questions. Similarly when Judy (therapist) completed the story stem in the 'Miniature Playroom' about the child's first play therapy session, Rob (8yrs) gave a spontaneous and quick response by enacting the child shouting 'Yip↑ee↑::::'[88] Rob proceeded to demonstrate immediate engagement in reciprocal play between the child and therapist figures in the 'Miniature Playroom', reinforcing this message. Rob switched techniques halfway through the evaluation session and gave a similarly positive response during the Expert Show.

Similarly 'L-man' (10.10yrs) described a positive first impression and immediate engagement with the equipment in the therapy room. L-man's description highlighted a high level of engagement in his first session, and an enthusiastic desire to return the following week, Leanne and Jack replied positively when the 'child caller' in the Expert Show asked what the first session would be like, using words such as 'fun', and 'you'll be happy'. However, it should be borne in mind that the 'need to please' both the therapist and the child callers was coded several times for Leanne and Jack. This issue is discussed in full in chapter nine. Marble's play demonstration in the 'Miniature Playroom' was implicitly positive. She enacted the child immediately engaging in play with the sand.

**First Impressions: Difficult Experiences**

One child, Susie (5.6yrs) using the 'Miniature Playroom', described only difficult experiences about the start of the play therapy intervention. Lucy (therapist) began the story

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[88] (955)

  ::: = elongated speech

  ↑ = upward intonation

stem about the first session in the playroom and asked Susie what the little girl thought about being there. Susie's non-verbal communication in the 'here and now' of the evaluation session paralleled her verbal response. She recollected her scared feelings as she picked up and hugged a teddy bear, as if to comfort herself[89].

There was also an element of regression in Susie's communication as she used a younger tone of voice when she named feeling scared. Susie enacted the child figure taking a really long walk to get to the 'Miniature Playroom'.

All the other children who commented on their first impressions of play therapy presented a mixture of difficult and positive experiences.

**First Impressions: Mixed Feelings**
Nine children commented on a mixture of positive and difficult feelings. Hannah and Billy simply described mixed feelings. The other seven children extended their comments about mixed feelings to reflect a process of familiarisation and their feelings becoming more positive over time as they became familiar with the playroom.

Hannah described being frozen in her first session. Her manner and affect whilst she gave this response suggested that the first session was a particularly difficult experience for her. Her non-verbal cues and verbal comments were in synchrony[90]. Billy said that his first session was bad, that he was shocked and hated the first session. It is important to note that Billy was referring to the assessment by the generic service *before* attending play therapy[91]. However, his therapist also noted that 'he was very smiley and tense in his first (play therapy) session, could not relax…seemed to think he had to tell me things…did not really believe me when I said he could choose….He was like this for the first few sessions and gradually relaxed.' Both Hannah and Billy also emphasised the importance of choice in association with positive experiences and feelings regarding the first play therapy session[92].

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[89] See Figure 53 pg. 323 chapter nine for a visual re-construction of this moment.
[90] The process of Hannah's sessions is presented in detail in chapter eight and a visual still of this moment is presented in chapter nine, pg 323, figure 54.
[91] The reader is also directed to the visual still of this moment in chapter nine, pg 322, figure 52 and the discussion regarding this seemingly dramatised communication.
[92] This theme is explored in full in the section entitled During play therapy: The Child's Choice below.

Seven other children described their feelings changing over time as they became at ease with play therapy. Two of these children, Eddie and Lee, described this process occurring during an initial home visit by the therapist.

Eddie enacted the child figure, in the 'Miniature Playroom', as being uncertain about who the therapist was when she arrived for her initial home visit. He appears to enact a conversation between the child figure and the mother figure:

> **Eddie:** {picks up child figure} Mum who's this (.) this is the therapist I was talking about (.)      [what therapist↑
> **Rachel (therapist)**:[{nods head}
> **Eddie:** you haven't talked of no therapist mum (.) I said when we drove home from school (.) oh *that* therapist[93]

This play conveyed a difficult and confusing first impression of play therapy for Eddie, and maybe indicates that he was feeling anxious about the meeting. It also demonstrates children's reliance on their parents for support. By the end of the meeting Eddie stated that the child figure was happy because he had met the therapist. Thus, he seemingly moved from feeling uncertain and confused to a positive feeling of being happy by the end of the initial meeting.

Lee, in the 'Miniature Playroom', played out a story in which the child figure felt 'so scared' and shy and hid behind the sofa during a home visit. Lee enacted the father figure setting  a limit on the little brother, and the child figure being afforded private time with the therapist and parent figures. The therapist figure engaged the child figure by showing him the toys she had brought. The child figure was shown to engage in play with the therapist and parent figures, and became more confident. Lee continued the story by demonstrating

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[93] (333:337)
↑ = upward intonation
 (.) = pause
[ = overlapping speech

that part of the meeting was between the adults only. He enacted the child figure leaving the meeting willingly.

Interestingly, whilst the first play therapy session was anxiety-provoking for some, Lee represented the child figure in the 'Miniature Playroom' responding very positively to the first session. He described not knowing what it would be like with a sense of excitement and expectation. Lee was highly engaged and animated when he commented excitedly that the child figure didn't even know what would happen on the very first time. Arguably the toys his therapist brought to the initial meeting and the engagement with her in the home visit succeeded in preparing Lee for beginning play therapy, enabling him to readily engage.

The remaining five children all described the familiarisation process happening from the first session onwards. Three of these made specific comments about how long this took. Charlie described it as a gradual process and Sarah described it taking a few weeks. Herbert felt it was better by the second session. Herbert appeared surprised at himself that he had felt anxious in his first session. However, he was able to name this anxiety and identify making a connection with his therapist as the source of his felt sense of security:

> **Herbert:** Er:::you'll fee::l y- y-you'll feel scare:::d er (.) for some reason but I
> I felt a bit scared {eyebrows raised} at firs::t=
> **Polly:** =OK=
> **Herbert:** =the→first→play→sessions but→ after (.) my second my second
> play session after I got to know Polly:::↓ I knew {head nod} I knew
> that→everything→was→gonna→be    O::K::↓ so:: {sits upright looks at
> therapist} [94]

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There was also variation in *how* this familiarisation process was described. Three children (Cathy; Sarah and Bob, 13.9yrs) focused on the importance of getting to know and trust the therapist[95]. Cathy particularly emphasised the role of her family supporting her and the clear information she received from her therapist about when her sessions would take place and what to expect. Bob also emphasised engagement with equipment in the room helping the process. Similar to Susie (above) Charlie alluded to the playroom being a long distance from home when he advised a child caller that it would take a long time to get there.

**First Impressions: Neutral or Unclear Expressions**

Two further children made comments or played about the initial home visit and/or first session but their comments were unclear or neutral.

Emma (8.11yrs) had difficulty completing the story stem regarding the first session, she withdrew and became anxious. This may have been a mirroring of her feelings in the first actual play therapy session[96]. Gabriella's (8.9yrs) views were factual or neutral. She spontaneously made comment, during a call in the Expert Show, about the home visit and the preparation her therapist had undertaken. Unlike Lee and Eddie, Gabriella simply stated what happened. She spontaneously commented on being shown photos of the playroom and demonstrated actions of flicking through the pictures. This suggested that this was a significant memory for Gabriella. It demonstrates an alternative to taking a bag of toys to the initial meeting by way of preparing the child.

**Summary of the Children's Views of 'The Beginning Phase of Play Therapy'**

The children's descriptions of the beginning phase of play therapy provide rich detail about this process from a child's perspective. Establishing rapport, a sense of permissiveness and security are highlighted as the important factors in helping children to engage at the beginning of play therapy. Furthermore having support from family and discovering that children are afforded choice in play therapy sessions were experienced as positive factors. West (1996) has written about the first session in play therapy and suggests that in general terms children approach the play room in one of three ways: plunging into activity with the

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[95] This is described in detail below in the section on Play therapists.
[96] Discussed in full in chapter nine under the section 'here and now reality' or 'mirrored reality'?

toys and/or the therapist; feeling uncertain or a little lost; or less frequently feeling overwhelmed. It seems that the children's views in this study mirror West's observations. As detailed above, Rob, Lee and Marble describe quickly becoming immersed in play. Charlie; Cathy; Bob; Herbert and Eddie described feelings of uncertainty and being shy, whilst Hannah seemed to be overwhelmed by the experience to the point of being frozen. Having presented and summarised the children's views of this beginning phase I now provide a discussion of these findings relating them to current literature.

## Discussion and Implications of the Children's Views of 'The Beginning Phase of Play Therapy'

*Reasons for Referral*

Parents, referrers or other professionals involved in the child's care may need to be reminded that children may have their own ideas about how they want to use their time and what aspects of their emotional lives they want/need to explore. As Wilson and Ryan (2005) note, although statutory agencies may refer children due to abuse, this issue in itself is not always the most significant issue from the child's perspective. This assertion appeared to be borne out in Martin's responses regarding the reason for referral to play therapy. Although issues around the abuse he had suffered were referred to in his account, it appeared likely that *for him* the central issue was a sense of loss or bereavement. Similarly with Billy anxiety was recorded as the reason for referral. However, Billy himself commented that anger was a primary reason for coming to play therapy. His therapist recorded that Billy used his time in therapy to explore his anger regarding parental separation. It seems, at least for these two children, they experienced their therapists adhering to Landreth's ninth tenet: "Children will take the therapeutic experience to where they need to be" (1991:50).

*Initial Engagement*

The importance of consistency and structuring the child's intervention, in order for the child to have a sense of what is happening, has long been emphasised in play therapy training and literature (Wilson and Ryan, 2005; Axline, 1989). Cathy's response highlighted her appreciation of being well-informed prior to play therapy starting.

Only four children talked and/or played about the initial meeting or home visit with their therapist. Three of these (Lee, Eddie, and Emma, all detailed above) were prompted by the specific story stem in the 'Miniature Playroom'. Of the children using the 'Expert Show' technique, only Gabriella commented on the home visit. One may expect more comments about the preparation play therapists undertake, to help familiarise children and provide information they need, given that this is emphasised as important in play therapy training. There are a number of possible explanations for this. One is to note that a question regarding this initial visit is not included on the 'Expert Show' interview schedule[97]. This is a limitation which has led to alterations to the schedule.

The story enacted by Lee, regarding the home visit, demonstrates the therapist readily achieving an atmosphere of permissiveness and security which Ryan (2001) argues is a primary task for the therapist at the initial stage. Arguably Lee's initial anxieties were reduced due to the availability of his parents, whom he included in his enacted role play along with the therapist figure. Lee demonstrated the therapist figure having a bag of toys available for the child figure to explore. This appeared to reduce the child figure's levels of anxiety. This enactment seemed to illustrate the relaxed atmosphere that Ryan (2001) advocates. It also highlighted the helpfulness of some play therapists' practice of imparting information about play therapy in non-verbal active ways. The presence of play during family sessions was highlighted as important by children in Stith et. al.'s (1996) study and has been advocated in general for the largely verbal arena of family therapy sessions (see Gil, 1994). Initial meetings are potentially a time in the process of play therapy where verbal, rather than play, communication may take the fore. The data from this study points to the incorporation of play in this very first meeting being important. The reduced anxiety arguably experienced by children seems to enable them to process the information play therapists tell them.

The varying approaches and feelings children described regarding the first session or meeting highlights the need to attend to the child's individualised responses from the very beginning of engagement in therapy. Therapists need to be highly adaptive and responsive to children's reactions to this 'strange situation'. The novelty of the situation and separation

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[97] There is a specific story stem regarding this part of the process in the miniature playroom schedule.

from the child's caregiver arguably recreates an emotionally stressful situation, such as Ainsworth's 'strange situation' (described in chapter four). It is likely that children's attachment behaviours are evoked at these times, the children's descriptions of their feelings and approaches to the first session certainly suggest that this is the case.

As stated above there were two codes found to be directly associated with positive experiences of the beginning phase of therapy were: support from family, and the importance of choice. There is an increasing emphasis in child therapy literature in general, and particularly play therapy literature, on the role of parents and carers in child therapy interventions. The importance of building a good therapeutic alliance with parents is emphasised (e.g. Ryan, et. al. 1995; Hill 2006, Crane, 2001). Carroll's (2002b) study similarly revealed support from carers in the initial stages as a valued factor. The children's views of the role of parents and family members, in this study, are further explored below. The central focus of NDPT allowing the child choice and following their lead was reviewed in chapter two; this theme is also recapitulated below.

Following discussion of this first stage of the play therapy intervention I now turn back to presenting the findings and consider the middle phase of play therapy.

## Play Therapy: The Middle

In this section I record the children's communications about the play therapy environment and atmosphere, beyond the beginning stages of the intervention. Clearly the atmosphere afforded to children in play therapy is created and experienced within the interpersonal relationship between therapist and child, and this is apparent in the exploration of the themes below. And, as this relationship is central to our understanding of the child's experience of play therapy, I dedicate an entire section to the role of the play therapist. After which I comment upon the role of parents and extended family in children's play therapy interventions. I conclude by detailing what children's views were of the progress or review meetings that play therapists hold at intervals during the play therapy intervention.

**The Play Therapy Environment and Atmosphere**

*The Playroom*

Physical aspects of the playroom were mentioned by seven children. This included comments about the colour, size and comfort afforded by the room and furniture. The playroom was described as an 'amazing' or 'fun' place by seven children and a place of safety or happiness by two children. Mess was named as something one child did not like.

Herbert and Marble commented on the seats being 'very comfy' and a place for the 'kid' or play therapist to rest. Herbert mentioned that the room was sometimes cold, but added that his therapist heated it with a special pump. Herbert, Charlie, and Sarah commented on their playrooms being colourful. Lee and L-man commented on the playroom being big. Lee's comment evoked a sense of delight and discovery when he thought back with his therapist to the first time he saw the playroom. Martin said the playroom had chandeliers.

Herbert, Eddie, Charlie, Sarah, Cathy and Rob all named the playroom as a room where you can have fun. Elizabeth (8.7yrs) suggested 'it might be amaz::::ing'.[98] She highlighted creating a safe space in the playroom with the puppet theatre.

Herbert impressed how integral the actual playroom is to play therapy. He told a 'trainee play therapist' who called in for advice that the first thing she should do is get a playroom. Herbert's additional comments demonstrated that the importance of the room goes beyond concrete pragmatics. Similar to Elizabeth he described finding an emotionally safe place in the playroom which enabled him to explore his internal emotional world:

> **Herbert:** {sits back in seat looks ahead}  =We::ll if you have ha↑ppy↑ fee::lings *real::ly*  it's just like (.) er: you: (.)  {sits forward looks downward at desk}  you're just like on top of the worl::d like seeing all other planets and tha::t so→just→imagine *that* yer::↓ so if you're  if you're not hap↑py↑:: just imagine just imagine some:thing:: (.)  which is:: (.)  like the *best* part→ of→the→play:::↓room:: go over there::: and just play with it and  it should make you happy again[99]

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[98] (173).
[99] (342:346)
::: = elongated speech
→ = fast paced speech in comparison to usual pace

Hannah identified something she did not like about the playroom: times the room became messy with all the toys.

*The Toys and Materials*

There were 109 references to toys and/or materials during play therapy made by the children in this study. Often children listed a whole range of toys which one could play with in the playroom. Sometimes children provided rich descriptions or demonstrations about the use of toys and activities they engaged in during play therapy. In this section I provide an overview of the toys and activities children mentioned by presenting this data in tabular form. I proceed by detailing interesting comments and play demonstrations shared in the evaluation sessions.

Table 8 below details the toys and materials grouped together in broad categories. A figure greater than 1 denotes comments about several different toys or activities within the same category[100]. For example Eddie mentioned play dough and chalks in his evaluation session. Therefore the figure 2 is recorded under the category 'art and creative' for Eddie. Some children repeated references to the same toy. However, the reference to that toy or activity is only recorded once in this table. For example Herbert made several references to goo at different points throughout his evaluation session. However this is only recorded once under sensory play.

The table is laid out in two major sections. Columns 2-10 comprise the left hand section which details the data from the female participants. Columns 11-20 comprise the right hand section which details the data from the male participants. Each section presents the participants in age-ascending order. This allows the reader to make comparisons within this small sample across age and gender more easily.

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↑ = upward intonation
↓ = downward intonation
(.) = pause
*italicised text* = Emphasized stretches of talk or non-verbal communication
[100] For a breakdown of categories and the specific toys/materials children referred to see Table ii appendix 28. This table also denotes, in red text, the favourite toy/activity children named.

Table 8: Toys and Materials commented upon in PBEs

| Child | Susie | Emma | Marble | Hannah | Gabriella | Elizabeth | Leanne | Cathy | Sarah | Jack | Lee | Rob | Eddie | Herbert | Charlie | Bradley | Martin | L-man | Bob | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Female | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | | | | | | | | | | | 9 |
| Male | | | | | | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 10 |
| 4-7 yrs | 1 | | | | | | | | | 1 | 1 | 1 | 1 | 1 | | | | | | 6 |
| 8-11 yrs | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | | | | | | | 1 | 1 | 1 | | | 10 |
| 12+yrs | | | | | | | | | 1 | | | | | | | | | 1 | 1 | 3 |
| Art & creative | 0 | 3 | 2 | 3 | 1 | 1 | 1 | 5 | 4 | 1 | 2 | 3 | 2 | 1 | 3 | 2 | 1 | 1 | 1 | 37 |
| Music | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 2 |
| Sensory | 0 | 0 | 2 | 1 | 2 | 0 | 0 | 1 | 1 | 0 | 1 | 2 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 13 |
| Symbolic/Nurture | 1 | 3 | 1 | 2 | 4 | 1 | 1 | 4 | 2 | 1 | 1 | 0 | 1 | 2 | 0 | 2 | 1 | 2 | 0 | 29 |
| Physical/games | 0 | 2 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 2 | 1 | 1 | 0 | 2 | 2 | 13 |
| Aggressive toys | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 4 | 1 | 0 | 10 |

As can be seen from Table 8 all categories of toys were mentioned at least once. Art and craft materials were mentioned most frequently. Every child, except Susie (5.6yrs), referred to art and craft materials in play therapy. Susie referred to only one toy which was directly linked to the play therapy intervention. However, she was one of the children who used the 'Miniature Playroom' only. She appeared to use some toys in the stories but it was unclear which ones[101]. Susie chose a power ranger figure to be the play therapist, in the actual PBE session. However, these toys were not explicitly linked to toys she played with in her play therapy sessions. Only two children, Herbert and Martin, mentioned musical instruments and only two children, Gabriella and Sarah, mentioned toys related to role play (costumes and phones).

*Gender and Age-Appropriate Toys*

There was a relatively even spread of toys and activities mentioned by children across gender and age categories. However, it is worthy of note that male participants mentioned games (physical and board games) more frequently than the females. Interestingly three children (Marble, Hannah, and Charlie) mentioned the availability of gender appropriate toys. Two boys (Herbert and Lee) expressed their dislike of 'girly' toys such as dolls and 'princess stuff'.

Hannah (8.5yrs) also emphasised the importance of toys and activities which were appropriate for all ages. Hannah initiated an additional call in the 'Expert Show' and made it clear that she wanted her therapist to pretend to be a sixteen year old ringing in to ask about the things available to her. Hannah proceeded to pretend that another child called to ask "why does everyone always play with the water"[102]. In her reply Hannah used a much younger regressed tone of voice and told the caller that most people like it. Similarly, Sarah, (11.6yrs), mentioned the permissibility of playing in the sandpit. Hannah and Sarah's responses indicated that this freedom to choose younger or older things was afforded to them and seemed important to them.

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[101] A significant weakness of this analysis is the poor camerawork with children using the miniature playroom technique. It was not always possible to see which toys the child was playing with. Therefore unless the child or therapist verbally named the toy it was not possible to identify which toys the child figure was shown to be playing with.
[102] (511).

*Personal Significance of 'Toys'*

'Toys' seemed to be personally significant to Billy who put a lot of emphasis on there being 'really nice stuff'[103] and introduced the idea of a child caller winning a '*luxury::: toy set*'[104]. There seemed to be something about the material aspect of the toys which was significant to Billy. Interestingly Billy's therapist recorded in the pre-evaluation questionnaire that Billy's father (who had left the family home) could be inappropriately generous with gifts. For instance, he bought the children animals which the children weren't able to keep. In the post-evaluation questionnaire she recorded that Billy himself was optimistic and generous in nature and, similar to the pretend 'prize' given to 'the audience' in the evaluation session, at the end of the intervention he had brought a real gift for his therapist and the staff.

*Expression of Strong Emotions Through Toys*

For four children discussion and exploration of the toys and activities in the playroom enabled them to share emotionally important memories of their times in play therapy. Herbert described the cathartic benefits of painting to release anger. He also described the soothing benefits of musical instruments and card games at the end of sessions. Martin was verbally tentative about sharing the angry play of hitting a teddy in his therapy session. Martin's therapist addressed his concern and made it explicit that it was permissible to play in this way and tell others about it. Martin appeared to be comfortable enough within his relationship with his therapist, during the evaluation session, to explore this. Sarah described the use of imagery to help her express her angry feelings in the playroom and was very clear to the caller that this was permissible.

Cathy's Expert Show evaluation session took place in the same playroom as the play therapy intervention. She initiated a tour of the room and the toys and equipment in it. Interwoven in Cathy's concrete, rather matter of fact, naming of most of the toys and equipment in the playroom were emotionally important memories: the sand tray to create stories, the punching bag to release anger and the whiteboard to share a message with her therapist through non-verbal means. Cathy's non-verbal communications highlighted these three activities as most important. She was more animated for example smiling when demonstrating the play with sand and screwing up her face when talking about the whiteboard. She also spent more time talking about them and in more

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[103] (57)
[104] (373)

detail. She also gave demonstrations with these three activities. Cathy walked over to the whiteboard suddenly and purposefully. However, she appeared a little uncertain about telling the audience about writing on the whiteboard. It is highly possible that she used the whiteboard to write things she felt embarrassed or bad about. Writing it on the whiteboard arguably afforded her more distance in her sessions with her therapist. And a way to get rid of what was written completely

*Food*

Three children highlighted that in addition to toys there would be food available in the playroom. Marble simply stated that there would be food. Herbert and Hannah commented on the therapeutic benefits of having food and drink during play therapy. Hannah volunteered that children would get a drink and biscuit if they were feeling sad, whilst Herbert highlighted the calming benefits of having a drink if a child was angry.

Interestingly the theme of food was also prevalent within the evaluation sessions themselves. Herbert drank frequently during his evaluation session and appeared to use drinking as a way of regulating himself[105]. It was evident that this was the signal he used to have a rest and slow down from his usual fast paced verbal delivery. Thus his expressed views of the function food and drink corroborated the observations of his behaviour within the 'Expert Show' itself.

*Mess*

Six children made comments which were coded under the theme of mess. Both Herbert and Rob highlighted that it is the play therapist's job to tidy up the playroom before the child arrives. Rob enacted this with the 'Miniature Playroom'. Whilst the child figure was shown to be waiting in the waiting room (enacted by the therapist), Rob interjected that the therapist (figure) was in the playroom 'tidying up'.

Mess seemed to be a significant personal issue for Eddie. He portrayed the child figure in the 'Miniature Playroom' as putting constraints on himself on the mess he created:

> **Eddie:** {puts child figure back in playroom wiggles child figure} Time to clear up now {inaudible}

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[105] This observation was also made of Gabriella and Bradley. However, they did not verbally express a view or enact through play that food and drink was important to them in their actual therapy sessions.

**Rachel:** Oh right (0.2) it's the end of time and the little boy

tidies up [yeah

**Eddie:**      [{nods head rolls up plasticine places back in playroom}[106]

Eddie played out a similar scene at the end of another session. However, later his comments suggest that his therapist put constraints on the mess he was making due to being concerned about what his mum's reaction might be. It is highly possible that this child's need to be tidy, portrayed early on in the session, was linked to his worries about his mum's expectations. It is possible that his play therapist limited the mess he made, but his comments could also reflect his own personal fears about his mother's response rather than the therapist putting constraints on this herself.

Lee enacted play demonstrations in the 'Miniature Playroom' where the child figure made a mess with the toys. He was clear that making a mess was permitted by the therapist figure. Lee proceeded by playing out two further play scenes where the toy animals themselves tidy 'the mess' with the child figure, but then enacted the toys going back in their usual places and exclaimed, as the child figure, that he didn't realise that would happen. This may highlight a dislike of NDPT practice, whereby toys are returned to the same place at the beginning of each session.  However, it may signify disappointment at having to finish the play therapy session and leave the fantasy world he had been playing within. The play involved diggers and toy animals coming to life.

As noted above Hannah shared a dislike of the playroom becoming messy. Bob was explicit about the significance and the meaning making a mess in the therapy room had for him. He shared that if you had a bad day, because you were feeling angry,  you were likely to go into the playroom and mess it all up. His therapist recorded in the pre-evaluation questionnaire that making a mess was a main theme of Bob's session and was seen by the therapist as Bob's 'protest'.

*The Importance of Choice*

Over half of the children (eleven) described being able to choose in their sessions.

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[106] (273:278)

(0.2) = A pause timed in tenths of a second

[ =Overlapping utterances or non-verbal codes are marked by parallel square brackets

Children made general comments about choice and comments specifically about the therapist following the child's lead and instruction. Finally there were comments about children having choice over the process and decisions made in play therapy interventions.

Children often listed a wide range of toys and activities which were available to choose from. They commented that children are able to *do* anything they like in play therapy. Four children described asking permission to do things in the playroom all enacted a permissive response being given by the therapist[107]. There was a sense for three of these children that this permissiveness was surprising or unexpected. Sarah advised child callers not to be afraid to ask the therapist. Emma played out the child figure's uncertainty and the therapist figure's warm, affirmative, permissive responses in the 'Miniature Playroom'. Interestingly in the two play sequences which followed Emma played out the child figure confidently exercising her right to choose without the need to request permission. She enacted the child figure telling the therapist figure that she was going to play in the sand and then suggesting that they both move on to play with the puppet theatre. Later Emma advised the 'trainee play therapist' during the call-in phase of the Expert Show to be explicit about the permissiveness of the playroom and provide encouragement to children, to help them overcome their anxiety.

Interestingly Emma presented in a timid and nervous manner but had sudden bursts of confidence throughout the process of the evaluation session. This seemed to mirror her experience of being uncertain, needing permission and encouragement to fully express herself. On consultation with Judy, Emma's therapist, she stated that Emma 'did manage to find what she needed to play with within my usual permissions to choose… I'm glad she…was able to choose for herself'.

Three children commented specifically on play therapists following the child's lead. (Elizabeth; Billy; and L-man). This is covered in the section below on Play Therapists…follow the child's lead.

Four children commented on the child being afforded choice regarding the *process of play therapy*. One of these, Elizabeth, commented on the therapist allowing choice

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[107] This is discussed further below in the section entitled 'Play Therapists…are permissive'.

about the end of each session. Another, Gabriella, commented on the child being able to decide whether or not her mum was invited into the room. It appeared that this child did not want her mum to be present when she was feeling angry and she was afforded autonomy by her play therapist regarding this issue. This is discussed in more detail in the section below on the role of carers in play therapy. The other two children, Sarah and L-man, suggested that the therapist would allow the child choice about when the therapy ended. They suggested that if a child wanted more sessions they could ask for them. L-man particularly made it clear that this would be taken into consideration and it would be likely that this would be granted.

*Limits on Choice*

Whilst there was an emphasis on the choice afforded to children in the playroom, there was also acknowledgement that the child's choice was not always granted unconditionally. Eleven children acknowledged that there were sometimes limitations to the choice permitted. For one child, Marble, this was about negotiating whether or not to go to a party rather than the play therapy session. Marble enacted a disagreement between a child caller and the therapist. The therapist was instructed by Marble to tell the child caller that she had to come to play therapy. However, the child's choice won out. Marble's therapist recorded in the post-evaluation questionnaire that "the 'party dilemma' was often a real dilemma faced by 'Marble'… she had ambivalence about this but often chose the party/other activity". Thus it seems likely that the conflict was located within the child.

The other ten children focused on the limits set on their behaviour within the play therapy room. These limits are discussed in full in the section below entitled 'play therapists…set limits'.

*End of Each Play Therapy Session*

Four children made specific references to the end of each play therapy session. Eddie enacted the therapist figure giving the child figure time warnings at the end of each play therapy session and also identified it as a time to tidy up. Herbert identified the end of play therapy sessions as a time to 'chill out' by playing musical instruments or card games. During a story completion in the 'Miniature Playroom' Emma simply stated that the child figure goes home at the end of the session. However, Emma's sad low tone of voice pointed to the disappointment she felt when each play therapy session ended. Lee

enacted several play session endings in the 'Miniature Playroom'. In the first he demonstrated the therapist telling him it's time to go and the child 'grabbing' his paintings. Lee reported that 'hometime' was something he didn't like about play therapy. He enacted the child figure being disappointed and reluctant to leave. Conversely in a later story he enacted the child figure asking the therapist figure if he can go home. It seems possible that Lee had different experiences of 'hometime' in play therapy as he progressed through the process of the intervention. Later in the evaluation session Lee returned to this issue of personal significance when Judy, his therapist, asked him about the different sorts of feelings he had in the playroom. Lee articulated the mixed feelings of sometimes being sad and sometimes excited to get home for a surprise.

**Summary**

Children made several comments about the play therapy environment and atmosphere. They described the playroom as a fun, predictable and safe place. They made many references to the toys and activities they engaged in. Art and craft materials were commented upon most frequently. Several children highlighted the availability of gender appropriate toys and some commented on the need for toys which span a wide age range. The personal significance of toys and their potential for facilitating expression of children's strong emotions has been considered.

A small number of children highlighted the importance of food and its role in emotional regulation. A theme regarding mess being permissible in the playroom was explored. The oldest participant in the study, Bob, was explicit about the link between making a physical mess and the emotional and symbolic significance of this.

Lastly the importance of choice was noted as a repeated theme. Most children acknowledged that this choice is not wholly unconditional and limits are sometimes set in play therapy. Four children commented on the end of each play therapy session, two of whom particularly highlighted how difficult it was to leave and this feeling changing as the therapy progressed. I now discuss these issues in relation to the literature before returning to the views expressed by children on the middle phase of play therapy, and specifically what they shared about their play therapists.

**Discussion and Implications of the Children's Views of the Play Therapy Environment and Atmosphere**

*The Playroom*

The playroom was described as being a place for fun. This seems to reflect the playful atmosphere play therapists strive to create for troubled children. As Ryan and Wilson (1995) highlight, such an atmosphere is thought to be essential for maltreated children in particular[108], because they tend to have missed out on playful interactions with their carers (Tinbergen and Tinbergen, 1983 and Crittenden, 1992b cited in Ryan and Wilson, 1995). Herbert emphasised the centrality of the playroom when he advised the trainee therapist that the first thing she would need to think about was getting a playroom. Whilst this is clearly a very concrete answer, it points to how important the room was for the child. As reported in chapter three, Carroll's (2002b:196-8) study highlighted negative views of the play therapy environment when therapists did not have a dedicated playroom. These included the room used being described as 'cold', 'dirty', 'dark and gloomy', 'too crowded' or in other ways uninviting or difficult due to changes. Whilst Carroll (2002b) describes these as practical difficulties it seems clear that these issues can convey an emotional message of not being cared for.

In this study, Herbert's response highlights the predictable nature of play therapists' playrooms. In play therapy training there is an emphasis placed on the importance of the therapy room as a safe place where consistency is highly valued. Ryan and Wilson (1996) highlight the theoretical underpinnings of creating a predictable and consistent external environment. They argue that this provides the safe secure base that attachment theorists illuminate. From this safe base the child can explore the world. Ryan and Wilson (1996) assert that this felt security in the external world can translate to the child's internal emotional world: "The more secure and familiar children feel in the setting, the more they are freed to address deep-seated and often frightening feelings" (Wilson and Ryan, 2005:169). Of course, as Ryan and Wilson (1996) point out the atmosphere of safety and security in the playroom does not stop at the physical predictability of the playroom but is created by the play therapist herself who strives to mirror this consistency in an emotional sense. This premise will be returned to in the section below on the role of the play therapist.

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[108] Most of the children in this study (16 of 20) were maltreated or had attachment difficulties.

As Landreth (1991:109) states "the atmosphere in the playroom is of critical importance because that is what impacts the child first. The playroom should have an atmosphere of its own which conveys warmth…". The above comments from children in this study suggest they experienced such an atmosphere. They describe elements of the room which provided them with comfort. Herbert's comments illustrate the steps his play therapist took to increase the comfort afforded to him when the room was physically cold. Landreth (1991) asserts that the room should communicate 'this is a place for children'. The above comments by Charlie, Lee, Sarah and Elizabeth suggest that they heard this message clearly.

*Toys and Activities*

There were many comments about toys and activities. Individual choice and finding a medium of expression best suited to the individual child is emphasised in NDPT. The wide spread of toys and activities mentioned by the children across all categories illustrates this point. The relative lack of comment regarding musical instruments suggests that these may not be regularly included in play therapists playrooms. This may be due to the lack of interest children had in instruments, or practical requirements regarding noise levels, or play therapists limited training in the use of musical instruments. The use of musical instruments for two children indicated benefits and relationship building with the therapist. Perhaps further training and encouragement of play therapists incorporating musical instruments into their practice more is indicated (see Carmichael, 2002[109]).

Interestingly gender and age appropriate toys were a theme in the data. This is an issue play therapists purposefully pay attention to, providing toys and materials which "extend the age range of children at either end,  so that the child is free to be as young or as old as s/her wants" (Wilson and Ryan, 2005:165) and that appeal to both genders (Woodhouse, 2005 unpublished). In Carroll's (2002b) study two children talked about being bored in play therapy and this seemed to be linked to the toys and activities available. The children recommended play therapists included toys for older boys. In this study both boys and girls commented that there were boys and girls toys available to them. The eldest girl in this study, Sarah (11.6yrs), shared her enjoyment of younger

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[109] The forthcoming BAPT conference, July 2010, includes a workshop on music in play therapy by a music therapist Joy Hasler, entitled: 'Broken chords: music in play therapy with traumatised children and their families'

play with the sand pit. Similarly Hannah's (8.5yrs) description of both younger water play being available and activities such as writing for older teenagers. These examples illustrate that the age and gender needs of children in this study seemed to be met.

A weakness of the PBE schedules is the absence of a cue regarding diversity issues in relation to the toys and equipment available to children in play therapy. Whilst issues around age and gender-appropriate toys arose directly from the children, there were no views expressed regarding culturally appropriate toys and equipment. Providing children with a range of materials, which reflect different cultural or religious symbols and figures, is commented upon in play therapy training. The need to provide a range of figures for the 'Miniature Playroom' that represent children and adults from different backgrounds and allow representation of disability is emphasised in the training on PBEs. However, it is unclear whether or not therapists included these in their 'Miniature Playroom' kits and there is not a cue to explore with children whether or not they felt the toys and equipment reflected their life experience. Therefore future schedules will include prompts on the appropriateness of the toys in relation to diversity issues.

*Expression of Strong Emotions*
Similar to Carroll's (2002b) study some of the children in this study were able to provide rich descriptions regarding expressing their emotions through toys and activities. Axline (1989:16) asserts that in NDPT children are afforded the opportunity to play out their: "…accumulated feelings of tension, frustration, insecurity, aggression, fear… bring them to the surface, gets them out in the open, faces them, learns to control them, or abandons them". Sarah's account certainly depicted an ability to get her anger out in the open and face the source of this anger. She later described abandoning this anger.

Ginsberg (1993) reviews the conflicting theories on the value of catharsis and emotional release. Whilst Sarah's account supports the benefits outlined in Ginsberg's chapter Martin's case is less clear. In contrast to Sarah, Martin was more tentative about sharing his experience of aggressive play. This is possibly a reflection that Martin has not, as yet, accepted this part of himself. Ginsberg (1993) presents Nichols and Efran's (1985) argument that this is the first stage in therapeutic catharsis. In actuality Martin's therapist, Nick, recorded that Martin's recognition of his anger in the PBE session was the first time that Martin was able to acknowledge these feelings. In contrast to Sarah,

Martin shared that he did not think his anger had changed by the end of play therapy. Nick recorded that Martin's levels of aggression had been extremely high during his play therapy intervention and whilst there had been some reduction mid-way through the intervention, a significant increase was seen again when Martin's care arrangements were changed. Martin's therapy finished prematurely, thus it is not possible to know whether his release of aggression in play therapy would have resulted in eventual reduction.

*Food*

West (1992) acknowledges that food within play therapy has been seen as a way to meet children's basic needs. Maslow's (1971) hierarchy of needs suggests that children may not be able to explore their emotional difficulties if their basic needs are not catered for. Thus as West (1992) acknowledges, some play therapists provide refreshments for children within play therapy sessions to meet this basic need. West (1992) also details some examples of children's use of food within play therapy. These examples focus on children saving or binging on food and the ways in which they share food with their therapists or eat the food on their own. However, West (1992) does not extend her descriptions to analyse the purpose or meanings of these varying approaches. West's examples (1992) point to children exploring themes of personal significance, such as experience of neglect. In contrast Hannah and Herbert's comments in this study clearly locate the purpose in helping the child to both physically and emotionally regulate. Haworth and Keller (2002) acknowledge that the use of food in play therapy has received little attention. They provide a comprehensive overview of the use of food in the therapy room and possible meanings, particularly in relation to 'neurotic' children. They briefly mention that food in play therapy sessions has been seen as serving a comforting function when the child loses at games or before a vacation period. A further issue explored was aggressive reactions toward food. However, food serving a calming function to *reduce* anger or high energy levels as Herbert describes is not explored.

*Mess*

Wilson and Ryan (2005) highlight children's need to make a mess in play therapy sessions can occur for various reasons. These include overly rigid or highly inconsistent messages about mess from adults in their lives, being highly sensitive to external change, or frightening and/or abusive experiences which have involved mess. For Lee it was unclear which of these reasons may be most likely. However, it is clear that he

enjoyed the permissibility of being able to make a mess and accepted his therapist's limits on this. This suggests that there was a sense of containment in Lee's sessions. Bob was clearly able to identify his need to make a mess was an expression of anger following a bad day. It seems children may want to metaphorically leave therapists with the 'messy emotions' children internally experience.

However, permissibility of mess was not liked by all children. Hannah shared that she did not like it when all the toys were out as it became messy. Interestingly her therapist, Judy, commented in the post-evaluation questionnaire that she had not picked up this cue from Hannah during the actual sessions. In fact she stated that Hannah 'seemed not to care at all'. Judy separately noted that themes of control and freedom vs. restriction were evident throughout Hannah's play therapy intervention. Possibly Hannah found it overwhelming at times to be in control and have freedom and needed her therapist to actively contain the mess she created. The level of mess may not have been to an extreme level and therefore ordinarily the therapist would not deem it necessary to set limits or consider that a child may be feeling anxious. However, in this inhibited and reportedly[110] avoidant child a lower level of mess may have induced some level of stress. Judy noted that her views regarding Hannah's functioning had changed since the PBE, she stated: "I had somehow forgotten how anxious she could be. Hannah masks it so well behind her smile." Perhaps the structure of the PBE and explicit focus on addressing a child's need to please enabled Hannah to briefly share some of her more difficult feelings. This is a process issue which will be returned to in chapters eight and nine.

*The Importance of Choice*

A theme in Carroll's (2002b) study was the children's emphasis on the importance of choice. Over half the children in this study echoed this. Non-directive play therapists believe that children themselves will find the medium of expression which best suits them. Thus they do not direct the child to the toys or equipment which therapists themselves feel would help the child to express issues of emotional importance, rather "…the therapist waits patiently for the child to discover *their* unique self." (Landreth, 1991:54). The comments made by children in this study highlight that this approach was both noticed and appeared to be significant to children. Furthermore for some children it

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[110] Therapists report in pre-evaluation questionnaire

appears that they found this way of relating unfamiliar. This reflects the arguments made in Ryan and Wilson's (1995) paper that some children may not have experienced responsive accepting caregiving and the therapy relationship is an opportunity to experience and rework their patterns of relating.

I now turn back to the findings of this study and present the children's views of their play therapists.

## The Play Therapist

In this section I focus on 'who' play therapists are, detailing the monikers children ascribed to them, the qualities children perceived play therapists to possess and the comments they made on the gender of their therapist. Following this I consider the comments and play demonstrations relating to 'what' play therapists do. This includes play therapists following the child's lead, sometimes taking the lead themselves, showing acceptance and permissivity, whilst providing structure and setting limits on children in the playroom, thus creating the 'permissive atmosphere' referred to above. Children also commented on play therapists helping them in various different ways including: showing concern and attending to their physical needs; talking and listening to them; cheering them up and calming them down. Children's communications suggested that they experienced play therapists as interested *active* observers who watch and play with children, who provide encouragement and praise and sometimes show their own feelings. The importance of the relationship between child and therapist is highlighted before concluding this section by outlining the children's recommendations for play therapists.

## Who are Play Therapists?

Children in this study appeared to draw on their previous and current experiences of adult roles to try and 'place' their play therapists. Five named the play therapist a 'play teacher' (Eddie; Billy; Marble; Elizabeth; Cathy). Elizabeth also referred to her play therapist as a 'helper' as did Leanne. In addition to being called a teacher Billy referred to his play therapist by name. This was true of Herbert, Emma and Martin. L-man referred to the Play Therapist as a 'Play Leader'; a common figure in some children's lives[111]. Bob and Susie made reference to the 'play therapist'. Gabriella was the only

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[111] The term 'play leader' is similar to a teacher, but is usually afforded to those running play-schemes or after school clubs and therefore has more playful connotations.

child to refer to the play therapist as a 'person'. Whilst Eddie referred to his play therapist as a 'play friend' and a 'toy':



| |
|---|
| **Eddie:** the play teacher's really whatever you would like because they're fun they're like a toy you can play with {looks at camera; smiles:::}[112] |
| **Figure 2: "They're like a toy"** |

One child expressed his dislike of the therapist having a dual role of play therapist and social worker. Martin raised this dual role several times in the session. It was clear in his description that he was fearful of the consequences of having a social worker in his life[113].

**What Qualities do Play Therapists Possess?**

There were eight comments from seven children and young people which ascribed a specific quality to their play therapist. Charlie described his therapist as 'quite a kind lady'. Gabriella described her therapist as kind initially but amended this to "a little bit kind and a little bit nasty". Eddie described his therapist as "really really good". Martin; Elizabeth; Cathy and Herbert all described their therapists as 'nice':

**Herbert:** Er:: the *play↑ therapis↑t has↑ got to be::* always *nice* because (.) if

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[112] (966:975)

[113] This is detailed in the 'therapeutic encounters' section in chapter nine.

they're like:: they're not nice:: (.)  there's no point being a play therapy 'cos {looks at therapist} you're getting *chil*dren {looks to right of room slightly upward}  who→aren't→nice probably {looks downward toward therapist} who are getting all sorts of *stuff* and then they should be nice to ya' so:: {looks up and to right again and then back downward} I I'm thinking that they'll {looks at therapist::} be nice to ya'[114]

## Play Therapists' Gender

The 'Expert Show' interview schedule has a specific cue to ascertain children's views of the gender of their play therapist. Unfortunately this was not included in the 'Miniature Playroom' schedule. Furthermore it is also one of the questions therapists tended to miss out during the 'Expert Show'. However, there were twelve comments from nine children on their thoughts regarding the therapists' gender. Elizabeth, Bob, Marble and Herbert felt that it would make no difference. Rob was not sure what it would be like. Similarly Billy said he didn't really know but thought it would be just the same. Marble highlighted that there would be a physical difference, she commented that the man would be "twice as taller" {looking upward smiling}[115]. Herbert contemplated possible differences between male and female therapists out loud:

**Herbert:** *Well*::: *I* played with a la:::dy::↓ and: *actually* it was *pretty fun*↑ so::: (.) yeah↓ it'll be {plays with phone wire} it might be *pretty*↑ *fun*↑ because it was pretty fun for me::: {eyebrows raised} because I played with a *la::dy* I didn't play with a ma:n {looks up} [so:: if a *man*

**Polly:**                                                         [OK

**Herbert:** if a *man* you→could→played→football {eyebrows raised gestures outward} *but even* a lady↑ can play football they could so→you never:: know:::↓[116]

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Three participants (two male and one female) who all had female therapists found the idea of having a male therapist difficult. Charlie was highly animated when he shared that a "man's a little bit *grumpy*"[117] and advised callers to "stick to a girl"[118]. Similarly L-man felt having a male therapist would not be "very good".

Unlike these two boys, Hannah felt that it was not men *per se* that were less desirable but the child and therapist being matched in gender should be the aim. Conversely Gabriella seemed to imply that a male therapist would be desirable. It is worthy of note that both Hannah and Gabriella were the only two participants where other gender related issues were spontaneously referred to[119]. The fact that Hannah and Gabriella raised the topic of gender themselves suggests that this is an area of personal significance to them. This was particularly marked in Hannah's evaluation session. She suddenly told the caller that they should not think she's a boy and made it clear that she is a girl. She later requested that all the callers from that point forward should be girls, despite all the names given for the 'child callers' being gender-neutral and therefore possible to assign to either gender[120].

**What do Play Therapists' Do?**

Children in this study shared further rich information about their play therapists providing thick descriptions of what play therapists *do*.

*Play Therapists…Follow the Child's Lead*

There were nine comments or descriptions of play therapists clearly following the child's lead in interactions. These were made by seven different children (Eddie; Charlie; Rob; Hannah; Billy; Cathy; L-man):

> **Eddie**: and they'll play whatever you want her to play with[121]

Billy was confident in his response which also alluded to the idea that play therapists following the child's lead does not mean that they are passive. His experience suggested

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[117] (230)
[118] (233)
[119] Excluding brief comments made about boys and girls' toys in the playroom, see section on 'Toys' above.
[120] Also see Hannah's comments in the section above on 'gender and age appropriate toys'.
[121] (970)

a responsive and active relationship: "she helped me whenever I wanted help and to not stop she played with them she would"[122].

This intricate balance, of permissiveness coupled with active responsiveness, is a thread which weaves its way through this section on the play therapists' role.

*Play Therapists…Sometimes Take the Lead*
In contrast to the above comments about play therapists allowing children to lead, there were comments from two children who alluded to their play therapists taking a more directive stance. Gabriella said that on first meeting the therapist she would tell you "what you need to do and um how it's going to be"[123].

This gives the impression that she experienced her play therapist as prescriptive in their first encounter. However, it is likely that Gabriella had a generalised expectation of adults being controlling and prescriptive. The context of this therapy intervention taking place in an EBD[124] school is of relevance. There are often very clear rules and boundaries for children to follow in these settings. It follows that Gabriella may expect this to be the case in her therapy sessions within this school setting. Of note is the fact that Gabriella was referring to her first meeting with the play therapist where her expectations based on other adult relationships is likely to be most pronounced.

Sarah commented on her play therapist leading at the beginning of the intervention by asking her questions. Sarah advised callers to tell their therapist if they are not comfortable answering their questions. It is not usual NDPT practice to ask questions. Interestingly later in the evaluation session Sarah provided advice to the 'trainee play therapist' telling her to get to know the child first before going into all of the questions. Sarah's therapist noted in the post-evaluation questionnaire that she was:

> '..surprised that Sarah identified play therapy with 'questions' much of the
> work was non-directive. Maybe Sarah found it difficult to have someone
> so interested in her and my comments were then perceived as questions she
> had to respond to'.

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[122] (456)
[123] (346)
[124] Emotional and Behavioural Difficulties

This child came from a large family and receiving one to one attention was reportedly unfamiliar to her. It seems the issue may have been that Sarah experienced the beginning process as overwhelming or intrusive. Whilst the basic tenets of being non-directive - by not asking questions - may have been adhered to it is not clear what her therapist meant by 'much of the work' being non-directive. It seems that the need to adjust the *pace* of interaction and respond to Sarah's discomfort/unfamiliarity with one to one attention may have been outside the therapist's awareness at the time of the intervention. The advice from Sarah seems clear: to go at the child's pace. In the post-evaluation questionnaire her therapist did demonstrate an ability to listen to this advice and reflect upon her practice.

*Play Therapists…Show Acceptance*
Three children described ways in which the therapist was accepting of them. When Bob described making a mess in the playroom he further commented that the play therapist would be accepting of this. Similarly Herbert described play therapists as accepting toward children if they became angry:

> **Polly:** … what would happen in the playroom in play sessions if I got angry:
> **Herbert:** Well you could tell the play:: therapist {looks at camera; looks ahead}   and then she would like↑ (.)  play with ya':::  or anything:::↓ or she could even just let you go:: er go to a calm place in the playroom:::[125]

He later described his play therapist accepting his need to have time to be sad:

> **Herbert:** oo↑ sa↑d: (.)  er::: (.)  my play therapist did (.)  that she gave me er:: that she gave me just like …er a few minutes just to calm::: down and all that you know:::[126]

Similarly Elizabeth described her therapist's acceptance of her need for space when she

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[125] (354:358)
↑ = intonation upward
↓ = intonation downward
::: = elongated communication
(.) = a pause which is noticeable but too short to measure
[126] (572:575)

was feeling sad.:

> **Elizabeth**:*hhhh O:K:: {puts drink down sits upright} if you feel really
> sad and worried {leans forward } you don't need to feel worried about it
> [she can {nods head} leave you alone for a little bit
> **Judy:**[oh::
> **Elizabeth**: you can have a sit down::: in a [place
> **Judy:**                                                                    [yeah
> **Elizabeth:** {leans forward picks up miniature puppet theatre from table
> takes phone away from ear} just like this pretend you were seeing me for a
> bit you can sit down there in a place just↑ like↑ this↑ {shows
> puppet theatre to camera puts phone to ear} you can go inside it like I do
> you can [sit in there you can think about what time you want
> **Judy:**   [umm
> **Elizabeth:** {adjusts position on seat looks at camera} you can make a
> show↑ for↑ her↑ to watch aswell with [puppets {smiles} and lots of things
> **Judy**:                                                        [oh {smiles}[127]

Elizabeth's comments suggest she was afforded both physical and emotional space by
her therapist. Herbert also made comments about his therapist which suggest that he did
not experience his therapist as accepting of *all* of his emotions. Polly, his therapist, (in
role as a trainee therapist) asked advice about what to do if a child got really excited in
the playroom:

> **Herbert:** =O↑o::↑ {*smiles::::* looks upward small jump in seat looks
> slightly to right} really→*excited* well *I::* got {eyebrows raised} really::
> excited *act*↑ually:: and the play therapist was a bit  a bit annoyed I think so
> yer::: {smiles:::}
> …
> **Herbert:** so:: if a child gets annoyed {looks at phone presses buttons on
> phone} *don't::: get don't* get angry with 'hem and start shouting at 'hem↑
> {puts phone to ear} otherwise they'll go otherwise they'll go sa:::d↓ it will
> make them probably even *worse:::r {looks at therapist}*

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[127] (334:348)
[127] (582:594)

…

> **Polly:** *Right* it's important for the play therapist not to get angry then {nods head} [128]

It is possible that this therapist did shout, or use a firm voice with this child when he became over-excitable. I suggest the term 'over-excitable' as Herbert used the word 'annoyed'. However, it seems likely that Herbert was referring to a time that the therapist needed to set limits on his behaviour in the session, possibly to help him emotionally regulate. A further possibility is that this was part of a role play. One likely possibility was that this child *expected* the therapist to be annoyed with him, or feared that she was when he became excited in the playroom. This may be based on his internal working model and expectations of how adults relate to him. Herbert referred to the difficulties in his relationship with his mother and that she had had enough of him being angry so took him to play therapy. This suggests that his experience of adults, when he becomes excited or over-excitable, is one of annoyance. Therefore it is likely that he would expect his therapist to be like this also.

When the therapist's post-evaluation questionnaire was opened[129] it revealed a corroborating analysis of Herbert's response to this question and some additional information. She stated:

> 'Herbert became very animated in an intense role-play about battling for control, testing whether people could be trusted…I felt that I was able to contain the role play and didn't feel annoyed with him – I wonder if anger was actually the reaction that he expected from me rather than that which he actually received?'

While it is not conclusive that this interpretation is accurate, and one could argue bias[130], the similarity between my own analysis and that of the therapist is striking. Furthermore it is supported by additional information about Herbert's difficulties and experiences of relating to his mother.

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[129] The reader is reminded that therapists' questionnaires were opened after my own analysis of the children's views had been completed.
[130] This is suggested due to both myself and the therapist being trained non-directive play therapists, and therefore likely to interpret children's communications in similar ways.

*Play Therapists…Are Permissive*

There were twelve quotes from eight children commenting on or describing the therapist being permissive within play therapy. As noted above, Lee and Bob commented on their therapist permitting mess. Both Lee and Elizabeth talked about being allowed to go home if the child needed to. Emma talked about being allowed to take art work home. Rob, Sarah, Leanne, and Eddie shared their experience of their play therapist's being accepting and permissive regarding the activities the child chose.

*Play Therapists…Set Limits*

Whilst play therapists were experienced as permissive, children also commented on there being limitations to this permissiveness. This was particularly in terms of keeping them safe. There were twelve quotes from ten children regarding play therapists setting limits in the playroom.

Leanne hinted at the possibility of limits, but found it difficult to articulate what the limitations might be. Gabriella and Eddie made comments about there being a general atmosphere of permissiveness with some limitations. Eddie had clearly internalised the general atmosphere of permissiveness and the specific limits which were in place:

> **Eddie:** …it's supposed to be not for being bad or doing what your play friend says she will just say you can do any:::thing you want and the important thing is to keep both of you safe [and that nobody gets hurt[131]

Eddie and Herbert clearly shared their experience of *specific limit setting*. They both explicitly referred to the limit of *keeping physically safe* during play with swords:

> **Herbert:** … you *can* er *actually* play with anything it might be play swords but you can't *ac-actually* touch the body {gesturing with left hand as if holding a sword} you've got to pretend it and if you do like fighting you've got to punch *away::↓* {makes a fist and makes punching motion out to the side in controlled manner} from the person you're punching[132]

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[131] (903:906) [ = overlapping utterances :::: =elongated communication
[132] (184:189) *italicised text* = emphasis

The therapist recorded that she had to set and reinforce limits across a couple of sessions regarding sword play and play fights. In particular she noted that Herbert had played a Kung Fu character where he punched the air close to the therapist's face. Interestingly, Herbert also suggested the need for caution with the whiteboard in the room, for 'health and safety' reasons. It would be unusual for a non-directive play therapist to set such a limit. Herbert's therapist recorded that this was an interactive whiteboard. However, she did not recall setting limits on this. It is possible that the context of this intervention, a school setting, may be influencing this child's view. It is usual for there to be more limits and boundaries set on children in the classroom setting compared to a play therapy room, particularly with expensive equipment such as interactive whiteboards. Whilst in general play therapists who work within school settings try to compensate for these issues and emphasise the difference in the playroom itself, albeit in the school building, it is likely that some children will continue to generalise the limitations placed on them in the school setting to the playroom. Herbert's comments may be an example of this.

Both Lee and Eddie made comments about limits with regards to the *time* in the playroom and specifically having to finish at the end of the session. Bob and Hannah made comments about the limits with regard to the *physical space*. Hannah highlighted the limit of staying in the room, with the exception on needing the toilet, and Bob talked about restricted areas in the room whilst playing a game. Bob proceeded by detailing the consequences of breaking limits in the playroom, which he had very clearly internalised.

Emma, Martin and Elizabeth made comments about there being limitations on *feelings* they had in the playroom. Emma commented that children are not supposed to be 'hyper' and able to 'calm down'. Her therapist, Judy, noted that Emma never became over-excited in the playroom. However, Emma's mother talked of Emma being 'hypo'.

Martin's comments suggested the possibility that angry feelings were discouraged and not permitted. He stated that a child would be taken back to his mum if he was angry in the playroom. However, as detailed in the section above, Martin also shared that it was permitted for him to hit the teddy to let out his angry feelings. Martin's clear anxiety about sharing this with the 'TV audience' suggested that allowing expression of anger may be his own personal issue rather than his therapist encouraging avoidance of it or employing distraction techniques.

Elizabeth told a caller that children could do anything they liked, but then added the caveat "except being nasty"[133]. Both my own and the therapist's independent interpretation of this comment was that it was likely to be Elizabeth's own internal fear of being seen as nasty, rather than an external message from the therapist or style of intervention.

*Play Therapists…Help You*

There were nineteen comments and descriptions from twelve different children about play therapists helping children. Participants described several different ways therapists helped them including: attending to physical comfort needs; providing help when children need it; providing help when hurt or ill and getting help from parents; cheering children up; calming children down; taking care and responsibility.

Herbert described his therapist taking care of his *physical comfort* by bringing a heater, as mentioned already. Charlie mentioned his play therapist providing *help when* he *needed* it. Herbert, Marble and Eddie described therapists' providing help when children were *hurt or ill*. In all of these examples the therapist sought help from the parents. Eddie enacted a story in the 'Miniature Playroom' where the play therapist figure took care of the child figure when he was physically hurt:

> **Rachel:** oh it looks like she's (therapist figure) she's carrying him {looks at child:::} and she's caring for him (child figure)
>
> **Eddie:** {puts down child figure. Walks therapist figure out of playroom}
>
> **Rachel:** oh and he's having a lay down (.) oh and Lisa's [gone far away
>
> **Eddie:**                                                          [{eye contact}
>
> **Rachel:** and then she's back
>
> **Eddie:** {Manipulates child figure::: manipulates therapist figure:::}
>
> **Rachel:** oh and it looks like maybe Josh has hurt his [arm and she's making it better yeah↑
>
> **Eddie:**                                                          [{nods head}
>
> …

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[133] (314)

**Rachel:** So Lisa is telling mum {looks at child:::} Josh is really hurt and he needs some extra looking [after {nods head}

**Eddie (as mother figure):**   [It's alright I'll take him home[134]

This 'physical hurt' may have actually occurred. However, Eddie's enactment may also be a symbolic representation of the child experiencing the play therapist as caring when he experiences emotional hurt, if so this highlights a strong therapeutic alliance between both the therapist and child and the parent. It also alludes to the reworking of attachment experiences. I return to the themes of the therapeutic relationship and the importance of the family below.

There were nine comments, from four different participants, (Eddie; Herbert; Martin; L-man) about play therapists *cheering children up*. Eddie referred to therapists' being able to cheer children up when they have angry feelings, and make them happy when they are feeling unhappy. It was clear from Eddie's description that angry feelings were acknowledged first, before the child progressed to a more 'cheerful' place.

Four children commented on their play therapist's *helping them to calm down*. (Herbert; Elizabeth; Jack: L-man)  It is noteworthy that these four children were all referred due to issues related to anger or violence[135]. Elizabeth simply stated that this was one of the things play therapists did, the other three children gave descriptions of *how* play therapists did this. Jack said that the play therapist would tell the child to count to ten. His therapist noted that this was a strategy used within school, by school staff, rather than the playroom. L-man said the therapist would ask the child if they were alright and probably play a game with them to forget about everything.

As presented above, Herbert shared that play therapists help children to calm down when they're angry.  Interestingly Herbert also mentioned therapists taking care and responsibility of 'people':

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[134] (514:525 & 530:533)   ::: = elongated communication [ = overlapping utterances

[135] Jack, Herbert, and L-man, were referred due to anger problems. Elizabeth, L-man, and Herbert, witnessed domestic violence. Elizabeth and L-man had also experienced physical abuse. L-man and Jack had conduct problems.

**Polly:** …what things are important to know about being a play therapist?

**Herbert:** {puts phone to ear looks upward} Well::: first→thing→is::: to→know::: is about to take: care::: er::: take er ::: (.) take responsibil↑ity:: about peo:::ple:::

**Polly:** Right {warm tone of voice}

**Herbert:** Er to take (.) {leans forward nods head::} er yer to to make {nods head:: looks at therapist} make people ha↑ppy::[136]

This comment gives the overall sense that Herbert really felt cared for by his therapist and that she had his best interests in mind.

*Play Therapists…Talk and Listen to You*

Twelve comments, from eight participants, referred to play therapists talking and listening to them. Charlie said play therapists 'talk to you'. Eddie made it explicit that he chatted to his play therapist when he was physically or emotionally hurt and this made him feel better. Marble pretended to be a play therapist during the 'Expert Show' and conveyed her belief that children who were feeling sad would tell their therapist. Bob also shared that children could talk to their play therapist about things that they were worried about. Cathy spontaneously provided information about children being able to tell their play therapist's about their worries. Leanne made a very similar comment about telling your therapist about your problems and your angry feelings.

Elizabeth emphasised the importance of being able to tell your play therapist something which the therapist will not only listen to but also keep confidential. It is worthy of note here that Elizabeth was the only child who explicitly raised confidentiality as an important part of play therapy. However, this is not explicitly cued for in the interview schedule. One other child, Martin, alluded to issues related to confidentiality. He suggested that the therapist would talk to his parents 'a bit' about his behaviour in the playroom. This implied that there was some break in the usual confidentiality afforded to children during play therapy. Usual practice is to talk to parents and professionals about the themes of the play rather than specific details and behaviour. However for children this may be hard to understand and perhaps the phrase 'a bit' was Martin's way of explaining this. The mention of this was neutral and did not seem to hold intense

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[136]  (544:50)

emotional significance for this child. Some children seemed to suggest that they wanted to keep some of their information confidential during the evaluation session itself and their therapists helped to manage this confidentiality (this is discussed in more detail in chapter nine).

*Play Therapists…Watch You*

There were ten comments from seven children about play therapists 'watching' children. It is worthy of note that all of these comments originated from children who had Judy as their therapist. Whilst it should be borne in mind that there is more data in this sample from Judy than from any other therapist, it is striking that seven out of the nine children who had Judy as their therapist commented on this.

Some of these children just commented on their therapist 'watching'. Lee demonstrated this in the 'Miniature Playroom' showing the therapist admiring his play with animals and trucks. He made further comment that the therapist *likes* watching. Elizabeth commented on her therapist 'watching' her play with her parents. This is likely to have been an experience of a family play observation outside of the individual NDPT experience. Lee, Elizabeth and Billy made comments about the therapist 'watching' them do something. Elizabeth commented on her therapist watching a puppet show. Billy's comments suggested that he was confident that the therapist would follow his lead, but would also be a willing and interested observer. Rob enacted the therapist figure watching the child figure paint and suggested that the therapist was thinking that the child was having fun. This suggests active awareness of the child's feelings on the therapist's part, or the child's egocentric viewpoint.

*Play therapists…Play With You*

There were twenty-four specific comments, from twelve children about play therapists playing with children. This suggests children experience play therapists being *active and involved* in the play, in addition to being interested observers. Nine of these children made a general statement or demonstrated the play therapist playing with the child. Seven children gave more specific descriptions or demonstrations of that play.

Emma and Rob commented on the play therapist playing *alongside* the child when modelling with play dough. There were particular activities which were named as play which children did *together* with their play therapists. Herbert and Bob both commented

on playing board games together with the play therapist. Martin mentioned playing drums with his therapist and Eddie enacted the child and therapist figure playing together with the sand. Lee and Emma's demonstrations of a child and therapist figure playing ball together demonstrated basic reciprocity in the play. Lee expanded on this play showing reciprocal car play.

There were comments from Eddie, Herbert, and Billy, that children can ask their play therapists to 'join in' if they want to. Eddie's comment about being able to ask the therapist to join in appeared to suggest a feeling of autonomy on the child's part. Herbert expressed his confidence that play therapists' would play with children:

> **Herbert:** …so→don't→be→*afraid* that the play therapist won't play with ya' *she will*[137]

There were two comments from children about play with play therapists which they did not like. When asked if there was anything the child caller would dislike about his play therapist, Herbert expressed dislike of his therapist being "pretty rubbish↑ at foot:::ball↑::" (see comments below). Jack felt that children would not like it when the play therapist played with dolls. It is not clear whether or not the therapist led the play in this way[138] or whether Jack simply disliked the presence of dolls in the playroom.

*Play Therapists…Provide Encouragement and Praise*
Three children commented or demonstrated play therapists encouraging, admiring or praising the child's play. Emma and Rob played out the play therapist making positive verbal comments about things the child figure had painted. Lee demonstrated the therapist figure being an active, interested observer who was admiring of his play.

*Play Therapists…Sometimes Show their own Feelings*
There were three explicit examples in the data of therapists showing their own feelings in a therapeutic way. L-man suggested that play therapists share and match the child's emotions stating that if the child was excited the play therapist would get excited with them. The second example came from Eddie who described his play therapist congruently sharing feelings of discomfort:

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[137] (273:274)
[138] This would not be usual in NDPT practice.

**Rachel (verbalising Eddie's actions with the figures):** ..they're both playing with the sand (0.2) … she's (therapist figure) taking her shoes off (0.1) She's standing in the sand

**Eddie:** Footprints

**Rachel:** Footprints and I wonder how she feels when she stands in the sand

**Eddie:** Awkward[139]

Toward the end of the evaluation session Eddie impressed how important the therapist's transparency was to him:

**Eddie:** (.)Well there's only one question that I wanna tell {shakes head} a play teacher is really really good and there's so much {shakes head} you can tell about 'em[140]

Returning to Herbert's comments regarding his therapist, playing football with him, he also shared that she showed her own feelings of being nervous:

**Herbert:** {looks downward} Well::: my play↑ my play thera↑pist (.) when I was a kid:::↓ (.) was just about to er (.) to::: er {eyebrows raised} *play↑ foot↑ball* with me

**Polly:** Right

**Herbert:** And then she wa:::s she was *ner:::v*ous because she thought I was going to *beat* her (.) well→ win→her *real*ly yer win her {sits back in seat looks ahead looks upward} and so then::: I said *cheer:: up↑* I-I-I'll make I'll make sure you score some goals::: so that made her *not↑ (.)* very nervous so you could do that↑ and like:: and so if so if you're new at somethin'↑ a ki:::d

**Polly:** um:::

**Herbert:** might come over to you and say '*it's al::right:::*' {in whispered voice with reassuring manner}[141]

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[139] (184:192) (0.2) A pause timed in tenths of a second
[140] (1055:1057)
[141] (530:537) ::: = elongated communication → = fast speech ↑↓ = intonation up/down

It was hypothesised that Herbert may have had a significant need to win and be the strongest within interpersonal relationships and not demonstrate any weakness. The therapist sharing feelings of anxiety that she would lose in this instance would be therapeutic for this child. The shift to him taking care of the therapist, or being mindful/empathic to his play partner, may demonstrate an improvement in his emotional and social development. An alternative interpretation is that the child felt he needed to care for the therapist and her sharing of feelings was inhibiting to him. However, data from the therapist's questionnaire supported the former hypothesis:

"…I lack any kind of football skills, but Herbert also put me in role as a 'really rubbish' player whereas he pretended to be Ronaldo and Tevez – the two best players in the world."

There is further support that Herbert did not experience inappropriate role-reversal afforded by the comment Herbert made directly after the above quote:

**Herbert:** But say if a kid if a *ki:::d (.)* is say:: un↓ha↑ppy::: er:: you can go over to them and make them happy::: that's that's what I think you can be good at[142]

It is suggested that the therapist's congruent sharing of her own vulnerability enabled this child to show his own vulnerability and subsequently accept care and attention from the therapist.

**The Importance of the Therapeutic Relationship**

There were nineteen specific comments and demonstrations from ten children which pointed to the importance of the therapeutic relationship. Some of these comments were coded as pointing to the importance of the therapeutic relationship due to contextual information rather than in-depth rich descriptions provided by the child. For instance Charlie was asked what the room would be like. The first thing he said is that the room will be yellow, followed by the fact that "there will be a person with you who might be

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*italicised text* = emphasis * * = quieter voice
[142] (538:540)

called Judy"[143]. Similarly with Emma she was asked what kind of things the child does and the first response was that she plays with the therapist. The immediacy of these comments suggested that the play therapist herself was an important part of the play therapy experience for these children. However, it is also possible that these children process things in a concrete manner and therefore commented on concrete facts.

Whilst Billy did not explicitly say anything about the importance of his relationship with the play therapist, it is implicit in his spontaneous addition to the 'Expert Show'. Billy introduced a competition for the audience watching the 'Expert Show', where they had to guess which play therapist - out of an imaginary three - was *his* play therapist. The fact that Billy chose to spend a significant amount of the session on this play, which centred on 'the play therapist', indicates that this was an area of emotional importance to him. The positive connotations of the winner being lucky, and winning something special, further suggested that the play therapist was an important person from Billy's perspective.

Eddie and Elizabeth indicated how important their therapists were to them by their statements about never forgetting them (Eddie) and continuing to remember the therapist even when you are grown up (Elizabeth). During the evaluation session itself Lee, Rob and Marble all requested a memento of their therapist Judy. Rob requested a photo, whilst Lee and Marble wanted to make and exchange pictures with Judy.

Herbert and Sarah made more explicit and rich comments about the importance of the therapeutic relationship. They both made several comments about developing trust in the relationship with their therapists. For example, Sarah told a 'trainee play therapist' who called in that the therapist might "be able to have like a *bond* or a communication"[144] with one of the children.

Herbert's description of growth in the relationship was really striking:

> **Herbert:** So like like like when ya when ya start with your play therapist::
> (.)  your relationship grows::: up↑ {raises left hand from desk height to head height}

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[143] (163)
[144] (358)

**Polly:** Right::

**Herbert:** you know:::↓ it grows up↑ into hardened you→ begin→to→ get {nods head} *really*→ be→ friends:: {eyebrows raised} like when I started with my play therapist I was like dead sh↓y::↑↑ but my relationship with my play therapist was *really* good[145]

**Recommendations for Play Therapists from Children**

Six children made recommendations about what play therapists should do. It was not always clear whether or not the child already experienced this with their own play therapist and felt other play therapists should do this too, or whether this advice was aimed at their own play therapists also.

As noted above, Herbert recommended that therapists should not shout or get angry at a child if the child becomes annoying or excited, but rather tell them to calm down. Sarah and Cathy both highlighted the need for play therapists to listen to children, find out what has happened to them and what their worries are. Importantly for Sarah the use of age-appropriate understandable language, and proceeding at an unobtrusive pace, was seen as essential.

Leanne made general comments that therapists should help children and give them the things they want. She also recommended that therapists specifically help children to feel safe and that they get more people to help. Leanne explicitly told her therapist within the evaluation session that she continued to feel unsafe. It became apparent that Leanne's therapist had referred Leanne to another service for further therapeutic input. Thus it seems these recommendations are based on Leanne's direct experience.

Lastly, two children made recommendations related to their carers. Eddie recommended that children should attend progress meetings and Lee's play in the 'Miniature Playroom' suggested that he would have liked 'nanny' to be involved more (both of these examples are discussed further in the section below).

**Summary of Children's Views of Play Therapists**

Children described their play therapists in a variety of ways. Being kind or nice were oft

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[145] (792:797)

quoted qualities. Mixed views regarding the gender of the play therapist were expressed. An exploration of play therapists being permissive, accepting and following the child's lead whilst maintaining an active role has been presented. Children communicated that play therapists set limits, mainly when needed. The limits described by children were related to keeping the child and therapist physically and emotionally safe, related to time and the session ending, the physical space and perhaps surprisingly feelings. However, the limits on feelings appeared to be related to therapists helping the child to emotionally regulate or related to the child's own internal fears and expectations.

Play therapists were described as providing help to children when needed, particularly in terms of physical comfort, providing physical and emotional care when children are hurt or ill, cheering children up and calming them down. Children also shared that play therapists sometimes talk and listen to them, play both together and alongside them and actively watch them. The importance of the therapeutic relationship was evident in children's descriptions and play demonstrations. Children made recommendations to play therapists to: keep children safe; listen to them; refrain from asking intrusive questions at the early stages of the intervention; and to use understandable age appropriate language.

### Discussion and Implications of Children's Views of Play Therapists
*Who are Play Therapists?*
There are many factors which contribute to our understanding of how children view play therapists. Clearly play therapists are not an homogenous group. Furthermore the same therapist will have a different relationship with every individual child. Individual children will also bring their own internal expectations of adults and perceive the play therapist's role in varying ways. Children will draw on their prior experience of adults to try and place the therapist and their role. Children will also bring their own individual emotional issues to therapy and project particular roles onto the therapist within the therapy session itself. Nonetheless it is interesting to learn from the children in this study the various ways they perceive their play therapist.

In Axline's detailed case study, 'Dibs' questioned who his play therapist was, reportedly stating: "You're not a mother. You're not a teacher, you're not a member of mother's bridge club. What are you? It does not really matter. You are the lady of the wonderful playroom" (Axline, 1964:204). Similarly children in this study seemed to

draw on their current experiences of adults to make sense of the play therapist's role. Children allied their therapists with teachers. This may be reflective of the setting or perhaps children drawing on other known adult roles to make sense of the play therapist's role. One child referred to another allied role, that of 'play leader'. Whilst the term 'leader' may suggest directiveness, in general terms 'play leaders' are not seen as authoritarian in their approach and in comparison to other figures in children's lives, such as teachers, there is generally a relaxation of rules and emphasis on free-play (see Hughes, 2001 and Brown, 2003).

However, it was Eddie and Herbert's comments about their play therapists which were as illuminating as Dibs. Eddie stated that a play therapist is 'like a toy you can play with'. A toy evokes a sense of playfulness and stimulation. Newson and Newson (1979) write about the infant's first 'toy' being the human face. They highlight that responsive facial movements to the baby's actions are particularly appealing to infants who will "attempt to bring them under his own mastery and control" (1979:30). Ryan and Wilson (1995) assert that this predisposition toward personally meaningful interactions can be (re)activated in therapy with troubled children. Eddie's further comment that a play therapist is "really whatever you would like" certainly evokes a sense of his play therapist being responsive, flexible and adaptable to his needs.. In other words he has learnt that he can be an effective communicator within an interpersonal relationship.

Herbert stated that play therapist's have to be *'always nice'* explaining that they have to see children who are 'not nice'. His comment highlights how accepting play therapists need to be of all children, even those who 'aren't nice', along with why Herbert thinks children go to play therapy, and possibly how he feels about himself. This seems to mirror Landreth's (1991) assertion that therapist's need to be open-minded and not judge or evaluate children. It encapsulates the concept of unconditional positive regard (Rogers, 1951).

*Gender of Therapist*

Children in this study shared mixed views, when asked, about the best match between child and therapist in terms of gender. Wilson and Ryan (2005) concur with Jehu et. al's (1989) conclusions that, with regard to sexual abuse survivors: the psychotherapy literature is inconclusive on the best therapist-child matching in terms of gender. Wilson and Ryan (2005) proceed by exploring the advantages and disadvantages of male and

female therapists and conclude by highlighting the importance of considering each child's individual needs. Allowing children choice of gender is somewhat limited by the availability of males in these roles. In this study only one of the seven therapists who participated was male[146]. This has an impact on the research data available in this area.

It is difficult to ascertain why the two children in this study, Charlie and L-man, were adverse to male therapists. One possibility is that they had previously experienced, or were currently experiencing negative interactions with adult males. From the therapists' pre-evaluation questionnaires it was clear that a primary reason for referral for both of these boys was domestic violence. L-man had also experienced physical abuse, although it is not clear whether the perpetrator was male or female. Certainly from the small amount of data from this study it is apparent that children can sometimes have strong views about the gender of their therapist, but the preferred combination differs between individuals.

As Wilson and Ryan (2005) suggest, other diversity issues may be more significant to children. The children in this study did not raise any views regarding other diversity issues such as disability, race, ethnicity, or religion. However, there is no specific cue for this in either schedule. Research on children's views of these issues is beginning, for example Beresford (2008) sought d/Deaf children's views of their therapists in specialist mental health settings for d/Deaf children and families in the UK. She found that d/Deaf children expressed a preference for working with a Deaf therapist. Several factors may impact on this preference. For instance competence in the child's first language BSL (British Sign Language) whilst the hearing therapists in this study had some competence in BSL it was not a high level. However, additional factors such as Deaf therapist's understanding of Deaf culture, and children having a Deaf adult role model are also possible reasons for being matched with a therapist who shares identity factors with the child (see Beresford, 2008). Unfortunately, similar to the limited number of males in these roles, choice is limited due to the low number of Deaf therapists.

Unfortunately no d/Deaf children were included in this study, nor blind or partially sighted children nor children with physical disabilities. In Carroll's (2002b) research a

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[146] This is consistent with the ratio in the profession generally in the UK.

letter from a therapist who works with blind and partially sighted children was reproduced stating that she would not be inviting children she worked with to take part in the research because "they 'see' the world in a very different way…(and) could not engage in a semi-structured interview"[147]. This is a clear area of development and an issue I return to in chapter nine.

Malcolm's (2003) unpublished dissertation highlights the gap in the child therapy research, particularly in the UK, on cultural issues. She acknowledges that there is a focus on providing dolls of different skin colours in the playroom but there is little effort made in addressing deeper issues. She highlights that the focus on self-actualisation inherent in person-centred theories of therapy maybe Eurocentric and hold little meaning to different cultural groups. However, she acknowledges that there is scope for NDPT therapists to work in non-oppressive ways within play therapy. Whilst there is a book dedicated to cultural issues in play therapy edited by Gil and Drewes (2005) this is American based. A recent MA dissertation in the UK focused on a small cohort of Bangladeshi participants (five) in the UK and their experiences of play (Fisk, 2008, unpublished) thus research focused on this area is beginning. Hearing the children's views of these issues seems essential.

*What do Play Therapists Do? Following and Leading*
A theme threading through the data was the description of a trusting environment being created by the therapists. As highlighted in the discussion on the play therapy environment above, both physical predictability and emotional consistency are primary aims of the play therapist. Wilson and Ryan (2005) assert that the therapeutic relationship mirrors children's primary attachment relationships. The example given by Elizabeth regarding finding a space to sit and think in the puppet theatre encapsulates the practice of non-directive play therapists. The description suggested that Elizabeth's therapist followed the child's pace and was responsive to her individual patterns of relating. The therapist did not intrude on the safe place Elizabeth had created, rather she afforded Elizabeth the time and space she needed to feel comfortable.

From an attachment perspective the puppet theatre appeared to provide Elizabeth with a 'safe/secure base' in the room (Bowlby, 1973) to which she could retreat when she was

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[147] See Carroll's (2002b appendix six)

feeling vulnerable. Elizabeth talked about her therapist allowing her 'space' when she retreated to the puppet theatre. This appeared to reflect both the physical distance Elizabeth needed and the emotional space, or acceptance of her feelings. Interestingly, Elizabeth added that children can enact a puppet show for the therapist to watch. It appears that she could rely on her therapist to be there as an interested observer, who was reliably emotional responsive, ready to connect with Elizabeth when she felt able to explore and communicate through the puppets. This alert sensitivity is similar to descriptions from Stern's (1985) work on mother and infant interaction where the attuned mother patiently waits, holding her gaze on the infant in readiness for any interaction the infant initiates.

Wilson and Ryan (2005) highlight the need to become a familiar and unobtrusive figure to children at the start of play therapy, in order to create a trusting environment and build a therapeutic relationship. Sarah's comments indicated that the prioritisation of gathering information directly from children compromised the therapist's ability to be unobtrusive, and was rather experienced as intrusive at the beginning stages of therapy. She clearly described a good relationship which later developed with her therapist. However, her message was clear: therapists need to be mindful of pace at the beginning of play therapy. Sarah's views echo the views expressed by older children and adolescents in Day et. al's (2006) study who commented on personal questions at the beginning stages feeling intrusive. This has implications for therapists and clinicians who try to ascertain children and young people's views in their initial assessments to determine whether or not provision of service is warranted. In community mental health settings initial assessments often follow a model of one to three sessions. This is a very limited amount of time to build up a trusting relationship in which children and young people are likely to feel at ease with sharing issues of emotional importance. Such short assessments may elicit little response from the child or young person. This may lead clinicians to conclude that the child or young person is not in need of a service, when in fact this may be a reflection of their difficulties in sharing personal information in the initial stages of engagement. Further research in this area is warranted.

*Permissivity with Limit Setting*
The data highlighted that whilst children are afforded a good deal of choice within play therapy sessions, in order to facilitate their self-expression, there are limitations to ensure their safety, both physically and emotionally. Several children spontaneously

made comments about the limits set in the playroom. Eddie's comments on limits, that play therapy is 'not for being bad' or following the therapist's instructions but doing anything you want as long as 'nobody gets hurt', seem to encapsulate Axline's (1989) second, third and eighth principle of NDPT. These detail that the therapist is accepting of the child, establishes a feeling of permissiveness but sets limits which anchor the therapy to the world of reality[148].

Landreth and Sweeney, (1977:23) argue that "children do not feel safe, valued, or accepted in a completely permissive relationship". This constitutes a central argument for the use of limits in therapy. Wilson et. al. assert that an important balance needs to be struck: "…the skill needed is to establish a level of permissiveness which is sufficient to allow the child to express and explore feelings freely, and at the same time to set boundaries to the child's behaviour which will both offer a sense of security and the potential for certain therapeutic experiences" (1992:205).  Therefore limits which provide safety and security in the play room not only ensure the physical safety of both the child and therapist, but provide an emotional security for the child to explore their feelings (see O'Sullivan and Ryan, 2009). If the child becomes emotionally dysregulated the therapist needs to purposefully misattune to the child to help regulate their emotions to provide a sense of emotional security. The concept of purposeful misattunement and specific examples are explored in chapter eight.  It is clear from the examples above that most of the children experienced therapists setting individualised limits who adhered to Landreth's (1991) advice to set limits only when needed.

*Play Therapists Help You: Talking, Watching, Listening, and Playing*
Children in this study made comments and played about therapists providing help when they needed it. Non-directive play therapists follow the Rogerian principle that every child has an innate drive toward health given the right environment in which to thrive (see Wilson and Ryan, 2005). Therefore they are trained not to intervene and solve the child's problems but rather to provide help only when needed.

Children did share some experiences of employing basic strategies to cope with their emotions. This mirrors Harris and Lipian's (1991) research on children's strategies for changing their emotional state when ill. Similar to the reports by children in this study,

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[148] See chapter two for a full reproduction of these principles.

of being cheered up by engaging in an activity with their therapist, the most popular strategy among six year old children in Harris and Lipian's study was engagement in an enjoyable activity for example playing with toys or friends. For the ten year old's, in Harris and Lipian's study, both activity orientated strategies and 'mentalistic' strategies were suggested. The authors provide an example of a boy sharing that he could read a book as this would get him away from feeling sad and get him 'into' the book. He named several activities he could do and acknowledged that they would be to 'distract him'(1991:247). Similarly 'L-man' 10.10 year old in this study linked the activity of playing a game with forgetting about things. More sophisticated strategies were not described by children in this study. The reliance on language in the Expert Show is a weakness in terms of facilitating deeper expressions of the complex processes which occur in play therapy. This will be explored further in chapter nine.

Children were aware of their therapists' 'watching' them. The children's comments and demonstrations suggested that sometimes they may want play therapists to 'watch' them in order to demonstrate a skill they have acquired. This correlates with children proudly demonstrating to a responsive person their mastery of skills which begins in infancy (Schore, 2003). Other times children appeared to be describing the need for therapists to 'witness' or 'hear' their story through play. Lee's description of his therapist watching his play with animals and trucks was a clear example of this.

A common misunderstanding of NDPT is that the therapist is passive. However, proponents of NDPT, as far back as Virginia Axline, have emphasised that this is not the case: "while the non-directive play therapist's role seems to be one of passivity, that is far from the actuality" (Axline, 1989:60). The children's communications, regarding what play therapists' do, suggest that play therapists are active observers who are sensitively alert and responsive to the child's cues.

*Use of Encouragement, Praise and Congruence*
Axline asserts that "encouragement, approval and praise are taboo in a NDPT session" (1089:90). Since Axline's writing NDPT has evolved. There has been a distinction made between making encouraging statements and offering praise to children in the filial play therapy literature; the former being seen as therapeutic (see Landreth and Bratton, 2006, chapter 14 and Bratton, et. al. 2006). Whilst there were only a few comments about play therapists using encouragement and praise, it was clear that some

therapists occasionally do make encouraging statements.

The use of congruence in NDPT practised in the UK has developed over the years and has recently been fully detailed by Ryan and Courtney (2009). The examples Rob, Emma and Lee gave of their therapist, Judy making encouraging comments about their artwork and/or play are similar to Ryan and Courtney's (2009) description of a therapist sharing their own pleasure when witnessing a child's enjoyment in play therapy.

Ryan and Courtney (2009) provide a full and detailed account of how non-directive play therapists from the UK use congruence within therapy sessions. They highlight the use of the therapists' own feelings which arise within the relationship, and judging when to share these feelings. They assert that "sometimes these feelings mirror children's expressed and half-conscious feelings and are closer to empathic responses" (2009:5). This seems to reflect the experience L-man described above, of mutual excitement. Eddie's play about the therapist figure experiencing discomfort in sand seems to be an example of the therapist's "own, unique, internal responses" (Ryan and Courtney, 2009:5) to the child she is trying to help.

Later in the session Eddie commented that something which was really good about play therapists was their transparency: "there's so much you can tell about 'em"[149]. This seems to demonstrate one of the benefits of using congruence: "Unspoken interactions between therapists and children are clarified and deepened by therapists' stating what they feel" (Ryan and Courtney, 2009:7). Eddie's comment suggests that he developed a deep understanding of his therapist and importantly it was easy for him to read and understand her emotional cues. This seems essential for children who have received confusing, possibly abusive or manipulative emotional cues from adults.

Herbert's description of his therapist being nervous when playing football appears to be a good example of the therapist's congruent sharing of her own vulnerability. It is suggested that this may have enabled Herbert to show his own vulnerability and subsequently accept care and attention from his therapist. This interpretation illustrates an advantage of using congruence highlighted by Ryan and Courtney (2009:7): "Children become more aware of their own feelings … through interacting with and

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[149] (1057)

understanding their own and the other person's feelings within close relationships".

The comments and descriptions by children of therapists using congruence was limited in this study. However, this is expectable for two reasons. First, therapists are trained to use genuine expression of their own feelings relatively sparingly and only when deemed therapeutic (Ryan and Courtney, 2009). Second, congruence is a difficult concept for adults to describe. Therefore the absence of detailed descriptions of this skill by child participants is unsurprising. As Ryan and Courtney (2009:7) describe congruence is "highly personal and expressed differently within each unique therapeutic relationship".

*Importance of the Therapeutic Relationship*
A theme in the therapeutic literature is the finding that the most important factor in the success of therapeutic interventions is the therapeutic relationship, over and above the type of therapeutic model followed (Truax and Mitchell, 1971). There were several comments and play enactments which indicated the relationship being of central importance.

As detailed in chapter four, Ryan and Wilson argue "NDPT recreates conditions similar to the optimum socialization processes of an infant and carer during normal development" (1995:30). They highlight the common assertion that the therapeutic relationship has important attachment properties similar to an individual's primary relationships. These properties include "emotional availability, dependability, empathic attunement, sensitivity to developmental needs and provision of comfort and security" (Zeenah et. al.,1990, cited in Ryan and Wilson, 1995 p.30). Sarah's comment about a "bond or communication" developing suggests that she found her therapist to be emotionally available and attuned to her. Sarah's further comments on children developing trust with their therapists also highlights the therapist as a dependable figure. Sarah described her therapist being accepting of her need to play in the sandpit (as detailed in the section above on 'gender and age appropriate toys'). Whilst this is arguably a developmentally younger activity to Sarah's chronological age (11.6yrs), it demonstrates the therapists' sensitivity to Sarah's developmental needs.

Sarah's comments and Herbert's description of his relationship with his play therapist 'growing' and 'hardening' truly encapsulate Axline's (1989) first principle of NDPT, of a warm, friendly relationship with the child being developed. Furthermore these

comments emphasise that these two children experienced a trusting relationship. This echoes Day et. al.'s (2006) finding in their study on older children's views of family therapy. Wilson and Ryan (2005) argue that the therapist's role is to show children that "they can trust us to trust them and that they can thus trust themselves" Erikson (1968:97).

It is also of note that both of these participants made comments about things they did not like about their therapist, or things she could do better[150]. This implies that these participants felt safe enough in their relationship with their therapist to share both positive aspects of their experience and more difficult feelings.

**The Family**

In this section I return to presenting the findings on the middle phase of play therapy. Specifically I detail the comments and demonstrations children made about family figures and their role in relation to play therapy. Several of the children in this study mentioned their carers or other family members' roles.

*Support from Parents*

Three children highlighted that their parents could be relied upon for support (Marble, Leanne, and Cathy). Marble played out her therapist getting her parents' help when she was hurt. Cathy commented on the support afforded to her by her parents at the start of play therapy. Leanne commented on how children could tell their mum if there was something they did not like during the course of play therapy.

*Support from Extended Family*

Support from grandparents was suggested in two children's play. In Susie's play enactment in the 'Miniature Playroom' it was clear that her granddad played an important supporting role in transporting Susie to therapy. Lee enacted a nanny figure supporting him (discussed below). Cathy talked in a positive manner about big brothers and sisters coming to the centre. It is unclear what role her siblings had, but likely they came and waited with her parents. Emma expressed involvement of siblings during the home visit in a neutral way: two babies and a sister were introduced.

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[150] See section above Play Therapists…Show Acceptance re: Herbert and Play Therapists…Sometimes Take the Lead re: Sarah.

*Mixed Support and Availability from Parents and Extended Family*

Herbert, Eddie, Lee and Gabriella all mentioned both support and difficulties or some form of ambivalence in their relationship with their parents. Herbert suggested that he could only tell his mum the good things about play therapy. Herbert also commented on needing his parents if he were having an asthma attack. Herbert's mixed feelings are discussed further below with regards to joint play therapy[151].

Eddie also commented on his therapist taking him to his parents when he was hurt. However, Eddie played out parent figures being distant from the child figure during play therapy sessions by enacting the parents going shopping. There are no specific prompts in the PBE schedules regarding the parent figures *during* the sessions. Parent figures are introduced in the 'Miniature Playroom' at the start of the story. The therapist enacts the parent figure arriving with the child figure and then sitting in the waiting room. The parent figures are not referred to again by the therapists. Therefore the spontaneous commenting by Eddie about his parents, what they were doing and where they were during his play therapy session, signified that this was likely to be an issue of personal importance to him. It certainly highlights that he was aware and thought about what his parents were doing and where they were during his time in the playroom. Furthermore the significant physical distance Eddie moved the father figure (to the far side of the table) in his play conveys a sense of distance and unavailability. Potential difficulties in the parent-child relationship for Eddie were also pointed to when he explored his feelings about the ending of the play therapy intervention. Eddie's therapy ended due to the therapy service prioritising work with Eddie's parents (this is discussed in more detail in the section on endings). Eddie also represented extended family being unsupportive. He enacted a brother figure pushing the child protagonist during the initial home visit. However, Rachel, Eddie's therapist, recorded that Eddie did not have a brother and it was possible, drawing from information in sessions and the progress meeting with parents, that this hostility represented Eddie's relationship with his father.

Lee's comments about the support of his parents also reflected mixed feelings. During the initial choosing of characters for the stories he dismissed the parent figures. With regard to progress meetings Lee suggested that his parents were only supportive of the play therapy on the condition that he was well behaved (see section on progress

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[151] The reader is reminded that Herbert's mother observed/joined in 6 of the 9 therapy session.

meetings below for further details). He demonstrated the child figure taking his paintings with him from the playroom and returning to the parent figures. The parents were portrayed as being at least physically available. In another story he commented that his mum and dad were waiting in the car in the car park for him, whilst emphasising his nanny as the central support figure. He commented on nanny taking him to his sessions, and within the story he wanted nanny to be invited to the progress meeting. Lee's therapist noted in the post-evaluation questionnaire that Lee did not have a nanny and his mother had grown up in care. She suggested that Lee may have a desire for a grandmother figure and that his play prompted her to find out about possible external family supports. Thus, the evaluation prompted an important awareness of further needs.

*Joint Play Therapy*

For three children in this study, Herbert, Rob, and possibly Elizabeth individual play therapy was adapted to incorporate an element of joint play therapy, whereby the parent joined the child for part of the session. There were also two children, Hannah and Gabriella, who were in the process of changing to filial play therapy. Therefore they had some experience of play therapy sessions with their carer(s) observing, in preparation for filial therapy to begin.  See Table 6 in chapter six for details of the interventions employed.

Herbert's mother joined him in play therapy sessions for six out of the nine sessions. Overall he was positive about the experience, however he did share some mixed feelings. Early on in his evaluation session difficulties in the parent-child relationship were alluded to. He said that he and his mum had 'separated' and that his mum had had enough of his anger (see section above on Beginnings: reason for referral). He further expressed his mixed feelings when he was asked about his mum joining his time:

> **Herbert:** Well:::{looks downward} if you do love your mum: *real:::ly* much you'll feel joyful {looks upwards} but→if→you're→ like::: kin:::d of like ratty {looks downward} with with her sometimes like or she annoys:::: ya' sometimes[152]

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[152] (729: 731) → =fast speech ::: = elongated communication

He expanded on this and appeared to suggest that a child might not be completely genuine with their mum:

**Polly:** …is there anything↑ that I won't↑ like about it↑

**Herbert:** Well like I say:: if you not really *keen:::* on her {takes phone away from ear looks at phone presses buttons} and then::: you don't really *like↑* her or someit

**Polly:** Um::

**Herbert:** {manipulates phone} You could just er say 'ah:: {Scrunches up cheeks looks at therapist} are you OK↑:: mum↑' {false concern tone of voice looks at phone again manipulates phone} and she'll just say '*yer↑*' and you'll just say 'yer:::' and then she could just join in:::[153]

However, he had previously expressed his excitement that mums might be allowed to join in playtimes, stating that after a few sessions "there's a *good* chance you'll play with your *mum* as well:::"[154]. Subsequently he was asked by his therapist (in role as a child caller) whether children play on their own or with the therapist. Herbert made the distinction again between having sessions with the play therapist on your own at first, but then your mum joining. Herbert's positive feelings about his mum joining him in play therapy really came to the fore when his play therapist asked him if there were any special things that happened to him during his play sessions. Herbert responded: "Er::me me *mu::m real*ly↑ coming in *yer↑* so that was a kinda special"[155]. Later he specifically identified painting with his mum as being special. He also emphasised that the benefits of joint play therapy include having the opportunity to *play* with your mum.

Rob spontaneously suggested doing a story where the mother figure came in for the last session. Rob's affect and non-verbal communication suggested that this was a positive experience. However, Rob did not refer to the mother figure again as he became distracted. His therapist did not lead him back to thinking about his mum being in the last session so there was no further exploration of his views of her being included. Similarly, Elizabeth simply stated in a neutral manner that sometimes your mum or dad will come in and watch. Again there was no further exploration of this. Therefore,

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[153] (757:765)
[154] (220)
[155] (441:442)  ↑ = intonation up ::: = elongated communication

beyond Elizabeth's neutral demeanour and her spontaneously volunteering this information, there are no further clues as to how she felt about this happening. Her therapist, Judy, did not record on the questionnaires that Elizabeth's parents observed the sessions. Therefore it is likely that this was only minimal, or wished for.

Gabriella stressed the importance of being able to choose whether or not to invite her mum in for the last five minutes of her sessions. Her comments suggested that she would not be comfortable with her mum witnessing her anger in the playroom. She made it very clear that if she was feeling angry she would choose not to have her mum present. The only child who experienced joint play therapy but did not comment on it was Hannah. Interestingly the therapist later reported that the joint work and planned move to filial therapy did not progress.

*Progress Meetings*

Fifteen children made comments about the progress meetings play therapists hold with parents/carers/professionals. The four remaining children were not asked about the progress meetings (Hannah; Gabriella; Elizabeth and L-man). It is likely that they were not asked due to therapists' responding to these children's waning levels of engagement, particularly as this question is in the latter part of the schedule. Of those children who did share their views about the progress meeting, six of them knew at least something about the meeting. Eight of them did not know what happened. Three of these children appeared to find this experience of 'not knowing' difficult, and suggested additional attendees at the meeting. The five other children made neutral comments about 'not knowing'.

*'Known'*

One child shared her knowledge of *who* would be present at progress meetings. Marble enacted a teacher attending the meeting in addition to the parent figures. The remaining five of the six children who 'knew' something about progress meetings referred to *what* was talked about. Herbert, Martin, and Sarah commented that it would be a time for 'them', seemingly referring to the parents and therapists, to talk about what they (the child) had been doing in the playroom, and specifically what they liked.

Several children specifically referred to the 'progress made in therapy' being the topic of discussion in these meetings. For three children this was either mixed or neutral

progress. Lee commented that his mum would report a mixture: sometimes naughty and annoying sometimes very helpful and polite. Judy, his therapist recorded that this was a true reflection of his mother's feedback. Rob commented that "they'll talk about your personality" and proceeded to comment on the mixed progress he felt he'd made. Leanne commented that they'll talk about "how you've been".

Two children made explicitly positive comments about the meetings. Jack commented that the child caller would feel 'happy' about the meeting and Sarah, who was the only child in the study known to attend a progress meeting,  concentrated on the positive feedback about her development. It appeared that overall these children, who knew something about progress meetings, were positive about the meetings taking place.

*'Not Known'*

For some children knowing what happened at progress meetings did not seem to be a significant issue. Five children expressed relatively neutral feelings about not knowing what happened at progress meetings and/or were unclear about what would be talked about. For example Marble used the general term "play therapy type stuff"[156] to refer to what would be talked about and then abruptly disengaged the caller. Rob commented on not being there so wouldn't know what happened, and Susie said she could not remember talking about the progress meeting even with prompts from her therapist. Bob asserted: "there's nothing to be worried about"[157] and Billy stated: "…you won't even realise because you'll be too busy at school honestly"[158].

In contrast Lee and Eddie shared negative experiences of the elements of the meeting which they did not know about.  For Lee it appeared that his anxiety was about 'not knowing' whether the child figure (in the 'Miniature Playroom') would be continuing his sessions. He shared his worry that the parents might punish the child by withdrawing play therapy. A similar issue arose for Eddie. The mother figure had attended the meeting to ask for an extension to therapy. Eddie demonstrated how confusing 'not knowing' the outcome of the meeting was for the child figure. His therapist, Rachel suggested that the child figure might have preferred to be there:

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[156] (542)
[157] (433)
[158] (516)

**Rachel:** …I wonder how Josh (child figure) feels while his mum [and Lisa are having a chat {looks at child:::} while he's at school {looks at child:::}

**Eddie:**                                                                    [{looks at therapist}

**Eddie:** He feels bad {eye contact:::} because he doesn't really know what they're talking about

**Rachel:** {eye contact:::} Right he feels really bad because he doesn't know [what they're talking

**Eddie:** [{looks at figures on table}

…

**Rachel:** yeah and that doesn't feel so good I wonder whether Josh would have liked to have been there when mum and the play lady talked {looks at child:::}

**Eddie:** {nods head}

**Rachel:** Yeah {nods head looks at child:::} that would have felt better[159]

Rachel confirmed on her questionnaire that Eddie himself had not attended the progress meeting. Both Lee and Eddie shared that the child figures request for an extension to therapy was successful. However, the therapists would have to check with their managers first. Both actual therapists confirmed that this mirrored the children's actual experiences.

Similar to Eddie, Charlie also suggested that a child caller, on the 'Expert Show' should be invited to the meeting although he did not explicitly share that it was negative not being involved. It was implicit in Charlie's use of language that he felt this would be a preferable option. During the 'Expert Show' Charlie took on the role of therapist and invited the child caller to come to the meeting. Charlie added that he, as the therapist, was feeling 'generous' implying this was the right thing to do. Charlie also asserted that someone outside of the nuclear family should be invited to the progress meeting, in this case a representative from school.

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[159] (557:600)

**Summary of Children's Views of the Parent's Role and Progress Meetings**

The role of parents and other family members has been presented. Children had a mixture of experiences, some felt supported by their parents and others had mixed views. Some children in this study experienced greater involvement of their parents in their sessions. Overall this increased involvement was a positive experience for children. Children's views of progress meetings indicated that several children have neutral feelings about the meetings. However, others had negative experiences due to not being included or being given enough information.

**Discussion and Implications of Children's Views of the Parent's Role and Progress Meetings**

*The Parent's Role*

As noted in chapter two, there has been increasing recognition of the important role parents and carers play in successful therapy interventions (see Bratton et. al. 2005). The children's comments about relying on their parents for help and support if needed echo Wilson and Ryan's (2005) stated rationale for asking parents to wait nearby for children during the therapy session. This is to ensure parents/carers are both physically and emotionally available to children should they be needed during the therapy session; to act as a 'safe base'. Five children's comments suggested that they felt they could rely on the 'safe base' of their parents when their careseeking system was activated (Bowlby, 1973). In all of these instances the children describe incidents, illness or hurt, where it is expected that children's attachment behaviours would be activated (Bowlby 1973). Whilst these scenarios all depict physical hurt which needed attending to, it is highly likely that, in keeping with attachment theory and research, these children required emotional support at these times also.

Eddie's comments and enactment of parent figures being unavailable during sessions made it clear that children can be very aware of their parent's whereabouts during the session, and a trip to the local shops can feel like a big distance to children. His comments reinforce the rationale stated above of parents and carers acting as an emotional 'safe base' when they wait nearby.

Wilson and Ryan's (2001) findings suggest that it is possible for individual play therapy to have a positive impact and change on parental behaviour. Rachel, Eddie's therapist recorded that his parents did make changes at home following the progress meeting,

including having more fun at home and his mum becoming more involved. Reportedly Eddie had noticed this improvement and commented on it. However, it seems that this was not sustained in Eddie's case and his PBE indicated that in his view the therapy was ending prematurely. Rachel noted her surprise and concern at how sad Eddie was during the PBE. Furthermore, Rachel noted that Eddie seemed to use the 'Miniature Playroom' part of the session to work through ongoing emotional themes, for example hostile relationships within the home setting.

Rachel reflected upon her difficult decision making regarding whether it had been appropriate to offer play therapy to Eddie as she had concerns for his safety at home. Rachel indicated that the therapy was ending after eight sessions due to prioritising support for the parents. Without knowing further details of the case and the extent of the possible child protection issues it is not possible to know whether or not this was the best course of action. Clearly Eddie felt he was benefiting from play therapy (his pervasive feelings of sadness regarding the ending are presented in the section below), Rachel could also identify positive changes, and his parents were becoming more involved. Arguably, Eddie's parents engaged due to the initial focus on Eddie which, as Wilson and Ryan (2001) argue may have been experienced as less intimidating than work directly for them e.g. a parenting group. It seems highly possible that continuation of the individual therapy with Eddie alongside parent work may have been the best combination. However, from the information provided by Rachel it seems that other funding and service constraints are likely to have had an impact on this decision. This indicates that a comprehensive and flexible service is often needed to meet the child's needs. This may entail work with both the child and the parents rather than taking an either or position. If individual therapy only, is offered, in cases where the parents are not fulfilling the child's needs, consideration of a longer intervention with more progress meetings or integration of the parents in the sessions may be an effective way of working.

Herbert's therapist, Polly, was able to actively engage Herbert's mother who was supportive and willing to engage in joint play therapy. Here the therapist was able to support the primary attachment relationship. Whilst Herbert expressed mixed views about mothers' being involved in play therapy, it appeared, overall, that he found this a positive experience and he enjoyed having his mum join in the therapy. This lends support to the growing literature on the increased effectiveness of interventions when

parents are involved in therapy interventions (see Bratton et. al. 2005 and Freisinger, 2005 unpublished).

Gabriella's comments highlight the need to deliver highly individualised interventions and maintain the child's ability to chose and maintain confidentiality at times. Hill's (2006a) research highlights the benefits of working together with parents in therapy but also the tensions in maintaining a child's confidentiality. It seems Gabriella's therapist, Polly, was actively working toward creating a balance between the 'partnership approach' with parents and carers and respecting the child's need for privacy.  Previous studies have focused on parents' and therapists' views of being involved in children's therapeutic play sessions (e.g. Freisinger, 2005, unpublished; Cleveland and Landreth, 1997; Hill 2006a[160]). In Carroll's (2002b) research two children made brief mention of their carers taking them to therapy and the therapist briefly talking to the carer in the waiting room. The current study expands on this data. The children in this study had experienced a range of involvement, from parents/carers transporting and waiting for them, and attending progress meetings through to observation and/or active involvement in the sessions. Overall their views support the wider research that working in partnership with parents is helpful.

Further research in this area is warranted and is already underway. PBEs have been employed in a wider research study, by the author and Ryan, to ascertain children's views on filial therapy and play with parents who have undertaken the Webster-Stratton parenting programme. Other implementation and adaptations to PBEs to ascertain children's views in therapy are suggested in chapter ten.

*Progress Meetings*

Previous research on children's views of individual or group play therapy (Carroll, 2002 and Brownlie, 2006, unpublished, Green and Christensen, 2006) did not actively seek children's views of parental involvement nor progress meetings. Children's views, expressed in this study, point to the benefits of children themselves being included in progress meetings. The one child who did attend the progress meeting, Sarah (11.6 yrs),

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[160] In Hill's full study (2006b, unpublished) two young people and one young child were interviewed about their views of parents being involved in their therapy sessions. However, it appears that the two young people did not experience and did not want active involvement of their parents and the younger child did not share any views on this subject. Hill experienced significant recruitment difficulties when gaining consent to interview the potential pool of 17 children in his study. The resulting sample was 3.

spoke positively about it and was subsequently more aware of the issues discussed in this meeting. From a therapist's perspective there may be both practical and therapeutic issues to take into consideration with regard to children attending these meetings. It may not always be appropriate for the child to attend the entire meeting, and not all children would want to do so.

The need to balance children's rights to participate by attending meetings, which affect their care, and the child's right, to protection from potentially stressful adult discussions in the context of child protection meetings has been considered by Farnfield (1997) and latterly by Noon (2000). Progress meetings of therapy are not likely to be as stressful and emotionally charged as a child protection meeting. However, the principles of balancing the child's welfare and rights are similar. Turning to the research on statutory review meetings held for looked-after children provides further, perhaps more comparable data. Thomas and O'Kane, (1999) conducted a large study including the views of 225 looked-after children (aged 8-12 years), regarding their participation in statutory review meetings. They found that invitation to attend the meeting was influenced by the age of the child 63% of children aged 8 were not invited compared to 16% of 12 year olds. Reportedly most children thought that *all* children should be invited to attend at least part of the meeting, regardless of age. The authors found that fewer than a third of children (32%) had been consulted about who they thought should attend. Choice of time was only afforded to 23% and place to 24% of children.

Unfortunately, in the current study, data regarding how many children were invited to attend their therapy progress meeting and whether they were given choices regarding attendees, time and place was not obtained. However, it was clear that when children themselves do not attend they can be left with anxiety about what is discussed and several children would chose to go to the meeting if they were invited.

Some of the children in the current study also shared their own ideas about who should be invited to their therapy progress meetings. It is clear that this is individual to the child. For instance one child may have a supportive relationship with a grandparent whereas for another child the important figure may be their teacher. Play therapists are encouraged to think and work systemically during their training. However, there is little reference to progress/review meetings, where there is a clear opportunity to engage the wider system around the child, in the play therapy literature. The authors who do touch

on this area tend to focus on the issue of confidentiality in relation to progress meetings, rather than who should attend the meeting or preparing and de-briefing the child (see Wilson and Ryan, 2005; Crane 2001 and Landreth, 1991). In practice, although play therapists do hold meetings with a wide range of important people in the child's life, it is not general practice to ask the child if they have suggestions of who is important to them and should therefore attend these meetings. This is an area where the child's view is easily overlooked. In fact children may be able to help the therapist to identify supportive alliances which could be formed to support the individual work. It is suggested that play therapists' could more actively seek children's views regarding progress meetings, in terms of the child's own attendance, other attendees and what is discussed.

Returning to Thomas and O'Kane's (1999) study, preparation for looked-after children's review meetings involved discussion between the child and social worker in 88% of cases, consultation papers in 28% of cases, and alternative forms of communication such as activities or direct materials in only 14% of cases. Children reportedly found the meetings tedious and sometimes intrusive due to personal details being discussed in front of several adults including their teachers. Many participants complained that reviews involved sitting around and talking. They commented on the use of games and activities in the actual research study which they thought could usefully be used in the review process to make them more fun

In play therapy training therapists are encouraged to ask children if they want to attend part of the progress meeting or if they have a message they want to convey to their parents. Similar to some family therapy sessions, the need to have the primary focus on the parent and adult issues maybe indicated for at least part of the meeting. This is usually done through verbal communication. However, as Stith et. al. (1996, reviewed in chapter three) advocate with regard to family therapy sessions offering the child a range of ways of participating may be helpful. For example, writing or drawing, or bringing a puppet along to a progress meeting of the play therapy intervention may be an easier way for children to share their views during therapy progress meetings.

In this part of chapter seven I have detailed the children's views on the middle sessions of play therapy. The importance of choice emerged as a strong theme along with the therapist taking on an active observing role and helping children in a variety of ways.

Children also made several comments regarding the role of their family in play therapy indicating that many therapists consider not only the child's individual needs but the family system. Greater involvement of children in progress meetings was also indicated. I now turn to children's views on the end of the play therapy process.

## Play Therapy: The End

Children's feelings about ending play therapy are discussed in this section. Mixed feelings about the ending process were shared. Some children in this study found it difficult to explore their views on ending, the process of their exploration is discussed. Children were asked about the length of the therapy intervention and their views are presented in this section along with their comments about the outcome of play therapy.

### Children's Feelings about the End of the Play Therapy Intervention

Herbert and Jack named feeling sad. Herbert also highlighted that he thought children would leave the playroom with a "really happy joy"[161]. Susie named feeling scared. Billy acknowledged a mixture of being scared to go for the last time but "happy that's he's got through it"[162]. Cathy acknowledged that she would miss the playroom. Cathy also mentioned that "new people come all the time"[163] after your own play therapy has finished. However, she said this in a confident tone of voice which seemed to indicate it was not something which negatively affected her.

Martin highlighted the mixed feelings children might have about the end of their sessions. He stated that they might feel happy angry or sad. Unfortunately these feeling states were not explored further within Martin's session. Leanne shared mixed feelings of being sad that her therapy was coming to an end but happy because she had been missing out on other things by going to therapy. This sentiment was shared by Billy, Marble, and Bob.

A strong sense of both sadness and confusion were evoked by Eddie about his play therapy sessions ending, both in terms of his verbal statements and his sad and low demeanour during the evaluation session, which in itself is an ending. This was

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[161] (813)
[162] (612)
[163] (474)

particularly evident toward the end of the session and when he was responding to questions which focused on the ending process:

> **Rachel:** [{eye contact} and it's their last play time together and
>
> **Eddie:**   [{bites lip}
>
> **Rachel:** I wonder if you can show me what happens next
>
> **Eddie:** {kneels up gets close to miniature playroom puts something into the playroom moves child figure toward object picks up therapist and child figures}  [What's the matter? oh well it's my last playtime
>
> **Rachel:** [{looks at child:::}
>
> **Eddie:** and *I feel very sad* oh didn't you hear you've got two more have I?   [oh no I forgot {child laughs}
>
> **Rachel:**[oh so he {smiles looks at child::: laughs}
>
> **Eddie:** {smiles} It's your last today er
>
> **Rachel:** So it really is his last one today before he was a bit confused but now it really is his last one[164]

There was an element of confusion within Eddie's 'Miniature Playroom' story. He began playing out a story about the *final* session, but then replayed the moment he was told he had two more sessions. This confusion parallels the confusion of the child figure expressed in the story. His non-verbal communication lightened when he recalled this and realised his confusion in the 'here and now' of the evaluation session.

Eddie's feelings about the ending seemed to be particularly entwined with a sense of loss of the therapeutic relationship. Eddie proceeded to explore how difficult he found the ending as he continued the story about the last play session enacting the therapist figure giving him time warnings:

> **Rachel:** I wonder how Josh (child figure) feels {looks at child:::} when the time is running out
>
> **Eddie:** Josh where are ya? {as therapist figure}
>
> **Rachel:** Maybe he's hid maybe Josh doesn't want to go
>
> **Eddie:** Slip {makes therapist figure somersault and fall on the floor}

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[164] (619:631)  ::: = elongated communication [ = overlapping communication * * = quieter voice

**Rachel:** {looks at child} Oh now she's got hurt and it's really:: feeling like a disaster {nods head looks at child:::}

…And they go in the end I wonder what that was like for Josh

**Eddie:** *right bad* {moves furniture out of playroom}

…
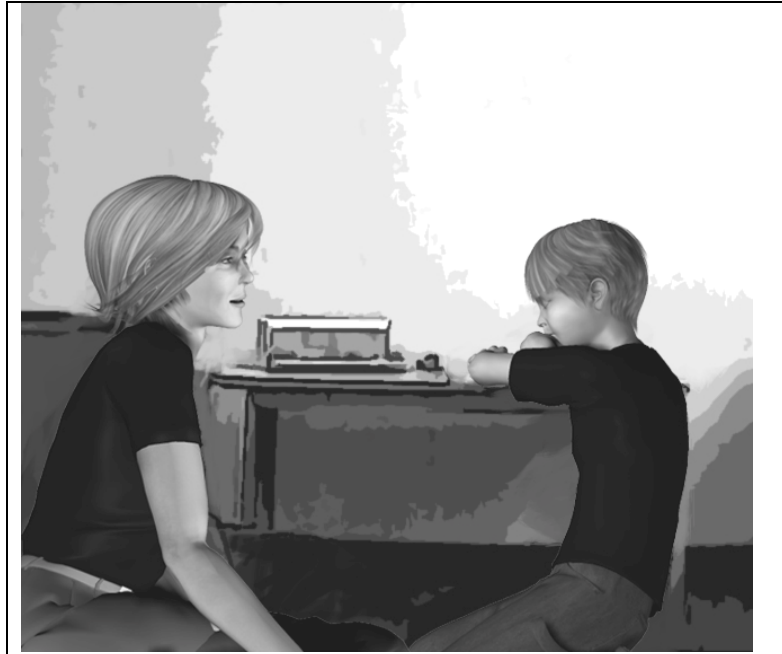


| **Eddie:** And he didn't {rests head down briefly on arm} he didn't want to leave Lisa {eye contact:::} [165] |
| --- |
| **Figure 3: "He didn't want to leave Lisa"** |

As noted above, Eddie's non-verbal communication matched his verbal statements of sadness. His affect and body movement were flat and lifeless. In addition Eddie held onto the therapist figure which seemed to communicate on a symbolic level that he did not want to let go or say goodbye to this important person. An element of catastrophe was introduced to the story, with the therapist figure hurting herself.

Eddie's strong feelings of sadness and loss about the end of play therapy were pervasive. He referred to them throughout the evaluation session. During engagement in the 'Expert Show', Eddie was asked about changes in play therapy. He began by responding to the question and then became focused on the idea that the pretend 'child callers' will be having play therapy instead of him. There was a sense of him feeling replaced. He called these new children a "lucky bunch". Toward the end of the

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[165] (639:655)

evaluation session the intensity of Eddie's feelings about the loss of the therapeutic relationship were heightened and his therapist responded in a highly therapeutic manner.

*The Importance of Keeping Memories*

Three children referred to keeping artwork they had created during their play therapy sessions. Within the 'Miniature Playroom' Eddie referred to a model which the therapist figure said she would keep for the child until the last day. Similarly Sarah referred to collecting the things she had made in a memory box. Marble emphasised the importance of exchanging pictures with the therapist. Lee wanted to exchange paintings with Judy in the evaluation itself and Rob wanted a photo of her.

*Difficulty in Exploring Endings*

Four of the children in this study seemed to find communicating about endings particularly difficult. During the 'Expert Show' Martin was able to talk for a short while about endings but then disengaged the call pretending that the line had gone dead. Similarly Marble gave an abrupt answer to the question about how children feel when play therapy ends and then disengaged the call. Susie was able to share that she thought 'the girl' felt scared because it was her last session and then disengaged from the task and expressed a need to play.

It is important to note that Susie found it difficult to engage in the PBEs in general and expressed a need to play throughout the session. Thus her difficulty and avoidance via distraction, in relation to this question about ending, is generalised across the whole session rather than specific to the area of endings. However, it is interesting to note that it appeared that Susie continued to have unresolved emotional issues and her strong need to play - which overrode her engagement with the PBEs - was a clear indicator to the observer that her sessions were finishing prematurely, this was confirmed on reading the therapist's questionnaire. The timing of PBEs is a topic I will return to in chapter nine.

During the 'Expert Show' L-man asked his play therapist to take the call about endings and answer it for him. This was in contrast to his responses previously in the evaluation session. He remained engaged listening and responding non-verbally to the therapist's suggestions about his feelings. He appeared to affirm with nods and eye contact that she was accurate. Similarly Sarah found it difficult to answer the question about ending,

saying she did not know. Again this was in contrast to how articulate and full her other responses were.

It should also be borne in mind that children may have experienced difficulty in answering the questions on endings purely because these questions come at the end of the interview schedule in the actual evaluation session itself. By this point children may be feeling tired and they may be affected by the parallel process of the evaluation session coming to an end also. Furthermore for Sarah it is highly possible that she was distracted by looking out of the window and seeing her parents arrive in the car park ready to collect her.

**Length of Play Therapy**

Most children were specifically asked their view on the length of the play therapy intervention. They were asked whether they felt they had had too many times, just the right number, or not enough. Their responses are explored here, these highlight children's experiences of therapists consulting with them and being flexible about the length of the intervention. This was an issue arising from the data rather than being prompted by the interview schedule.

*'Too Many'*

The only child who gave any indication that their play therapy intervention might have been too long was Herbert. He felt that a child "might get bored of the playroom"[166]. However, this may reflect Herbert trying to please the child caller rather than directly reflect his view. This is suggested because the therapist enacted the child caller having completed two sessions less than Herbert. Herbert confirmed that he personally did not get bored. He shared that he "just loved it"[167].

*'Just Right'*

Martin and Jack both shared brief responses that they felt the number of sessions they had was just right. Billy shared that he was not sure what would happen if a child was not ready to finish play therapy. He supplied possibilities but again it appeared that this was not the position he found himself in and that he was ready to finish. Similarly Cathy shared that a child is likely to have mixed feelings about the ending. On the one hand

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[166] (815)
[167] (816)

she felt they would express their desire to continue play therapy, but on the other hand they would recognise that they had received enough sessions.

*'Not Enough'- Premature Endings and Moving on*

A premature ending to play therapy and being referred onto other services was a significant issue for Leanne. Leanne made it clear that she did not feel that she had had enough play therapy sessions (see chapter nine for a discussion on the use of PBEs in the case of premature endings). She shared that she still did not feel safe and that she continued to feel scared. Later in the evaluation session she shared her sadness about ending. Her non-verbal communication added to the sense of discomfort Leanne felt about her play therapy sessions having to stop and the possibility of her being referred onto another service. Similarly, as previously stated, Susie's therapy appeared to end prematurely.

Rob shared that he didn't know if his fourteen sessions had been enough. However, he then suggested children should have "two hundred…or more"[168]. Later in the session he enacted the child figure painting and became absorbed himself in painting a butterfly. His therapist reflected his desire to prolong his own play therapy in the evaluation session itself. He provided affirmation of this suggestion with an excited whisper and nod of the head. An older child, L-man, was verbally explicit that he had not had enough sessions and repeatedly stated that he wanted more.

*Flexibility and Consultation*

For several children flexibility and consultation regarding the length of the play therapy intervention seemed to be an important factor. Herbert and Cathy highlighted that if a child needed to go back to play therapy in the future, that option would be available. L-man and Sarah shared that if a child didn't want to finish their sessions they would probably get more.

One therapist in this study, Judy, took a graded approach to the ending process of play therapy with a number of the children who participated in this study being invited to return for 'monthly visits'. This highlights a particular approach to endings taken by this therapist. It is likely that this is used for some but not all children dependent on their

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[168] (843:845)

individual needs, and possibly the pressures on the service this therapist works in. For Charlie it seemed to be a comforting thought that he would be returning and play therapy would be phased out rather than completely ending. Elizabeth also shared a positive view of monthly visits.

Lee explored his feelings about the process of moving to monthly visits further. Judy acknowledged his desire to continue coming for a long period of time and yet put realistic parameters on what was possible. This discussion had a feel of collaboration and compromise where the child's voice was heard. He was a part of the process of his sessions ending and he resolved that what was on offer would probably be good enough. It was agreed that this was not categorical and there was continued room for review and flexibility.

Bob's demeanour and tone of voice indicated his sadness about ending weekly play therapy sessions and moving to monthly sessions. However, he highlighted the fact that going to therapy sessions had meant that he had missed out on things at school. It was not altogether clear how Bob felt about returning to his lessons. However, his response directed the focus to life outside therapy and moving on. When he was asked directly about whether he'd had enough sessions, he appeared uncertain in himself but trusting in his play therapist to have made the right decision. It was clear that in Bob's experience it is the therapist who makes the choice about when play therapy should end. However, it seemed that his views had been taken into account and he himself felt ambivalent about whether or not it was the right time.

Marble also experienced the decision to end therapy as the therapist's domain. She made two comments about the child having no choice about when the sessions end. However, later in the evaluation session she played out a child ringing in to tell the therapist that she was not coming to her session because she was missing out on going to a party. Thus a similar theme of ambivalence to Bob was evident. On the one hand Marble appeared cross that her therapist made the decision that it was time to end, but on the other she portrayed the child figure giving her therapist signals that it was time for her to move on and return to normal daily life that she had been missing out on.

**Outcome of Play Therapy**

Six children were not asked about changes after attending play therapy. Three children said that things would still be the same after attending play therapy. Two children described mixed progress. They described some improvement but highlighted outstanding difficulties. Eight children reported positive changes in play therapy. Several of these comments were about positive changes in feeling states. Other changes focused on internal states labelled by the children as "personality" (Eddie[169]); "lifestyle" (Herbert[170]) or "quit being bad" (Elizabeth[171]).

*No Change*

Jack, Leanne and Rob all said that things would be the same after play therapy had finished. As discussed above, Leanne's therapy stopped prematurely and both Leanne and her therapist felt that the intervention had not met Leanne's therapeutic needs. With both Jack and Rob it was difficult to tell how much their comprehension of the evaluation session influenced their responses (this is discussed further in chapter nine).

*Mixed Progress*

Whilst Martin identified change in other areas he acknowledged that his anger was still the same. As noted above in the section on progress meetings, Lee reported mixed progress also.

*Positive Changes in Feeling States*

There were eleven comments about feelings positively changing after a play therapy intervention by six of the children. Herbert and Martin highlighted a decrease in sadness and increase in happiness:

Herbert: *Well sadness can* go away sometimes:::[172]

Herbert: (.)  I think it's gonna (.) {nods head} you know:: *leave::* with a *real*ly→ha↑ppy→joy::[173]

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[169] (987)
[170] (435)
[171] (134)
[172] (443) ::: = elongated communication (.) = a noticeable pause → = fast paced speech ↑↓ = intonation up/down
[173] (813)

Cathy shared that all 'your worries will go'[174] away in play therapy. Similarly Elizabeth and Billy's worries left them. They both emphasised the significant difference they felt play therapy would have on children.

Five children referred to anger or rudeness reducing and/or feeling calmer (Herbert, Elizabeth, Sarah, Cathy, and L-man). Herbert was highly articulate about the process of play therapy. He summarised the reasons a child might have worries and behave angrily, and the impact play therapy can have. His therapist asked him what would change, he replied:



**Herbert:** {looks slightly upward puts phone to ear eyebrows raised looks downward} *Well* your *life*↑style real::ly↑ …

…go to the play session sessions to re:::*lax*

**Figure 4: "…to re::*lax*"**

…

**Herbert:** …Like have fun: because→ if→ you're→ *an::gry*↑ play things er (.) makes ya':::: you know::↓ (.) dead (.) comfortable {gestures with left hand raises slightly and flops hand back down onto back of chair}[175]

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[174] (255)
[175] (435:437)

He explained that play therapy can help you to relax. As can be seen in Figure 4 above Herbert's non-verbal communication mirrored his verbal statement as if to affirm that he can now feel relaxed as his worries have left him.

**Summary of Children's Views of the End Phase of Play Therapy**

With regard to the end of intervention children tended to express a mixture of feelings; both sadness and a sense of happiness and triumphant feelings that they had overcome their difficulties and could return to everyday activities. For one child, Eddie, the ending was particularly difficult and a sense of deep sadness was expressed. Other children found it very difficult to talk or play about the ending indicating that they too found the ending hard.

Children's views regarding the length of therapy have been presented. Some children felt this was 'just right' although four felt they had not had enough. The importance of therapists consulting with children regarding the end of play therapy and being flexible in their decision making has been highlighted. Overall children indicated positive change in play therapy. Only one child clearly expressed her view that there was no change and in this case the therapy was ending prematurely due to funding constraints.

**Discussion and Implications of Children's Views of the End Phase of Play Therapy**
*Endings*
The mixed feelings expressed by the children in this study regarding endings mirror therapist's clinical experiences of emotionally troubled children's responses to endings (see Wilson and Ryan, 2005). Eddie's feelings of jealousy and rejection are highlighted by Wilson and Ryan (2005) as a common response for many troubled children ending therapy. The catastrophic elements introduced in Eddie's story were similar to some of the catastrophic responses children give in the play-based story-stem assessment (Hodges. et. al, 2002). Although this was expressed in a milder form to some catastrophic enactments in maltreated children's story stems it arguably highlights that leaving his therapist was an area of emotional difficulty.

Some children felt that they had not had enough play therapy sessions. Sometimes it is difficult to ascertain whether children's desire to continue play therapy is due to their therapeutic need or simply them having enjoyed their time and finding it hard to say goodbye. Wilson and Ryan (2005) provide a helpful discussion on making these

decisions in therapy. They acknowledge the variety of factors which are considered by therapists when making decisions about termination. These include the child's behaviour and ways of relating both in the playroom and outside environments along with funding constraints and other practical reasons.

Wilson and Ryan (2005) assert that the child's view needs to be taken into consideration and this can strongly influence the joint decision made about termination. They particularly emphasise the intensity of the child's communication being a guiding principle to therapists making judgements about the weight of the child's stated view. Here, it is suggested that Leanne and Susie were in further need of therapy because their views and/or behaviour regarding the ending was expressed with intensity. On reading the therapist's questionnaire it was clear that the therapist also felt that Susie and Leanne were in need of further therapy and their sessions were ending prematurely. It seemed that further therapy may have been beneficial to L-man, particularly due to his repeated message in the evaluation session of his need to continue and his feeling that he had not made enough progress. It appears that this was not a view held by the therapist as she did not indicate that his therapy had ended prematurely. However, it should be borne in mind that L-man had a six week break from the end of his therapy intervention to the evaluation session taking place[176]. Therefore he had time to reflect upon his needs, which may have changed in the time lag. In addition the return to the playroom after such a long break may have heightened the feelings of wanting to return for more sessions. In contrast it is suggested that Rob's views were not as intense and, whilst he would have liked to continue his sessions, his therapeutic needs for further sessions were not as strong.

The end of play therapy sessions can be more difficult for some children than others. The process described by Lee, of being upset and reluctant to leave in early sessions, to being interested in activities outside of the play therapy later is one of the indications that children are ready to end play therapy (see Wilson and Ryan, 2005). Therapy sessions clashing with outside activities is one area which can be difficult to negotiate in therapy and non-directive play therapists are trained to be mindful and respectful of children's wishes and feelings over the timing of session (e.g. see Wilson and Ryan, 2005). An interest in activities outside of therapy can be seen as a step toward health

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[176] This was due to practicalities, as discussed in chapter five optimal timing of PBEs is 2 weeks after therapy ending.

and an indicator that children are ready to end therapy (see Wilson and Ryan, 2005). This may have been Bob and Marble's experience. This is particularly suggested for Marble as her play sequence regarding choosing between a party and play therapy was enacted in the latter part of the evaluation session. Children may have ambivalent feelings about wanting to continue with their therapy sessions which they enjoy, whilst at the same time wanting to engage in normal outside activities with their peers. Collaboration with the children was indicated and listening to all levels of the child's communication seemed essential. Children's views in this study indicate that flexibility and consultation over the ending seem to help children manage the ending most effectively.

*Outcome of Play Therapy*

Interestingly children's comments on the outcome of play therapy centred on positive changes in feeling states. This supports the assertion that play therapy works primarily on an emotional level with children (see Wilson and Ryan, 2005). It also highlights that these are the changes children themselves experience and are aware of. These changes may not be highlighted in other outcome measures. It is possible that children in this study were more positive about the outcomes because they wanted to please their therapists who were conducting the evaluation. However, the above excerpts demonstrate that the changes the children stated were individual and were directly related to their own individual difficulties. For instance Cathy shared that she went to play therapy due to having worries. She later shared that children's worries would leave them as a result of attending play therapy. Similarly Sarah, an older girl with anger problems at the beginning of play therapy, shared the outcome of play therapy would be a reduction in anger and the development of safe ways to express angry feelings. It seems that children were able to express a wide range of feelings (see appendix 19 for a matrix of feelings expressed by children in this study) during PBEs particularly regarding their mixed feelings and experiences of the ending of play therapy interventions. This is counter to findings that children are unable to articulate their internal states during early and middle childhood adequately (see Harris and Lipian, 1991). PBEs undertaken by children's own therapists seem to enable them to do this.

## **Conclusions**

In this concluding segment of chapter seven I summarise the children's views presented above on the beginning, middle and end phases of play therapy, expressed in PBE

sessions. I summarise the implications for practice and the areas for future research.

**Summary of Findings of Children's Expressed Views**

Although only a few children shared their views regarding the preparation before play therapy began, it seemed that those that did appreciated clear information, the use of photographs and toys and the therapist visiting them at home. A thread running through the data was the impact of the support from carers. Both at the beginning, during progress meetings and in terms of the end of play therapy support from carers was associated with positive experiences and arguably more successful therapy. As stated above, this mirrors the research on outcomes of play therapy more generally. The playroom was generally experienced as a safe and fun place and seemed to promote a sense of predictability and security. Children talked and played about engaging with a wide range of toys and activities, particularly arts and crafts, reflecting the range of mediums available. The importance of being able to access toys across the age ranges and genders was emphasised by children. Two children emphasised the importance of food and drink in play therapy sessions as a way of regulating their emotions. One older child was able to articulate the metaphorical meaning of making a physical mess in the playroom as being reflective of his own 'emotional mess'.

A central theme running through the data was the importance of choice which children experienced in play therapy. Children's comments regarding their therapists generally reflected their experience of therapists as accepting, permissive and responsive. Children's descriptions of their parents waiting nearby, their therapists' responsiveness, the predictability of the playroom or particular special areas or activities all evoked a sense of the children establishing a safe base within therapy from which to explore. Whilst there were several examples of therapists being experienced as responsive and unobtrusive to children, one child emphasised the need to be mindful of pace, by not going too deep too quickly, at the beginning of play therapy. She emphasised the need to build up a trusting relationship first. Therapists were experienced as setting limits on unsafe specific behaviours and allusion was made to therapists using limits to help a child emotionally regulate.

Importantly it has been highlighted that children experienced their non-directive play therapists as active observers rather than passive onlookers. Therapists' use of congruence was also noticed by a small number of children in this study. One child

shared very positive views regarding his therapists' transparency and seemingly his ability to understand her. This seemed to be a highly unique and therapeutic experience for this child. A central finding which echoes Carroll's (2002b) research was the importance of the therapeutic relationship. Children talked about their relationship with their therapist's "growing" and "hardening" and "a bond" developing. Children's views on the ending of therapy mirrored the current practice literature on play therapy. They experienced a mixture of feelings and most of them found the ending difficult. Overall positive changes were experienced following play therapy, mostly regarding inner feeling states. When therapy was ending prematurely some children were able to fully articulate how difficult this was, that they were not ready to end and needed to continue therapy, other children were able to show this on a behavioural and non-verbal level.

*Implications for Practice*

As suggested in the theoretical and practice based literature parents played a significant part in the child's therapy which the children noticed and were positive about. This provides further support for therapists involving parents in their practice of therapy and demonstrating to parents that children notice their involvement, even if it is just in terms of waiting in the waiting area. Therapists inviting children to be part of progress/review meetings and facilitating their involvement in a variety of ways was indicated. This maybe achieved by inviting children to join for part of the meeting, and facilitating creative expression to share their views and/or asking them who they think should attend. Incorporating play in progress meetings, as play therapists already do in initial meetings seems likely to be beneficial.

Ensuring that there is a range of equipment available reflects children's diversity in terms of age, gender, ethnicity and disability was indicated as useful. The incorporation of food and drink in therapy sessions has received mixed responses from therapists. However, it was indicated as therapeutic from the two children who shared their views on this subject in this study. Further use of musical instruments in NDPT practice was also indicated as useful.

Flexibility and consultation regarding the ending of therapy was indicated as helpful. Therapists' are often frustrated by funding and service constraints which cut therapy short. The children's views expressed in this study corroborate the inappropriate timing of ending in some interventions. Presenting these findings to managers and

commissioners is indicated to promote their support and understanding of the careful planning which is needed when agreeing what children's therapeutic needs are and how these can be met. Arguably the use of PBEs helped children co-construct a coherent narrative of their experience of play therapy together with their therapists. The incorporation of PBEs into therapists' regular practice could help children to further process and articulate or demonstrate their feelings creating an enhanced therapeutic ending. However, there were other indications that in some circumstances this would be counter-therapeutic. This issue is discussed in depth in chapter nine.

*Further Research*

Further research indicated from this analysis includes deeper exploration of children's views of parents' involvement in their therapy. Research into the participation of children in therapy progress meetings, similar to Thomas and O'Kane's (2002) research of looked-after children's review meetings would be useful. Exploration of the use of musical instruments in play therapy is also indicated. Further studies using PBEs to facilitate children's views are indicated, in particular studies which include both cases where the therapy intervention has been successful and unsuccessful, as this study has done.

Throughout this chapter I have reflected upon the possible meanings and interpretations of the children's stated views and/or play demonstrations. I have drawn on their non-verbal communication, the context of the evaluation itself, the play therapy intervention and the child's wider experiences to record their views and important memories of play therapy. I have also presented the views of the therapists and their contributions to understanding the potential meanings of the children's communications. I return to the issue of therapist-child views corroborating or conflicting in chapter nine, along with a review of the specific strengths and limitations of each PBE method. First, in the next chapter, I consider the therapist-child interaction during PBEs in depth. I explore the impact the level of attunement in the therapist-child interaction has on the child's ability to engage in PBEs and therefore explore their views.

# CHAPTER EIGHT
# THE USE OF PLAY-BASED EVALUATION TECHNIQUES:
# THE IMPORTANCE OF ATTUNEMENT

**Introduction**

Whilst I have proposed that PBE methods themselves go some way to provide a facilitative environment, because they utilise the child's language of play as the vehicle of expression, unsurprisingly this research highlighted that the therapists themselves played an important part in providing a facilitating environment. This echoes both the reviewed research on therapeutic relationships (see chapter four) and the literature on building a rapport with children and attending to ethical issues within the children's participation and research literature (see chapter three).

Micro-analysis of the dyadic interaction applying attachment concepts seemed a useful endeavour to further understand the process issues I was observing. In order to fully share their views of therapy, within a PBE session, it followed that a child's exploratory system[177] would need to be actived and maintained as much as possible. Therefore it seemed important to systematically analyse the therapists' ability to facilitate the activation and maintenance of the child's exploratory system. I wanted to track 'effective responsive caregiving' within PBEs as McCluskey (2005) had achieved in the adult psychotherapy context. The reader will remember that effective responsive caregiving involves the caregiver's (therapist) ability to identify and attune to the careseeker's affect and/or express empathy to the careseeker. This enables the careseeker's exploratory system to activate.

In this chapter I explain the process of selecting four dyads and four particular segments of tape to analyse dyadic interactions in this detailed manner. I proceed by presenting each of the four exemplars providing brief summary information and a written description and analysis of each segment of interaction. This is illustrated with reconstructed visual stills to enhance the readers access to the non-verbal communication referred to. There follows a discussion of each dyad, incorporating the findings from the process analysis referred to in chapter six[178]. I link the findings to the literature presented in chapter four.

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[177] As referred to in Heard and Lake's (1997) Dynamics of Attachment model described in chapter four.
[178] See appendix 18 b and c for process code lists and definitions.

## Selection of Dyads

From prior analysis, which had involved repeated viewing of the tapes and careful transcription of the non-verbal communication, I already had an overall picture of the type of interaction in each dyad. Four exemplars of different patterns of attunement between therapist and child were identified. Whilst this was a subjective rating it is bolstered by my consistent use of clearly defined operational codes to analyse the therapists' and children's process in context. I underwent a consistent process of reviewing the analysis material, which is presented in Figure 5. The first box details the six documents which were reviewed. This resulted in categorising each dyad into three categories: Misattuned, some misattunements with repair, and highly attuned.

In reviewing these dyads I was aware that there were also significant child factors which were of interest. As McCluskey (2005) argues the concept of internal working models or IMER's[179] (referred to in chapter four) is an important one in making sense of any psychotherapy relationship she states:

> "In this relationship the careseeker (the client) brings to the experience their various templates of how their relationships with their earlier attachment figures have worked and this will both influence their behaviour in the therapeutic relationship and their experience of the therapist's response to them" (2005:75).

Whilst a limitation of the data available to me was the absence of data on the child's attachment style I did have some information on child factors to draw upon. Therefore I reviewed a second series of data, detailed in Figure 5, to further categorise the dyads in terms of whether the child was 'easy' or 'difficult' to engage. If the child appeared overly anxious or overly challenging and demanding or found the task difficult to understand they were classified as difficult to engage. This resulted in six categories, as detailed in the lowest layer of Figure 5. The number of dyads assigned to each category is detailed in brackets.

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[179] Internal working models of the experience of relationships.

**Categorising the interaction - Documents reviewed:**
- Initial reflection sheet
- Case Summary
- Engagement analysis (colour coded miniature transcript printouts)
- Time frame analysis
- Coding frequency table – therapists' process

| Misattuned – low level repair | Some misattunement – | Highly attuned |
|---|---|---|

**Incorporating child factors - Data and documents reviewed:**
- Observation of tapes
- Number of presenting problems at referral - reported by therapists
- Therapists pre-evaluation questionnaire
- Coding frequency table – child's process

| Misattuned – low level repair Child – difficult to engage (2) | Misattuned – low level repair Child – easy to engage (0) | Some misattunement – with repair Child – difficult to engage (5) | Some misattunement – with repair Child – easy to engage (4) | Highly attuned Child – difficult to engage (5) | Highly attuned Child – easy to engage (4) |
|---|---|---|---|---|---|

Figure 5: Process of categorising dyads

Thus a systematic procedure was followed and data was triangulated to provide an overview from which I was able to select the most extreme cases for further analysis. I had to limit this analysis to a maximum of four dyads, due to time and space. Therefore I chose the two cases at the extremes of the 'attunement continuum' which I had created. In the misattunement with repair category it became clear that there were two distinct patterns emerging. the group classified as easy to engage children were children who appeared to be repairing many of the ruptures in the attunement and the difficult to engage children were those whom the therapist appeared to be repairing the majority of the ruptures. Therefore the most significant examples of these two patterns were selected for further analysis. All four of these dyads utilised the 'Expert Show' only which also allowed for closer comparison.

These four exemplars are presented here:

1) **Herbert** (child) **and Polly** (therapist) - a *highly attuned* pairing, with an *easy to engage child*

2) **Bradley** (child) **and Emily** (therapist) - a *misattuned* pairing where there were very few repairs, with a *difficult to engage child*

3) **Cathy** (child) **and Lucy** (therapist) - a pairing with *some misattunements* where both the child and therapist repaired the ruptures, the *child was easy to engage*

4) **Hannah** (child) **and Judy** (therapist) - a pairing with *some misattunements* where the therapist repaired the ruptures with a *difficult to engage child*

I chose to study four separate segments of the video-taped evaluation session to further analyse the interaction and level of attunement. The segments selected and rationale for doing so is presented below:

**Segment One 'Initial Engagement':** The first five minutes of the evaluation session
*Rationale*: Here the therapist has the dual task of a) explaining the evaluation task. This includes explaining what will happen and why, gaining consent and setting out the ground rules of the engagement along with the set up of the

fantasy TV show, and b) engaging the child in the process and attending to their response to the task.

**Segment Two 'The First Call':**  Two minutes of tape from the point of the first call being introduced.

*Rationale:* This denotes the first time the therapist actively seeks the child's views about play therapy. Thus allowing analysis of a transition, it was deemed likely that there would be 'juncture points' (Koren-Karie et. al.'s, 2003[180]) evident at points of transition. Analysis of these was an important aim in terms of understanding the interaction between therapist and child. It was deemed that two minutes would allow enough time to analyse the child's response to the first call, the therapist's approach to this and some further exploration of the child's views beyond the first question.

**Segment Three 'The First break':**  Thirty seconds before, during and after the break in the show - initiated by either the child or therapist.

*Rationale:* This allowed analysis of another transition, specifically the therapists' ability to assist and structure the transition. In addition analysis before the break would capture therapists' awareness and ability to attune to the child's need for a break from the task. It also allowed an opportunity to analyse child and therapist both in and out of 'role' (as 'TV Expert' and 'TV Presenter' respectively).

**Segment Four 'Concluding Segment'**: The final five minutes of the evaluation.

*Rationale*: This would further help to identify how attuned the therapist was to the child's needs and readiness to end. This allowed analysis of therapists' structuring the ending  process, which may be challenging for some children.


**Process of Micro-analysis**

The micro-analysis involved viewing each segment of video tape first at full speed, then in slow motion. The transcript for each exact segment was identified and printed out

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[180] Previously referred to in chapter four juncture points were identified in Koren-Karie et.al.'s (2003) work with mothers and seven year old children constructing a narrative. Juncture points were defined as challenges by the child to the mother e.g. the child is unresponsive, talks about something the mother does not want to discuss or is uncooperative.

from Atlas-ti. This enabled corresponding viewing of the tape, and reading of the transcript which detailed the codes assigned in the thematic analysis in the margin and displayed the highlighted colour coding from the engagement analysis (referred to in chapter six see appendix 27 for an example printout).

McCluskey asserts that "vitality affects are possibly *the* cue to identifying the presence or absence of exploratory activity" (2005:113). Thus during this micro-analysis 'vitality affects'[181] were identified and captured by written description, video stills, time markers and line numbers in the transcript. The response to each vitality affect identified was recorded and classified as attuned or misattuned. Consideration of Stern's (1985) six specific types of matching was given (Absolute intensity; Intensity contour; Temporal beat; Rhythm; Duration; Shape[182]). 'Juncture points', (Koren-Karie et al's 2003), were also identified. These are times when the child presents the carer, in this case the therapist, with a challenge, for instance being unresponsive; uncooperative or talking about something the carer does not want to discuss, which I refer to in the analysis as a 'contentious response' for brevity. Again each response given by the 'carer' was noted. Before each segment was analysed I re-read Stern's descriptions (see appendix 3) the definition of a juncture point and the different modes I needed to attend to (facial expression; tone of voice; verbalisations; body movement and posture)[183]. The reader will remember, from chapter four, that affect can be attuned to cross-modally. The responses given *within the interaction* were attended to and McCluskey's (2005) description of purposeful misattunement was borne in mind:

> "This may involve 'tuning down' the client's affects in such a way as to bring them within manageable levels so that the client can think clearly. Or it may involve 'tuning up' and amplifying the client's affect so that they can begin to access their own affective experience" (McCluskey, 2005:79).

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[181] As detailed in chapter four vitality affects are defined by Stern (1985:156) as "those dynamic, kinetic qualities of feeling that distinguish animate from inanimate and that correspond to the momentary changes in feeling state". Kinetic terms such as 'surging' 'fading away' 'fleeting' 'explosive' 'crescendo' 'decrescendo' used to illustrate the quality of feeling which Stern refers to as 'vitality affects'.

[182] See pg 68 in chapter four for a brief description and appendix 3 for a full description of each.

[183] During this period of analysis I was concurrently reading research on the use of body awareness techniques and had recently completed three years study of British Sign Language (BSL) which involved close analysis of video. BSL incorporates not only hand movement but facial expression, eye movement and gaze and body posture (see Sutton-Spence and Woll, 1999). This contributed to my analytic skills during this analysis.

Following this process I applied the 'dynamics of attachment model' (Heard and Lake, 1997) to the sequences. These were set out in chapter four. Briefly, there are thought to be five inter-related systems: Careseeking, Caregiving, Exploratory/interest sharing, Sexual/affectional, and personal self defence systems. Importantly if the careseeking or caregiving systems are activated the other systems are inhibited. If the personal defence system is activated the exploratory system is inhibited. I adapted behaviour descriptors of four[184] of the five interrelated systems from Heard and Lake's (1982; 1997) and McCluskey's (2005) work. I considered the following behaviours to be indicative of each system being activated in this context:

Careseeking behaviours:

- indications of *tiredness or discomfort* (inc. sighs, yawns, frequent fidgeting, heavy body language, verbal/non-verbal requests for comfort such as food or drink)

- *Uncertainty, fear or distress* (conveyed in facial expression and/or tone of voice)

- *Seeking interaction* (inc. non-verbal and verbal requests to play or searching eye gaze)

- *Stating concerns* (making a verbal statement about worries or concerns or asking for help)

Caregiving behaviours:

- *Verbal statements*: a statement conveying the meaning and feeling of the careseeker's communication has been understood (incorporating empathy)

- *Cross-modal non-verbal attunement:*
  "…the therapist must be experienced as being in a state of vitalizing attunement to the patient, that is, the crescendos and decrescendos, cross modally of the therapist" (E.S. Wolf, personal communication 1991, cited in Schore, 1994:449).

- *Providing comfort* or actively *relieving child's discomfort*:  this includes physical and psychological, for instance providing a drink or providing structure by initiating breaks, regulating the overregulated child by setting limits in a calm manner; all *in response* to the child's careseeking cues.

Exploratory system/interest sharing system activated (N.B. can be individual or together with the therapist):

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[184] N.B. I have excluded application of the sexual system, although it is recognised that this may be evident in some children's behaviour for instance those who have been sexually abused. This was not one of the reasons for referral for any of the four children chosen for micro-analysis.

- *sharing of views* regarding play therapy or other areas of interest to the child;

- *play* behaviour

- *Exploring environment*

- Expressions of *pleasure joy* (verbal and non-verbal e.g. laughter, smiling)

Defensive behaviours:

- *Anger*

- *Fear*

- *Withdrawal*

- *Distress*

The findings of the micro-analysis for each of the four pairings are detailed below. First a brief description of each pairing is provided. This includes reference to the therapists' 'overall skill level' in PBEs, as described in chapter six. The total number of quotes coded as 'inhibitive responses' given by the therapist were subtracted from the 'facilitative responses' to provide an 'overall skill score'. Each evaluation was then grouped into five groups from very low – very high[185]. Next a description of the observed interaction, in terms of attunement, for each of the four segments is given, key behaviour descriptors and attachment terms are italicised to assist the reader. A selection of the reconstructed video stills[186] for each pairing is presented, to illustrate these descriptions. The time markers and corresponding transcript are detailed below each illustration. Heard and Lake's dynamics of attachment for caregiving model is applied throughout these descriptions. There follows an analysis and discussion of each dyad which incorporates reference to the process coding undertaken[187].


**Exemplar One: Highly Attuned Pairing; Easy to Engage Child**

Herbert (Child, 8.11yrs) and Polly (Therapist)

A highly attuned pairing in which the child appeared easy to engage, had relatively few reported presenting problems (compared to other children in the cohort) at the point of referral (anxiety/stress; anger; loss of father through separation; witness of domestic violence - reportedly low level in terms of severity and frequency), and completed a short term play therapy intervention (nine sessions). The therapist had previously

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[185] See appendix 25.

[186] As described in chapter six reconstructed video stills using animated computer models have been used to protect the anonymity of the child and therapist whilst allowing the reader access to this essential part of the analysis. Minute changes to the models facial expressions, direction of eye gaze, body positioning etc. is possible and I have re-created a close enough fit to the real visual still without compromising participant anonymity

[187] See appendix 18 b and c for process code lists and definitions.

conducted several PBEs (four, including one training session). She scored very highly on the therapist overall skill level in relation to this child.

**Initial Engagement** (time marker 0:00 – 5:00)

There were many examples of affect attunement between child and therapist and empathic responses made by the therapist in this first segment. The child quickly engaged in the task picking up the telephone in the first twenty seconds. This indicated that the child's '*exploratory system*' was activated. The child engaged in a high level of characterisation and displayed an open excited facial expression. The therapist responded with a wide smile and followed up this non-verbal communication with a verbal acknowledgement "making some phone calls already"[188]. The child made several dramatic movements with his body which the therapist matched, *cross modally*, with her tone of voice (animated) and verbal reflection of the child's affect. Thus the child and therapist were both *'interest sharing'*; their '*exploratory systems*' were active. See Figure 6:



**Herbert:** [{looks at camera lips form 'oo' shape; waves hand slowly to right in stylised manner; suddenly turns to Polly holds a pose; eye contact; smiles}

**Polly:** oh quite excited↑ {smiles:::} about that

0.54secs[189]

**Figure 6: Active interest sharing**

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[188] (009)
[189] Time marker

The child also matched the therapist's body language and shaping. The therapist outstretched her arm to the audience (see Figure 7) and the child matched this with his own added dance moves for emphasis (therapist and child's *'exploratory systems'* remain highly active see Figure 8).
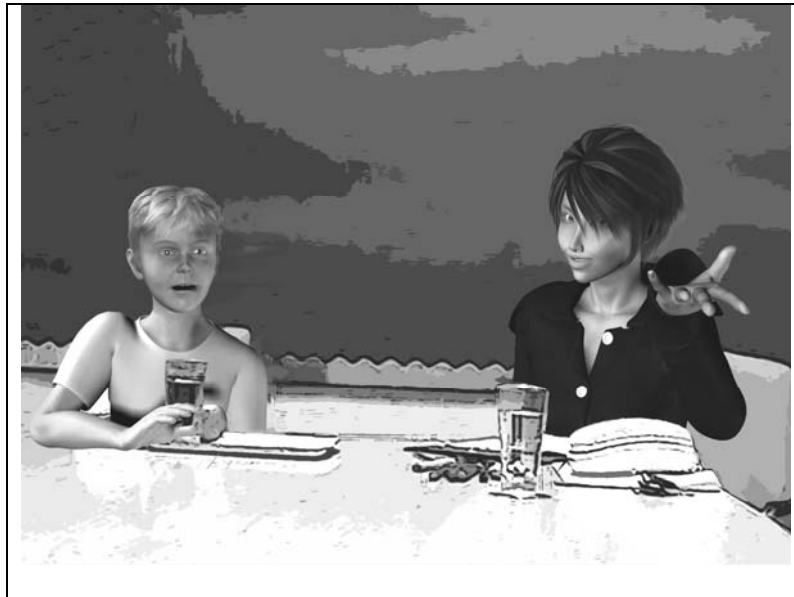


| |
|---|
| **Polly:** {gestures with open palm outwards in sweeping motion toward camera} |
| 1.02 |
| **Figure 7: Attuned dance 1** |



| |
|---|
| **Herbert**:{waves arms across in dance move swaying side to side} |
| 1.04 |
| **Figure 8: Attuned dance 2** |

The therapist indicated that the child knew a lot about play therapy, and the child questioned this (see Figure 4). This was the first identified *'juncture point (disagreement)'*. The therapist responded to this uncertainty with *purposeful misattunement*. Her warmth was indicated by her warm tone of voice and smile. She did not dismiss or ignore the child's 'negative' response but rather acknowledged it.



| |
|---|
| **Herbert:** 'Do↑ I↑' {scrunching up nose eye contact} |
| **Polly:** {laughs:: looks at child:::} you're not too sure whether you know enough about it |
| 1.12 |
| **Figure 8: Purposeful Misattunement** |

Another *juncture point* was evident when the therapist asked the child to decide on a ground rule. The child was *unresponsive* at this point. He responded with a pause and an uncertain facial expression. The child's *careseeking system* appeared to be activated. The therapist left *'space'* for this child, reflected his uncertainty in a tone of voice which matched his facial expression and also provided structure at this point. She offered the child a choice and rehearsed how he might be able to initiate a break. The pace and structuring was appropriate to the child's process: *therapist caregiving*. The child himself then rehearsed this, thus the child's *exploratory system* was re-activated. When the child was asked about a second ground rule the therapist was slow and gentle in pace and manner, including her tone of voice. The child himself set the ground rule and the therapist matched his body language by imitating his movement (both the therapist's and the child's *exploratory system* were re-activated).

When the child was asked about passing on a call the child himself acknowledged his usual process of doing what is asked of him, highlighting his need to please others. The therapist was responsive to the child's pace and made a reflective statement about this being difficult for him. The child demonstrated a small movement with his thumb to indicate that he would pass (see Figure 9). The therapist imitated this in a slightly exaggerated form (see Figure 10). This appeared to reinforce and communicate non-verbally that it was acceptable for the child to pass. The child then looked more confident and practiced this emphasised version (see Figure 11). Shortly after this sequence the therapist emphasised that there were no right or wrong answers. Thus child and therapist's *exploratory systems* remained highly activated.



**Herbert:** {smacks lips} *I'll*↑{leans back in chair} go→like→this↑{raises thumb to chest and moves in sweeping motion toward therapist}

4.44

**Figure 9: Facilitating the ground rules 1**

**Polly:** Right so you'll pass the call over {repeating thumb movement with emphasis}

4.45

**Figure 10: Facilitating the ground rules 2**



**Herbert:** {repeats thumb movement with emphasis

4.48

**Figure 11: Facilitating the ground rules 3**

The therapist remained responsive to the child's pace and offered choice during the process of making name badges for the show. There was a *highly attuned moment* when the child completed his name badge. The therapist made a 'lead in' statement:

**Polly:** {smiles sits back slightly} *Ri↑ght* so you want to be↑:::::

**Herbert:** {puts cap back on pen and puts pen with others on table holds up name badge dramatically} (.) *'Erbert* {loud dramatic tone of voice}

**Polly:** '*Erbert* {loud dramatic tone of voice smiles} OK

**Herbert:** *Den den dern:::::* {dramatic loud tone of voice; smiles::: peels off name badge looks at it carefully turning it over and sticks on chest smiles:::}

**Polly:** 'Er↑bert↓ the expert↑ {gravelly comical tone of voice; smiles}[190]

Here both the child's explosive and dramatic tone of voice and sudden dramatic body movement were matched by the therapist. A final *juncture point* was identified when the child was asked if he wanted to give the show a name. Again the child was *unresponsive*, he expressed his difficulty and then he turned to face the therapist (child *careseeking* non-verbals conveyed request for help). They held eye contact and their affect was matched (big open smiles). The therapist was responsive to the child's pace and reflected how hard it was to think (*therapist caregiving*). The child suddenly suggested a name for the show in a dramatic manner (*child's careseeking system acquiesced and exploratory system re-activated*).

At the end of this segment the therapist repeated the ground rule of it being OK to pass. This appeared to enable the child to explore the use of ground rules further (see Figures 12 and 13)

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[190] (085-091) ::: = elongated communication ↑↓ = intonation up/down *italicised text* = emphasis (.) = a noticeable pause too short to measure

**Herbert**: {sits upright points at phone} Can you↑ can ya↑like call can you *pass* {resting both hands on own phone}

6.44

**Figure 12: Further exploration 1**



**Herbert:** {points over with outstretched arm to Polly's phone} the phone call on to *you*↑{eye contact} (.) onto your phone

**Polly:** Yeah:↑ if you want to↑ if you want to transfer:: it (.)

6.46

**Figure 13: Further Exploration 2**

Following affirmation from the therapist that use of this ground rule was possible there was a *highly attuned moment*. The child said "coo:::l↑"[191] in an impressed tone of voice with a light open facial expression, his eyebrows were raised and he had a big smile. The therapist's smile and light tone of voice matched this child's affect as she reflected "you like that idea"[192] (*exploratory systems* remain activated).

**First Call**  (2 minutes; time marker: 07.00-09.00)
This segment began with a *misattunement* in pace. The therapist introduced the first call and pretended the phone was ringing. The child quickly picked up the phone and answered it (child's *exploratory system* activated). The therapist missed or ignored this verbal and non-verbal cue - that the child was ready and willing to take the call - and continued to ask whether or not the child wanted to take the call. Thus the therapist's *caregiving system* was activated rather than responding to the child's cue that he was ready to engage in *'interest sharing'*. The therapist *repaired this minor rupture* by quickly responding to the child's explicit affirmation that he was ready to take the call.

During the call the therapist was attentive to the child. She used head nods to demonstrate *active listening* and paraphrased what the child said. The child looked at the therapist for the majority of this segment, the therapist was turned slightly away from the child but her face could be seen by the child easily. When the child struggled to find the words to articulate his experience (*careseeking*) the therapist was *responsive*, in terms of *pace* and her tone of voice was warm. She provided *structure* by paraphrasing what he had said. (*therapist caregiving*). The child shared a high number of views about his experience of play therapy in this segment (*exploratory system activated*).

**Break** (1 minute 30 seconds; time marker: 17.30 – 19.00 including 30 seconds before the first break; 30 seconds during the break and 30 seconds after the break[193]).
This segment began with a *highly attuned moment*: the child and therapist put their phones down at the same time. The child puffed out a big exhalation and smiled (although enjoyment was clear there were also clear indicators of tiredness: child *careseeking*). There was eye contact as they both turned to look at each other and the

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[191] (120)
[192] (121)
[193] N.B. this is a continuous segment as the break only lasted 30 seconds

therapist exclaimed *"Wow::"* and laughed. Her verbalisation, tone of voice and body movement *matched* the child's *vitality affect.* The therapist was *responsive* to the child's pace and provided structure by suggesting a break (*therapist caregiving*). The child responded with an affirmative "*yep*". He then struggled to tell the audience that they were going on a break whilst simultaneously trying to draw. The therapist was *responsive* to this by providing structure. She addressed the audience regarding the transfer to the advert break herself. This *caregiving* from the therapist enabled the child to focus on his drawing, thereby accessing his *exploratory system*. The child communicated that a short break was adequate by writing 'the lines are now open' on his poster. The therapist was *responsive* to this quickening of pace and immediately supported the child through the transition back to the show. The therapist responded to the child's verbal and non-verbal cues by *matching* the child's excitement in her tone of voice and *matching* his arm movement (both therapist and child's exploratory systems activated; see Figures 14 and 15 below with corresponding transcript).



**Herbert:** {adjusts poster; carefully stands poster up; looks at camera; raises arm in air at head height; points down to poster; clicks fingers} *O:↓K* hit it cameraman {authoritative tone of voice}

20.23

**Figure 14: Attuned transition**

| |
|---|
| **Polly**: Right↑{leans forward; raises hand to camera; counts down on hand} five::→four→three::→two one::: an:::d *welcome*↑ {looks at interview schedule:::} back to the play↑ show::: |
| 20.28 |
| **Figure 15: Back to the playshow** |

In the call following the break the therapist was *attuned* to this child's quicker pace.


**Concluding Segment** (5 minutes time marker 41.23 - 46.23)

This segment began with a smooth transition over to the 'sofa area' the therapist praised the child's engagement in the task. Her emphasis that it had been "*really* helpful" was mirrored by the child's big smile. There was a *juncture point (contentious response)*[194] whereby the child provided a concrete answer to the therapist's question. In this instance the therapist did not challenge the child's comprehension of the question. She accepted his answer and later re-worded the question using concrete time cues to support the child.


When the child was asked why he went to play therapy his relaxed position and slower paced speech was *mirrored* by the play therapist in her *body language* and her soft *tone of voice* (see Figure 16)

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[194] Arguably this is similar to Koren-Karie et. al. (2003) description of a child discussing something the mother does not want to (discussed above)

44.36

**Figure 16: Attuned discussion**

There were two further *attuned* moments before the ending. The ending itself was *coherent* and the child stated that doing the evaluation had been "fun". The therapist was highly attuned to the child. She looked at him warmly smiling and used a warm tone of voice paraphrasing his comment and adding that she had enjoyed it also. Thus the child and therapist's *exploratory systems* were highly active during this segment.

**Discussion of Pairing**

**Summary of Interaction**

In this pairing a high level of attunement was evident in all four time segments. A high number of matched vitality affects have been described above. Importantly this therapist did not merely imitate the child's affect she matched it cross modally and frequently extended the child's expression by making verbal reflective statements. The segments presented above were characteristic of the entire session.

Similar to Koren-Karie et.al.'s (2003) findings[195], of emotionally matched mother and 7 year old child dyads, in this pairing the child was able to explore difficult themes regarding play therapy i.e. not all of his views were positive (see chapter seven for a full account). When these difficult themes were presented or he presented a challenge in the way he engaged with the process (e.g. unresponsive) the therapist responded openly. At these 'juncture points' there were no hostile, ignoring or dismissing reactions. The

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[195] Reviewed in chapter four.

therapist responded appropriately to the pace of the child, and the one misattunement evident in the micro-analysis was repaired swiftly. The therapist provided structure when needed but allowed 'space' for the child to develop his own ideas. Again this mirrors Koren-Karie, et.al.'s (2003) findings on emotionally matched mother-child dyads.

The therapist was responsive to the child's careseeking cues, (e.g. big sighs, uncertain facial expressions). When these careseeking needs were met, the therapist moved into her exploratory system and was able to use a high number of general prompts, paraphrasing, concrete cues and characterisation to enable the child to express his views fully. When the child's careseeking system was re-activated the therapist moved into her caregiving system and did not return to the exploratory system until the careseeking need was acquiesced. A high level of engagement in the PBE task throughout the session was evident.

The therapist also acted as caregiver by structuring breaks for this child. The child was able to access his exploratory system for the majority of the session. He shared the highest number of views about play therapy in this cohort (157)[196]. Furthermore his views were also detailed and full in quality[197]. In relation to the nine patterns of caregiver-careseeker interaction identified by McCluskey (2005:219-225) this pairing correlates with pattern one (effective careseeking/caregiving). The child had communication style A (wants to discuss feelings, conflicts and concerns) and the therapist followed pattern one in her responses (attuned to careseeker affect, regulate it through purposeful effective misattunement and attends to careseeking goals).

**Child Factors**

The child himself was easy to engage. The therapist reported that he was highly familiar with, and enthusiastic about, using role play in his play therapy sessions in general. Therefore the 'Expert Show' TV format was highly suited to his needs and preferences. Furthermore the play therapy intervention had been successful. The therapist commented on how fast this child had been able to work through issues of emotional importance, particularly through role play. His attachment with his mother (who became

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[196] (range 16-157)
[197] This child's views have been presented and discussed in detail in chapter seven.

part of the therapy sessions) had reportedly been strengthened. In addition to the fact that this child had fewer presenting problems, than many of the children in this study, it is likely that this child's careseeking needs were not high (at the point of evaluation). It is likely that this contributed to his ability to engage on an exploratory level for most of the evaluation session. The reader is reminded of McCluskey's (2005) statement regarding IMER's[198].

**Therapist's Skill Level**

It is argued that the child's exploration was facilitated by the therapist's high level of responsiveness, as stated above the therapist scored very highly on the therapist combined skill level analysis in relation to this child. It is suggested that this high level of attunement reflects the likely relationship this dyad had developed during the play therapy intervention. As suggested earlier it is unlikely that an 'outside' evaluator would have been able to be as responsive to this child's careseeking cues. Nor would an 'outsider' provide the accurate pacing and structuring this therapist was able to provide through their existing relationship.

**Conclusion**

The therapist's ability to be responsive to this child's careseeking cues arguably enabled this child to engage in this evaluation to the fullest extent. However, given this child was 'easy to engage' an 'outsiders' use of the technique is likely to have been 'good enough'.

I now consider a second dyad at the other end of the continuum of exploration and attunement.

**Exemplar Two: Misattuned Pairing; Difficult to Engage Child**

Bradley (Child, 8.5yrs) and Emily (Therapist). This pairing was characterised by misattunements. The child appeared difficult to engage, due to a mixture of anxiety and controlling behaviours. He had a reportedly high number of significant presenting problems at the point of referral (Emotional abuse; neglect; witness of domestic violence [high level of severity and duration]; anxiety/stress; anger; conduct problems; low self-esteem; trauma; poor peer relationships; attachment difficulties; behavioural

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[198] Internal working models of the experience of relationships, see pg 240 in this chapter.

problems at home and school, high number of transitions in and out of foster care and now in kinship care). He had completed 28 sessions of play therapy over a 9 month period, the therapy ended prematurely due to the child moving placement. The therapist had previously conducted one other PBE (as part of the training). She had a low score on the therapists combined skill level for PBEs in relation to this child.

**Initial Engagement** (0:00-5:00)

There were limited examples of *affect attunement* during this segment. There were a number of instances where the child had a high *'vitality affect'* which was not matched by the therapist. The segment began with the therapist standing over the child. She verbally suggested to the child that he would not remember the number he was writing on the board. The therapist made suggestions of different numbers to use. Thus the interaction on tape[199] began with the therapist being controlling and leading in terms of both her body language and verbal message to the child. The child refuted the therapist's suggestions and continued with his own number. There was a *mismatch* in *type and intensity of vitality* at 0.24 seconds. The child was calm and focused on writing his message on the whiteboard. In contrast the therapist's affect was of high intensity as she instructed the child to move onto the next task: making name badges.

There were several moments where the therapist was *preoccupied* with the task. The first clear example of this was in the first minute. The child became interested in the name badges however the therapist remained focused on her own badge and instructed the child to take the other badge. The therapist looked down at the interview schedule and provided an explanation of the task. She missed or ignored the child's non-verbal body communication of probable *anxiety* (his leg was shaking up and down). The child's *careseeking system* appeared to be activated. The therapist remained in her *exploratory system* and was fast paced in her explanation of the 'helpline'. The child's *anxiety* levels were expressed more intensely at this point. This indicated a rise in activation of his *careseeking system*. He asked in a fast paced manner "where *is* the helpline?"[200] The therapist provided a fantastical answer as if she were already in role: she told the child that the helpline was an "electronic thing" that the therapist could "key in". This did not match the child's level of understanding and needs. The child's

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[199] The child having written the name of the show on the board already indicated that the session had already started; it is not clear how much of the session is missing on the recording.
[200] (047)

*careseeking system* was not assuaged. The therapist became preoccupied with the timer which further ruptured her engagement with the child (see Figure 17):



1.53

**Figure 17: Preoccupation with the task**

The child sought help from the therapist regarding his badge (*careseeking*). The therapist responded in a physically intrusive manner as she tried to adjust the child's badge. There was a *'juncture point' (uncooperative)* as the child resisted the therapist's physical help. The therapist's affect inappropriately matched the child's *vitality affect* as they both tried to control the badge with their arms and hands (see Figure 18). The therapist and child's *defence systems* appeared to be activated.
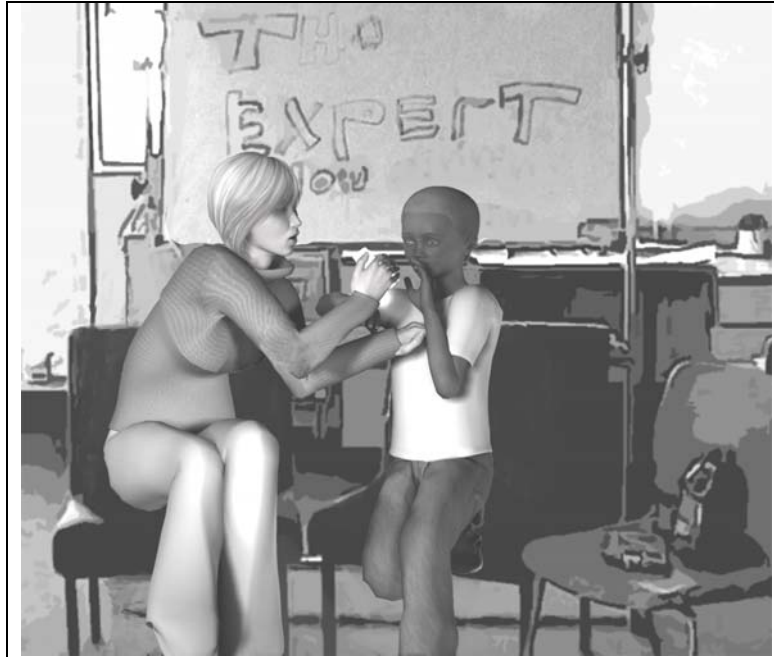


2.16

**Figure 18: Juncture point: careseeking unassuaged**

Immediately after this the therapist told the child that the badge was perfect, thereby dismissing the child's negative reaction to her advance. The child was excited by the snack and drink provided by the therapist and conveyed his excitement with an alert and upright body movement, an excited tone of voice and a smile. The therapist was *misattuned* as she focused on the task. She used a serious *tone of voice* and dismissed/ ignored the child's affect (see Figure 19).



**Bradley**: Oh {smiles leans over quickly bounces on seat a little picks up drink}

**Emily:** *Right* {puts left hand on Bradley's thigh looks at interview schedule}

**Bradley:** {looks at therapist} I thought it was fake {opening drink}

**Emily:** *No* (.) {grasps Bradley's forearm with left hand gesticulates with right hand} *listen (.) listen*

2.41

**Figure 19: Misattuned; preoccupation with task**

The therapist asked the child to think of ground rules for the show. However, she rejected the child's idea of saying "stop the show" and instructed him to signal (thus the therapist shut down the child's *exploratory system*). There followed two attuned sequences where the therapist used a gentle tone of voice which *matched* the child's body language and a second *attunement* where the therapist was *responsive* to the

child's pace and waited for a response. The child's slight smile was amplified by the therapist in her use of an excited tone of voice, here the child was enabled to access his *exploratory system* (see Figure 20).



**Bradley:** {sips drink eye contact} Anymore quest↑ions:↑

**Emily:** You're {sits very upright smiles; looks at child} gonna say that will↑ you↑

**Bradley:** {looks down sips drink} Y[er

**Emily:**                                        [O::K:↑ {looks at interview schedule}   that's good so→ if→you→ wanna stop you'll say {sits very upright} *hh anymore quest↑ions↑

3.05

**Figure 20: Attuned moments**

A further example of the child being excited about the task was evident. The therapist was *mismatched* in her response using a serious tone of voice to question what the child meant. The therapist then *repaired* this *rupture* by repeating her question in a gentler tone allowing 'space'. There was a further *mismatch* as the therapist provided a concrete response to the child's question rather than responding to the child's *affect*. In this concrete response and explanation the therapist introduced a new concept to the child the 'chat show'. This confused the child and raised his anxiety level. This was evident in the speed and intensity with which he asked "what's→the→chat→ show?" with a slightly startled and searching facial expression. Here the child's

*careseeking system* was highly activated. The therapist provided a quick response which did not adequately address the child's *careseeking* needs. Thus an *unsuccessful attempt at caregiving* resulted.

An *attuned moment* occurred when the child asked if he could take his drink outside. Both the child's and therapist's *vitality affects matched*: smiling, high intensity, jovial tone of voice. The therapist became *preoccupied* by the task again and she missed or ignored the child's exploration of the phone. At the end of the segment the therapist returned to the issue of passing a question to the helpline. The child anxiously asked where it was. This was marked by the intensity in his tone of voice and an anxious searching facial expression (*child careseeking*). The therapist was not attuned to his affect and provided a concrete response (*unsuccessful caregiving* by therapist see Figure 21).
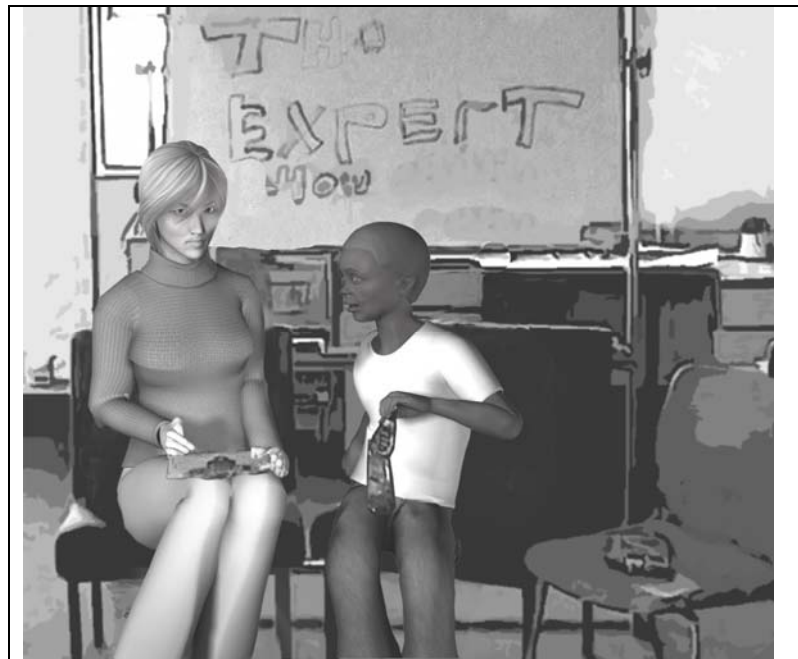


**Emily**: {looks at child}   If you wanna pass on a question you'll just say please send {gesturing to right}   that to the helpline {looks at interview schedule} yer↑

**Bradley:** Where's the helpline {leaning forward looking at direction Emily gestured in}

**Emily:** We just   {gestures to right looks right looks at interview schedule} it's done by telephone

4.39

**Figure 21: Unsuccessful caregiving**

**First Call** (6.42 -8.42)

This segment began with an *attuned moment*. There was eye contact and the therapist's high level *vitality affects* matched the child's (see Figure 22). The therapist was accepting of the child's change in pace and request for the therapist to take the call first. Here the therapist was appropriately *caregiving* in response to child's *careseeking* cues.



| |
|---|
| **Emily:** first→call {looks over to the right} rin::g rin:::g {turns to Bradley eye contact} *do→you→ [ want→to→take→it→[straight away {excited whisper} |
| **Bradley:** [{smiles:::} [{looks down at phone} |
| **Emily**: or shall I take it [first |
| **Bradley:**                [I'll→take it |
| 6.47 |
| **Figure 22: Matched vitality** |

However, there was a *'juncture point' (uncooperative)* at the beginning of this first call. The child immediately requested a break (*child careseeking*). The therapist ignored or missed this communication. The child reasserted his *careseeking needs* by suddenly leaning in close to the therapist and asking her to pass the caller to the helpline. The therapist accepted this. However, she remained in the *exploratory mode* and did not caregive by structuring this process to meet the child's needs. Rather she was

*misattuned* and instructed him to do it himself. This was an inappropriate use of a dramatic aside. The therapist instructed the child to maintain the role play, rather than *caregiving* within her own role in the play.

The child then reasserted *careseeking*, by leaning into the therapist and looking at the interview schedule asking her what was coming next. The child was also sucking on his drink, seemingly self-soothing, at this point (see Figure 23). The therapist appeared to have a *defensive response* to this *careseeking* which was slightly hostile and rejecting (see Figure 24 and 25).



8.21

**Figure 23: Reasserted careseeking**

8.22

**Figure 24: Careseeking dismissed**



**Emily**: {nudges Bradley away and hides interview schedule by bringing clipboard up to chest}   come→on→ you're→not supposed to look at this you're supposed to be over there

8.23

**Figure 25: Rigidity with task**

**Break** (30 secs before first break: 8.52; break 9.22; 30 secs of break up to 9.52; child agrees to start again 12.40; 30 secs after break -13.10)

This segment began with a *misattunement*. The child shared his experience of play therapy (*exploratory system activated*). His comment seemingly did not make sense to the therapist, or she disagreed with it. The therapist's tone of voice and level of intensity was strong, sudden, serious and questioning. The therapist's *defence system* appeared activated, this shut down the child's *exploratory system* and the child's *defence system* was activated. The child became uncooperative with the callers. He continually kicked his shoes off (*juncture point 'uncooperative')*.The child said: 'yer just shut up' he laughed and leaned in toward the therapist, seemingly searching for a response. The therapist ignored this and appeared preoccupied and focused on the task.

She continued with the interview questions. The child was slow in pace and the therapist interrupted with a further fast paced question. *Disengagement* followed, with the child requesting the call be passed to the helpline. This was a significant *'juncture point (unresponsive)'*. The therapist, in role as the child caller, sounded disappointed. The child told her he could not "stand it any longer" (high activation of *careseeking system*). The therapist ignored this stronger message of wanting to finish. She was *misattuned* emotionally and used a cajoling persuasive tone of voice saying "you don't want to try anymore". This was a further example of *ineffective caregiving* as the therapist was not responding in a genuine empathic manner. The child strongly reasserted his need for a break by shouting and using a downward motion with his arm. The therapist was *responsive*. Her *vitality affects* mirrored the child's as she clearly structured the break, using a clear loud confident tone of voice to address the audience (*appropriate caregiving*). The therapist turned to the child and asked him if the last question was difficult. This was *emotionally misattuned* to the child's complex affect of frustration, enjoying being in control, teasing the therapist and wanting to finish.

The child then stood up and walked toward the camera. He asked the therapist if he could watch the film so far. He was excited. This was demonstrated in his tone of voice and body movement. The therapist was *misattuned* to the child, she was serious and used closed in, short stiff body movements shaking her head and saying '*no'*. This may have been an appropriate place to set a limit as the therapist may have predicted, from the child's excited body language, that he would damage the camera. However, the therapist did not attend to this child's desire to explore, for example by reflecting his

excited feelings. The therapist's response seemed to shut down the child's *exploratory system* and the child's *defence system* was activated. He *withdrew* from the therapist and appeared agitated, walking around in a relatively quick impulsive manner. The therapist then switched to using a cajoling voice asking the child to come back toward her and have his break, indicating he should sit on the chair beside her again. This was *misattuned* with the child's need to be physically active and to have distance from the task, and possibly the therapist herself. The child disengaged from the therapist completely and conversed with the camera regarding his snack. The child's *defence system was highly activated.*

He became more chaotic as he threw his crisp packet across the room and panted like a dog to the camera. There appeared to be a distressed element to these actions rather than a playful overtone. The child's *defence system* seemed to remain active. There was continued *misattunement* as the therapist continued instructing the child and talking about the research. The therapist tried three times to re-engage the child in the task, every time the child avoided engagement. After three minutes of the break the child himself gave an explicit message that he was ready to take calls again by stating "*start now*".

The therapist was *misattuned* as she used an overly upbeat tone of voice stating that the child was refreshed. The child immediately told the therapist to inform the audience that the line was not working. This controlling behaviour indicated that the child's *defence system* remained active. The therapist was *misattuned* and dismissed the child's request. The therapist's *defence system* appeared to be activated as she responded to the child in a mildly hostile manner, with a serious tone of voice and dominant body position, leaning toward and slightly over the child (see Figure 26).

**Bradley:** My phone's not {looks at phone} Say the line's {points arms forward flurries hand looks ahead knocks crisps off chair accidentally} not working

**Emily:** no:: {shakes hand side to side a little} cos' I need you to help (.)  remember you→said→you→ [were gonna {eye contact::::}

**Bradley:**                                                   [{picks up crisp packet sits upright faces Emily eye contact; open mouth}

**Emily:** didn't ya

**Bradley:** Say the line's not working

**Emily**: and then what {serious tone of voice leans forward}

13.11

**Figure 26: Misattuned; defence systems activated**

**Concluding Segment** (24.20 - 29.20)

This segment began with the child saying that he didn't want to talk about the reasons why he was 'in care'. The therapist was *responsive* and matched the child's mid-low vitality affect with a warm soft tone of voice (*caregiving*). The child then appeared *fearful and anxious*, his voice was serious in tone and it became younger and quieter (*child's careseeking system activated*). The therapist responded by pausing and attending to the child. She turned to the child and responded with a warm, soft tone of voice, and made a structuring comment again, about the end of play therapy (*therapist*

*caregiving*). The child then told the therapist about a possible major change happening in his life. The therapist was sensitive and warm toward the child (*caregiving*). However, the child suddenly became *defensive* and told the therapist to forget about it. Here the therapist *purposefully misattuned* to the child and congruently stated that what he was telling her was important (*therapist caregiving*). However, she then quickly moved on stating that they could talk about the issue afterwards.

The child then *disengaged*. He repeatedly, and noisily, blew into his carton of juice. The therapist was *misattuned* to the child's *careseeking* behaviour as she focused on further questions. The child reasserted *careseeking* by asking where the helpline was. This again gave a strong message that he needed to finish, particularly as this statement was coupled with him standing up and trying to physically remove himself. The therapist curtailed this, both verbally and via touching his arm. The therapist did not attend to the child's *careseeking* needs but continued to try to get the child to access his *exploratory system* (see Figure 27).



| |
|---|
| **Bradley:** Where's the helpline {stands up and takes one step forwards} |
| **Emily:** {pulls child gently by lower arms back into seat} there isn't a helpline {in amused tone of voice} *it's just a pretend thing* {whispered} so um I wanted to *as::k you* {shrugs shoulders} did you find play… |
| 25.39 |
| **Figure 27: Misattuned: Careseeking unassauged** |

The therapist remained *preoccupied* with the task, and the quality of the recording. She gently removed the drink carton from the child's mouth. This was a further *misattunement* and denied the child his mechanism of self-soothing. Following this the child's *defence system* became activated he shouted and kicked off his shoes. For a short while he became pleasing by repeating the therapist's phrases and repeating responses he made earlier in the session.

The child was physically intrusive toward the therapist, touching her face. The therapist was *responsive* to the child but was *mismatched in pace* and continued to question the child. The child continued to question the therapist about things unrelated to the task.

There was a repeated *misattunement* at time marker 27.19 of Figure 27 time marker 25.39 (described above). The child appeared worried about the possibility of other children being able to see into the room. The therapist misunderstood this initially. The child reasserted his *careseeking* needs and was verbally explicit that he felt shy whilst pointing toward the door. The therapist was *responsive* momentarily (*caregiving*) but then a repeat *misattunement* of time marker 25.39 occurred. At the end of this segment there was clear relief evident in both the child and therapist's body language and facial expression. The child was upright and smiling and the therapist's shoulders relaxed as she smiled also (see Figure 28).
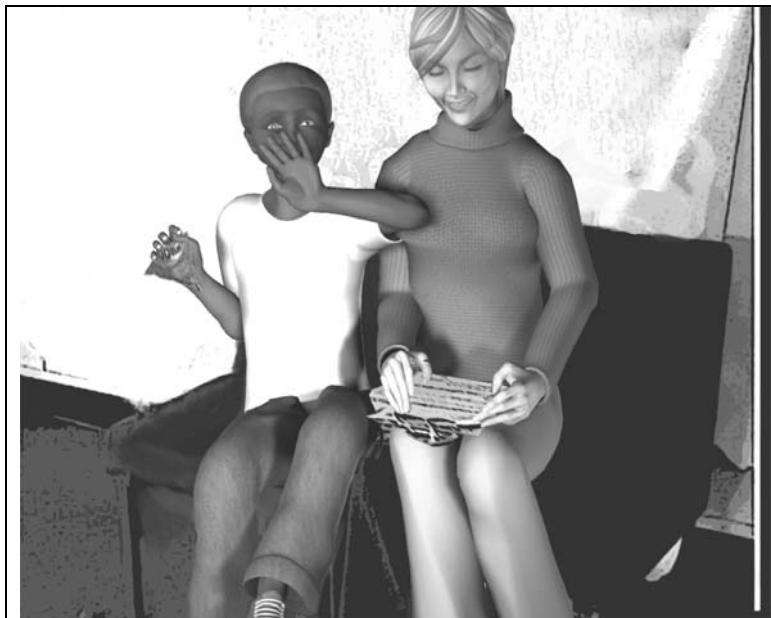


29.18

**Figure 28: Relief**

**Discussion of pairing**

**Summary of Interaction**

Several mismatched vitality affects have been described above. There were minimal examples of ruptures being repaired. There were some examples of attuned and responsive caregiving. The therapist was largely preoccupied with the task, often missing or ignoring the child's verbal and non-verbal communication. The therapist was at times intrusive and dismissed, refuted or curtailed the child's exploration. The therapist often approached the child on a cognitive level rather than responding to his affect. This pairing was characterised by a high level of misattunements throughout the evaluation session[201].

This dyad is similar to Koren-Karie et. al.'s (2003) description of emotionally mismatched mother–child dyads who are in the 'exaggerating; overreacting and overwhelming' group. Here the mother is either dismissive, hostile, or ignores the child's vitality affects, particularly when the child talks about something the mother does not want to discuss. Koren-Karie et. al (2003) describe these dyads being characterised by dysregulation, incoherence, sometimes expressed through repetitiveness. Another feature of these dyads was the child's strong need to please. Similarly, the views expressed by Bradley were repetitive in nature and the group of codes categorised as 'child's need to please'[202] was coded the highest number of times for this child, 35 (average 5.7).

The child's careseeking needs were often overlooked or dismissed by the therapist. As McCluskey (2005) states:

> "As a caregiver, sometimes, one has only to hesitate even momentarily, from engaging authentically, for the interaction to become set in a pattern. The careseeker will pick up the hesitation immediately and will either renew pressure or withdraw". (210-211).

The child in this dyad at times renewed the pressure to get his careseeking needs met, stating them in stronger, more vocal, or physical ways. This sometimes led to the

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[201] In comparison with the other 19 children in this study.
[202] 'Child's need to please' group included the following codes: child's need to please; checking therapist's reaction; asking permission; and child acquiesces see appendix 18b for full description.

caregiver's (therapist) caregiving system being activated and meeting the child's needs. Other times it was ineffective and the child withdrew. His defence system became activated more frequently across the course of the session and for longer periods of time. He withdrew from the therapist and engaged in dysregulated behaviour. For instance panting at the camera like a dog, unlike Hannah (described below), he did not turn back to the therapist to 'check in'. This indicates that he was unable to use his therapist as a 'safe base[203]'. At this point the therapist's own defence system appeared to be activated. Thus the therapist was ineffective in acquiescing the child's defence system. It is suggested that the session being recorded and being part of the research, knowing that the tape would be scrutinised, would compound the therapist's anxieties of 'getting it right'

The high activation of this child's careseeking system, and defence system, interfered with his ability to access his exploratory system. He shared the fewest views about play therapy in the data set (16 quotes were coded as relating to play therapy, average 59). Furthermore these views were concrete and brief in nature, as stated above they were often repetitive. In addition the amount this child's comments were a true reflection of his own views is questionable due to the coercive nature of the interaction. Whilst the codes 'child leads' and 'child's idea' were coded a high number of times (30, average 22) which may be indicative of a child accessing their exploratory system, when one studies these in context it is clear that these were often unsuccessful or short lived. This was due to the therapist refuting or curtailing the child's idea or lead. The power and consent issues will be considered further in the next chapter.

This pattern of interaction was most similar to McCluskey's (2005:224) pattern 7 described as ineffective caregiving: Careseeker states initial anxiety but diverts attention, caregiver misses original affect and pursues the detail of other issues, careseeker gives terse/teasing responses; caregiver keeps engaging, careseeker becomes dismissive, both careseeker and caregiver's self-defence systems become activated. The factors contributing to this pattern are considered below.

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[203] As described in chapter four: Ainsworth, (1978).

**Environmental and Contextual Factors**

The therapy was ending prematurely and the child had been in 'limbo' throughout the intervention with regards to his care arrangements. This child had a high number of presenting problems including attachment difficulties and he had experienced high levels of abuse. This increases the likelihood of dysregulated behaviour being observed (Main and Hesse, 1990). The therapist stated in her pre-evaluation questionnaire that the child "trusts no-one" and was very difficult to "soothe". Thus it is likely that this child had developed maladaptive ways of relating and in general it would be difficult to successfully acquiesce his careseeking and defence systems. This is likely to be compounded due to his current insecure care arrangements. The reader is again reminded of McCluskey's assertion that it is essential that the client's IMER is taken into consideration when making sense of interactions in psychotherapy.

**Child Factors**

During the evaluation session itself the child questioned or placed demands on the therapist throughout (coded 24 times) and the group of codes categorised as 'child disengages'[204] was coded a very high number of times for this child, 82 (mean 15 median 10). Therefore this child was categorised as a difficult to engage child.

However, these child factors during the evaluation session have to be understood in terms of the interaction. This child instigated the use of the ground rules a high number of times in the evaluation session (25). As described in some of the examples above the therapist often ignored or dismissed the child's use of a ground rule or emotional messages. Thus, it is expected that this child would try to disengage from the task a high number of times. He needed to try different strategies to ensure this therapist responded to his careseeking needs.

It is also possible that 'The Expert Show' was not suited to this child's needs. This child was highly active in the session demonstrating a need to move around. 'The Expert Show' is a relatively static activity. This therapist encouraged the child to remain seated and was rigid in her approach to him moving around. This may have been motivated by a desire to obtain a clear recording for the research. However, if the therapist had

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[204] 'Child disengages' group included the following codes: asking when the session will end; asking about the interview process; child avoids the question; child disengages a call; child distracted; child passes; child ignores therapist's instructions; child questions or makes demands on the therapist'.

allowed the child to move around more, both during the break and the session itself the child may have found engagement easier. It is possible that this still would not have met this child's needs and the 'Miniature Playroom' technique or the puppet technique may have been better suited to his need to be more physical. Furthermore 'The Expert Show' is highly reliant on the child's language skills and left-hemisphere processing (see Siegel, 1999). This child may have needed more active visual and tactile cues to share his memories of play therapy. This therapist did not offer the alternative techniques so it is not possible to comment further on this with regard to Bradley.

However, it is suggested that for this child conducting any PBE at this point may not have been in his best interests. Contra-indications[205] were present in Bradley's case, including the therapy ending prematurely, the instability of the child's home environment and the strong feelings regarding ending evoked in the therapist (see below). Furthermore there were indicators from this research that similar to the child Ryan (2004) presented[206], Bradley had highly complex needs and the therapeutic intervention was unsuccessful. As Ryan acknowledges there is continued debate in the play therapy literature regarding working with children in transition (see Carroll 2001, West, 1990 and Wolff 1986). Ryan (2004) suggests that consultation may be more helpful for these children, rather than direct engagement in therapy, it seems this may have been the case with Bradley.

**Therapist's Skill Level**

In my dual role as researcher and trainer this interaction and the therapist's skill level raised ethical considerations. These are discussed in the next chapter. Here analysis of the process between the dyad is focused upon. Analysis of the therapist's process revealed the lowest 'score' on the 'combined therapist skill' rating[207]. When this was broken down 'hindering interview skills' were coded high number of times[208] and 'therapist leads' was coded high number of times. There was not a high number of hindering acting skills. Facilitating skills in all areas (following the child's lead; making non-directive reflective statements; interviewing and acting) were recorded mid-high number of times in comparison to other dyads. However, it is important to note that

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[205] Contra-indicators to PBEs are discussed in chapter nine.
[206] Discussed in chapter four.
[207] This is a skill level specific to the PBE and does not reflect the therapist's skill level in play therapy sessions generally
[208] In comparison to the other dyads in this study, see appendix 24.

when the context was reviewed qualitatively, it became clear that this therapist gave the child mixed messages. She often initially demonstrated acceptance but refuted this later on. This therapist's 'combined skill' score resulted in a negative number as there were more quotes coded in the inhibiting categories than the facilitating category.

This therapist was preoccupied with the task and needed to focus on the interview schedule frequently. This is likely to be due to her unfamiliarity with the schedule and technique. This was the second time she had conducted an evaluation (the first being a training tape). Furthermore there was a four month interval between her attendance at the training and her training tape and a further four months between the training tape and this evaluation[209]. The focus on the interview schedule meant that she frequently missed the child's cues but also meant her resources were focused on the task rather than attuning to the child.

I am very grateful to this therapist's continued commitment and engagement with the research as her openness and willingness to reflect upon her experience allows us to gain a greater understanding of the use of PBEs. I have viewed two other PBE's conducted by this therapist. Unfortunately it has not been possible to include them in this study in full because the first was her training tape and in the latter tape a third person was included in the evaluation[210]. However, it is noteworthy here that this therapist's skill level was higher with both of these children, and they both engaged more fully in the PBE session.

**The Research Context**

It is suggested that the therapist's strong desire to 'get things right' for the research, to be accurate in her delivery of the protocol, led to her emphasis on the child 'performing' well. This therapist shared with the researcher a strong belief and commitment in the techniques and to research in play therapy in general. This strong desire to add to the evidence base of play therapy may have heightened this therapist's focus on the child sharing as much as she thought he was capable of, despite him indicating he was finding it difficult.

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[209] See table 5 in chapter six to compare training – training tape – research tape intervals.
[210] It was decided that this changed the dynamics of the interaction to such a degree that it would not be helpful to include it in the research cohort, particularly because the third person was off shot for the majority of the session. Therefore non-verbal communication from and directed to this person was not possible to document.

This therapist demonstrated some awareness of her tendency to 'chivvy' the child along (recorded in her post-evaluation questionnaire). This commitment to the research, and perhaps a positivist view of research[211], may have led to the therapist being rigid within the session (for instance initially hiding the interview schedule from the child). This highlights the need for therapists to have further training in the aims of qualitative research and how validity can be established in a variety of ways (see Flick, 2007). This was an issue in varying degrees for most participants in this study.

Further communication with this therapist, and completion of the post-data collection questionnaire, highlighted this therapist's growing awareness of the importance of putting the child's needs first and ensuring that a drive to gain 'good data' does not override this. Her advice to other therapists conducting the techniques was:

'Remember to let the child lead and do as little or as much as they want – don't' coax or encourage them to do more, even when you know they could'.

**The Influence of Therapists' Own Feelings**

It is suggested that this therapist's defence system was activated frequently throughout the evaluation session partly due to the context of the play therapy intervention. The work had ended prematurely and the therapist had recorded on the pre-evaluation questionnaire:

"This was a very unsatisfactory case and very difficult to work. I feel strongly for this child."

She stated that "little changed for him." Thus it is likely that the therapist's own difficult feelings regarding an unsuccessful intervention and possible feelings of powerlessness due to the external factors, which she had no control over, impacted on her ability to attune to this child's careseeking during the evaluation session. It is likely that these feelings would have been compounded by the fact that this was the last time the therapist would see the child. This coupled with the technique being new and demanding, and the child being challenging, may have contributed to the therapist's

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[211] Where validity is demonstrated by strict adherence to replicating conditions in experimental research (see Bryman, 2001),

defence system being activated. This led to her trying to maintain a sense of control in the session, via dominant/submissive patterns rather than supportive/companiable patterns of relating (see Heard and Lake, 1997). The therapist showed some awareness of this process in the post-evaluation questionnaire she acknowledged that the child was a "…bit reluctant and wanting to be in control…he seemed a bit different perhaps because I was in total control of the whole context and was directive."

Interestingly toward the end of the evaluation, the therapist did attune to the child and respond to his therapeutic needs rather than prioritising the task. It is suggested that the therapist was better able to access her caregiving system by this point as the demands of the evaluation task itself were reduced. At the end of the task clear relief was seen in the child but also the therapist.

In McCluskey's study a key finding was "that some caregivers performed very poorly according to their own, and other's standards (objective and subjective) while doing extremely well with different careseekers and with the same careseeker when that careseeker was in a *different state*." (2005:194). Here it is suggested that these are possibilities for this therapist and further it is quite possible that this therapist (caregiver) would have been more attuned to this child if she herself were in a 'different state' i.e. not one of anxiety and cognitive overload due to the pressures of the evaluation task.

**Conclusion**

In summary a combination of factors may have contributed to the high levels of misattunement observed in this dyad. These include child factors: high number of presenting problems (including attachment difficulties); high levels of challenging, controlling and anxious behaviour observed. The therapist factors include: limited experience of conducting PBEs; low level combined therapist skill in relation to this child; unresponsive to child cues and an activated defence system interfering with her ability to repair ruptures in the attunement. In addition the PBE technique may not have suited this child's needs nor be the right time to conduct an evaluation due to the premature ending of therapy and insecure care arrangements. It is striking that in this dyad with high levels of misattunement the lowest number of quotes were coded as the child expressing his views of play therapy. Furthermore the quality of these views was repetitive and limited. This points to ineffective caregiving resulting in the child's

exploratory system being closed down. It is suggested that an evaluation session was contra-indicated for this child.

## Misattuned Dyads with Repair

I now turn to two further examples where there were some misattunements, but also repair, in the interaction between therapist and child during the PBE session. The first example is a child who was easy to engage, similar to Herbert: Cathy. The second is a child who was difficult to engage, similar to Bradley: Hannah.

## Exemplar Three: Pairing with Misattunements and Repair; Easy to Engage Child

Cathy (Child 9.1yrs) and Lucy (Therapist). A pairing with initial attunement, however as the evaluation session progressed there were several misattunements where some ruptures in the attunement were repaired by the therapist and some managed by the child. The child appeared easy to engage. The child was referred due to experiencing neglect and witnessing domestic violence. She reportedly had attachment difficulties. She also had anxiety and self-esteem issues, and sleeping difficulties. She had received short term therapy (10 sessions) and had completed the therapeutic intervention planned. The therapist had some previous experience of PBEs (three previous evaluations completed one being a training tape). The therapist had a low score on the therapists combined skill level in relation to this child (with a previous child she had a lower score and with the second and later fourth evaluation her score had improved to a low-mid score).

### Initial Engagement (0:00-5:00)

At the beginning of this evaluation the therapist was *attuned* to the child. She matched the child's mid-low *vitality affects* with the use of a soft tone of voice. Then there was a *purposeful misattunement* where the therapist raised the affect level. Her body language was open, she stressed the permissiveness of the session and her tone of voice increased in intensity and shape. This was *responsive* to this child's anxious presentation and her need to please (see Figure 29).

**Lucy:** O↑K↑ now→you→can→call→it→{closes eyes tightly and opens whilst hands close in and open outward} *whatever::::* you want to call it

00:15

**Figure 29: Attending to anxiety**

The therapist then provided *structure* but remained responsive to this child's slow and gentle pace. Just over a minute into the evaluation the child's *careseeking system* was activated. She asked the therapist for help: how to spell 'expert' for her name badge. The therapist provided *reassurance* and addressed the child's need to please by letting her know it was her choice. This *caregiving* from the therapist resulted in the child's *careseeking need being acquiesced*. The child's body language relaxed and she re-engaged in creating her badge in a purposeful manner (*exploratory system activated*). The therapist became pre-occupied with the equipment available. The child waited patiently and looked concerned. The child's *caregiving system* seemed to be momentarily activated.

The therapist disregarded her previous concerns and re-focused on explaining the task to the child. There was *emotional resonance* between therapist and child during this explanation (see matched facial expression and relaxed body language in Figure 30).

2.09

**Figure 30: Re-focused on child**

There were two repeated sequences of the child seeking help from the therapist. The therapist responded in a similar way to the previous example (*therapist caregiving*, see Figure 31). The therapist remained attuned to the child, and *responsive to* the child's slow *pace*. The tone and intensity of her voice matched the care and 'shape' of the child's markings on her poster.
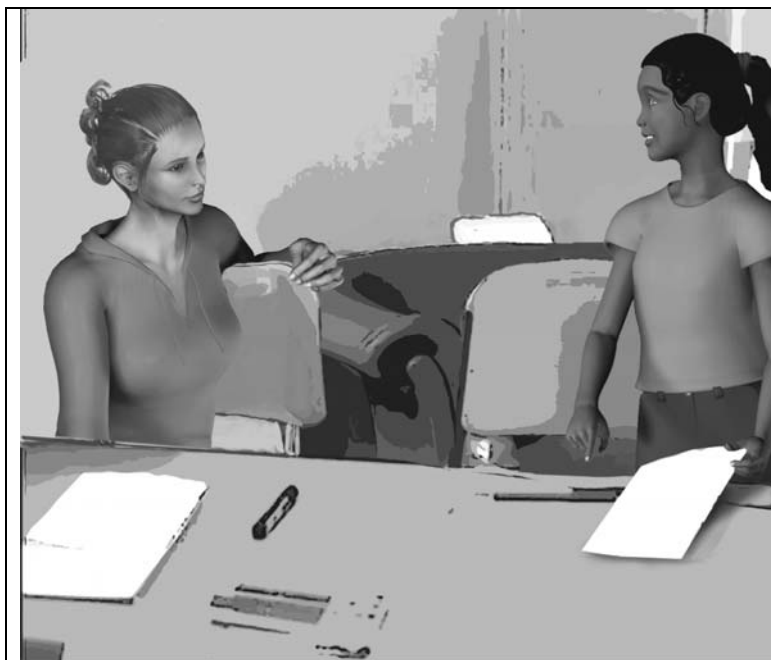


2.44

**Figure 31: Responsive caregiving to slow pace**

There was another *matched vitality affect* at time marker 3.47. The therapist's facial expression matched the contour of the child's vocalisation. The therapist asked the child how she would let her know if she wanted a break. The child looked at the therapist and told her that she didn't know *(child's careseeking system activated)*. The therapist was *responsive* and provided *structure*. She offered possible choices to the child *(therapist caregiving)*. The child's *careseeking* system had only just quietened when the therapist moved onto the next area of exploration. The therapist then proceeded a little too quickly to the next ground rule and there was a *slight mismatch* in *pace*. The *child repaired this slight rupture* by asserting her own response regarding the break *(child's exploratory system activated)*. The therapist was quickly *responsive* and matched the child's sudden animated tone of voice with an animated facial expression: raised eyebrows and she leant her head in toward the child. The therapist was accepting of the child's idea. The therapist rehearsed this with slightly more animation than the child had used. This again demonstrated a *purposeful misattunement*: raising the affect upward. The therapist remained *attuned* to the child's slow gentle *pace* to the end of this segment.

**First Call** (8.26 – 10.26)

This segment began with a *misattunement*. The therapist turned away and shielded her face from the child. She was *preoccupied* with enacting the child caller and reading from the interview script. She missed the non-verbal signals of increased anxiety the child displayed. The child's body had become tense/rigid, her eyes widened and her hands were raised to her mouth. She looked toward the therapist *(careseeking behaviour)* but the therapist was unavailable (see Figure 32).

8.26

**Figure 32: Careseeking cues missed**

When the therapist completed the caller's question she turned to face the child and in her role as the presenter she asked whether the child could answer the call. The child was slightly confused about the process and the therapist readily *attuned* to the child's *careseeking,* she provided *reassurance* by smiling and nodding her head *(caregiving)* (see Figure 33).



8.44

**Figure 33: Effective Caregiving**

The child answered the phone (*careseeking system was acquiesced and exploratory system enabled)*. However, the therapist was slightly *mismatched* in *pace*. The therapist did not respond immediately to the child answering the call. The child then filled the conversational gap on the phone which led to her playing a dual role as caller and expert. The child struggled to maintain this and looked to the therapist *(careseeking)*. The therapist did not pick up on this cue (possibly because the child taking on this dual role was confusing to the therapist). Instead of taking up the role as conversational partner the therapist remained in the presenter role (*child's exploratory system was shut down)*. The therapist then relatively quickly *repaired this misattunement*: by feeding in a question from the child caller through her role as the presenter (*exploratory system reactivated)*. The therapist remained *attuned* to the child: she looked at the child and reflected what the child said. She *matched* the child's mid-level vitality affect and the therapist became *responsive* again to the child's slower *pace* (see Figure 34).



9.48

**Figure 34: Repaired rupture**

**Break** 20.12 beginning of segment 20.42 break camera is off during break so runs straight back in 20.55 – 21.25

At the beginning of this segment the child was quiet and used an uncertain tone of voice. Her pace was slow. The therapist was *misattuned*: she responded to the child's

affect in an up-beat relatively fast paced manner. At time marker 20.42 the child initiated a break in a confident manner. The therapist accepted and *matched* the child's confident affect. The therapist *structured* the transition supporting the child to switch from being on the TV to having a break. The therapist turned off the camera during the break. When the camera was turned back on the child and therapist jointly structured the transition back to the task. The therapist waited patiently and allowed the child 'space' as she slowly provided the telephone number. The child then patiently waited for the therapist to introduce the next part of the show. There were no further *misattunements* nor moments of high attunement in the remainder of this section.

**Concluding Segment** (28.46 -33.46)

The therapist and child were sat on a sofa in a slightly different part of the room at the beginning of this segment. They had already transferred to the 'chat show' phase of the 'Expert Show'[212]. The therapist had just asked the child if what she said to the callers was the same as her own experience. The child responded by referring to a particular call she had previously taken. Whilst this call was not part of the concluding segment it is worthy of note here for the reader to understand the context and significance of the misattunement which followed.

In the call, referred to, there had been a series of *significant misattunements*. The child had shared her memories of important and special moments in play therapy. She focused on her fears and the importance of overcoming her worries. Her affect was heavy and sad. The therapist responded with a cheerful and matter of fact presenter voice and led the child to more concrete examples of 'activities' she engaged in during the intervention. Thus she was *mismatched* both in terms of affect and focus. The child was accessing emotion laden memories and the therapist led the discussion to more concrete cognitive memories. The therapist's *defence system* seemed to be *activated (avoidance/anxiety)*. At this *'juncture point' (contentious topic)* the therapist led the child to another area. At the end of this call the therapist 'broke the rules of engagement' by suddenly switching roles and the child caller 'Amelia', whom the therapist had been playing, 'disappeared' (the therapist had switched to being the presenter and maintained this role rather than returning to play Amelia to say goodbye). After a short while, of the therapist being the presenter, the child quietly said "bye

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[212] See chapter five for a reminder of this process.

Amelia" whilst holding the phone tight to her chest. This communication was missed/ignored by the therapist. The therapist appeared to be preoccupied with the demands of the task (*thus her caregiving system was disabled - she overlooked the child's careseeking needs*). The loss of the child caller 'Amelia' to whom the child had strongly identified with was left unresolved.

In the concluding segment the child recollected this earlier call with 'Amelia'. The therapist responded with a pause and did not acknowledge the emotional significance and meaning. The therapist then asked why the child was referred to the playroom. This is the next question on the interview schedule but in the context of this child's evaluation was *misattuned* because the call the child had been referring to was the one where she had shared information about why she had been referred. However, the child engaged in exploring this again despite this *misattunement* and was able to *repair the interaction* herself.

A further *misattunement* was identified as the child emphasised the importance of play therapy to her. The child was highly animated (in comparison to the rest of the session) her verbal communication was intensified. Her facial expression was highly animated with a smile and open smiling eyes. This was *mismatched* by the therapist: who remained serious and neutral in the role as a 'presenter' (see Figure 35).

**Cathy**: {looks upward then ahead} I really really *did* {eye contact} have *fun* {looks at therapist; looks in lap}

**Lucy**: {looks at interview schedule::} OK↑ well thank you very much for that K*↑ now I think↑ …{serious presenter tone of voice}

29.42

**Figure 35: Mismatched affect**

The therapist then provided structure to facilitate the child's previous request of doing a 'tour of the playroom'[213] *(therapist caregiving)*. However, the therapist became preoccupied with the video equipment and was *slightly mismatched* in terms of *pace*, going faster than the child. The child caught up and *repaired this slight rupture* herself. From time marker 30.41 to the end of the segment the child interacted directly and confidently with the camera[214]. The child's *exploratory system* was activated *throughout this part of the segment*. There was a last *misattunement* at the end. The child faced the camera, she had an animated facial expression. She was smiling, and

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[213] This evaluation took place in the same room as the therapy intervention. It was apparent from the child-therapist conversation that the child had previously requested to show the 'TV audience' the playroom and the things in it – hence undertaking a tour.
[214] The therapist could not be seen so it was unclear what the non-verbal communication is between therapist and child, there was one congruent verbal comment made by the therapist about trying hard to have the camera match the child's pace.

made an intense verbal comment. The therapist responded with a remark which closed down exploration (see Figure 36[215]).



| |
|---|
| **Cathy**: {walks back to sand tray; 2.0 stands by sand tray; puts hand in sand; turns to face camera; smiles}  this is my *really really* fa::↓vourite thing<br>**Lucy**: Alright↑:: *that's:: gr::eat:*↓ {turns off camera} |
| 33.46 |
| **Figure 36: Exploratory system closed down** |

**Discussion of Pairing**

**Summary of Interaction**

In this pairing a good level of attunement was evident in the initial engagement. The therapist was effective in engaging this quiet, anxious child. She was responsive to her slower pace and occasionally used purposeful misattunement to regulate the child's affect. During the first call the demands of the task increase for the therapist and this therapist's responsiveness became less consistent. However, both the child and therapist repaired the slight ruptures which occurred. The third segment, the break, demonstrated continued inconsistency. Following an initial misattunement, the therapist attuned to the child's needs. She was able to effectively facilitate the transition to and from the break. Difficulties in maintaining attunement were evident when switching roles was required. The therapist tended to play an up-beat presenter focusing on cognitive facts rather than emotion-laden memories raised by the child. The child appeared to repair several of the

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[215] Therapist is off-shot.

ruptures in attunement. This was characteristic of several other calls in the session and was clearly evident in the 'chat show' phase of the concluding segment. The child remained engaged in the task throughout the session and ended with her own unique way of sharing her views of play therapy.

This pattern of interaction held some similarities with Koren-Karie et. al.'s (2003) emotionally mismatched: exaggerating, overreacting and overwhelming category. Overdramatisation by the therapist in the presenter role was observed, some confusion and mismatch of affect was present. A need to please from the child and some role reversal was evident. There was some evidence of dismissal at juncture points, for instance the child talking about difficult emotions. However, some features present in Koren-Karie's sample were not present here, including negativity, and extreme or dysregulated narrative. There were parallels with Gertsch-Betten et. al.'s (2003) category of over-regulated mothers. These mothers avoided the affective core of the story and sought an accurate account, similar to this therapist's concentration on concrete facts. However, in terms of McCluskey's (2003) interactional patterns this dyad seemed to fluctuate between patterns two and three. Pattern two is ineffective caregiving where there is a cycle of the careseeker introducing issues and the caregiver interrupting or diverting the careseeker away from affect-laden content. In this pattern the careseeker persists initially but finally withdraws and gives up. Cathy did not give up, possibly because the caregiving was 'good enough' and attuned some of the time, or the caregiving in this relationship was usually more effective. At these times the interaction followed pattern three. Here the same pattern of initial mismatch is seen, but resolution occurs due to the caregiver refocusing and attuning to the careseekers needs. In addition Cathy's persistence and continued exploration may be a reflection of Cathy's capacity to self-regulate and her low careseeking needs at this stage of the therapy. These factors are considered further below.

**Child Factors**

In terms of the contribution of child factors it is interesting to note that whilst initial avoidance, nervousness, and fidgeting were coded in relation to this child, there was only one quote coded under the group of disengagement codes. The child actively leading or suggesting ideas was just below the average. 'Growing confidence' was coded three times across the course of the evaluation session. The child's need to please was evident but not overly high (5: range 0-16). This child did have a mid-high number

of presenting problems, including attachment difficulties. However the therapist highlighted in her pre-evaluation that Cathy was a 'resilient child' who had increased in confidence. Schore (2003a) suggests that difficulties in emotional regulation develop at the point where the caregiver fails to 'repair' and the growing child remains dysregulated. Cathy had seemingly developed the capacity to self-regulate, either via her early attachment relationships or through the therapy intervention. Thus she was not wholly dependent on the therapist making this repair. It is therefore suggested that Cathy was a child who was relatively easy to engage in the task.

The child shared a high number of views; there were 79 quotes assigned to a children's views code for this child (Mean:54, range: 16-157). The quality and depth of her views was also good. She shared her views on a wide range of topics. She both talked about and demonstrated her wide range of feelings about play therapy alongside more concrete comments about play therapy. This indicates that the child's 'exploratory system' was activated for a high proportion of the session.

**Therapist's Skill Level**

This therapist had only undertaken two other 'Expert Show' evaluations prior to this one[216]. The need to change role, maintain neutrality and follow the interview schedule whilst maintaining responsiveness to the child's needs is very demanding. It is suggested that as the demands of the task increased this therapist's ability to attune to the child decreased. The therapist herself recorded on the post-evaluation questionnaire that she had become confused at times during the evaluation session.

Emphasis in the training is placed on maintaining neutrality and ensuring that the child is not led by the therapist's responses. This was a skill this therapist was actively working on. She had received feedback in the training that she had a tendency to over-characterise the callers e.g. as overly nervous. This may have overly inhibited this therapist and led to her maintaining a seriousness and level of neutrality when she played the presenter, which was not emotionally attuned to this child. Hindering acting skills were coded quite frequently for this therapist (13 mean:3 [217]). However facilitating acting skills were also coded frequently (23 mean:13). Overuse of turning

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[216] One of these was a training tape and the third prior PBE had been one utilising the miniature playroom only.
[217] This mostly reflected being misattuned when engaged in characterisation, particularly as an overly up-beat or serious presenter.

away from the child when on the phone may also have originated from the training session. It was pointed out in the training that the phones meant the child did not have to be in direct eye contact with the interviewer and allowed the child a sense of distance. The code 'ignores/misses non-verbal or verbal cue from child' was coded 11 times (mean:5 median:3). An oversight in the training was not emphasising the importance of the child being able to see the interviewer's face and the interviewer maintaining the child in their peripheral vision. This allows the therapist to remain responsive to the child's non-verbal communication.

This therapist did not use many verbal reflections in her responses but focused on asking the questions on the interview schedule. The therapist was not overly leading however. Non-directive therapy skills were coded infrequently (23 mean:67). There is evidence from another case with this therapist, using the 'Miniature Playroom', that she is competent using verbal reflections and used them far more frequently (51). However, within the context of the TV show interview, it seems this therapist's use of reflection and paraphrasing was inhibited. Lucy commented on the follow-up e-mail questionnaire on the importance of practising the 'Expert Show' protocol in order to familiarise oneself with the schedule. She also noted that 'not trying too hard to follow the schedule to the letter as this ties you up in knots and can feel unnatural'. A further difficulty highlighted by Lucy was integrating a directive technique into non-directive practice. It is suggested that the 'Miniature Playroom' was more akin to Lucy's usual non-directive practice so she was able to use her existing skills more easily. Her initial perspective of the 'Expert Show' being a fixed direct technique which needed to follow a rigid structure to be valid for research seemed to disarm her and quash her use of non-directive skills. There was some improvement in her skill level overtime and from a qualitative perspective she appeared more confident, relaxed and natural with Sarah, her third 'Expert Show' evaluation.

**Influence of Therapist's Own Feelings**
It is possible that the therapist's defence system was occasionally activated during the evaluation session. This child had short term work and the therapist may have felt that she had not provided enough to assist this child. She stated on her post-evaluation session questionnaire that she had been worried that this child would not make sufficient progress due to external factors. Therefore listening to the child recount her fears and anxieties to 'Amelia' the child caller may have activated the therapist's

defence system, specifically avoidance. There is further support for this assertion in the therapist's pre-evaluation session questionnaire. The therapist recorded the following response:

> "Cathy's use of the therapeutic relationship to explore her worries and anxieties had a real impact on both of us."

Despite the above difficulties the use of facilitative interview skills for this therapist was coded frequently throughout the evaluation (30 mean:29). It is unclear whether the level of attunement in the relationship observed within the PBE session was characteristic of this dyad's relationship in the therapy intervention itself. Arguably, the attunement was mainly disrupted by the therapist trying to manage the demands of the task alongside being responsive to the child's needs. Without these demands it is likely that a more attuned relationship would be evident. If this were the case the child's ability to negotiate and manage the misattunements, in the evaluation, may be enhanced as they were happening within a relationship which was ordinarily more responsive. A limitation of this study is the lack of observational data of the intervention itself with which to compare the interaction observed in the evaluation session.

**Conclusion**

It is suggested that the therapist's combined skill level was 'good enough' in combination with the therapist's established relationship with the child and the child's characteristics (easy to engage). It is suggested that the combination of these factors enabled the child to make 'good enough' use of PBE. It is unclear and impossible to determine how much each factor contributed to the child's engagement. However, it is argued that increased attunement would have further enhanced this child's ability to access her exploratory system and thereby share her views further.

**<u>Exemplar Four: Pairing with Some Misattunements and Repair; Difficult to Engage Child</u>**

Hannah (Child 8.5yrs) and Judy (Therapist). An attuned pairing where ruptures in the attunement were repaired by the therapist. The child was categorised as difficult to engage, due to a high level of anxiety and controlling behaviours being observed. She had a high number of significant presenting problems (Attachment difficulties; anxiety/stress; self-harm; multiple bereavements; nightmares; behaviour problems at

both home and school and not coping academically). She had completed 12 sessions over four months and was due to move onto filial play therapy. Therefore this was not deemed to be the end of this child's need for therapeutic intervention. The therapist had a high level of previous experience and had previously conducted six PBEs, she scored very highly on the therapist's combined skill level in relation to this child (and highly or very highly for the eight other pairings included in this research).

**Initial Engagement** (0:00-5:00)

At the beginning of this interaction the child was in a *low vitality state*. Her facial expression was relatively immobile, there was avoidance of eye contact. She had closed body language, her arms were tightly crossed and her posture was slumped (see Figure 37). This was the first *'juncture point' (unresponsive/uncooperative)* and the child's *defence system* appeared to be activated. The therapist was slow in pace which matched the child's affect. She reflected that the child was looking uncomfortable (therapist's *caregiving system* was activated - verbal empathic statement).



0. 04

**Figure 37: Empathic response at juncture point**

The therapist was responsive to small non-verbal cues given by the child including a very small head nod which indicated affirmation (*child's defence system acquiesced and careseeking system activated).* By twelve seconds into the session the child displayed the first signs of engagement by holding eye contact with the therapist. Her arms relaxed slightly (see Figure 38).

0.12

**Figure 38: Initial engagement**

The therapist addressed the child's potential need to please, and commented on the process at a pace which was responsive to the child *(therapist caregiving whilst child's careseeking system activated).* By time marker 1.12 the child sat forward, moving into the space between herself and the therapist, her folded arms relaxed further and she maintained eye contact with the therapist indicating more active engagement *(the child's exploratory system was activated,* see Figure 39*).*



1.12

**Figure 39: Effective caregiving: engagement**

The child's vitality levels greatly increased in response to the therapist's use of rehearsal. The therapist enacted a child ringing into the show. Figure 40 below illustrates the child's relaxed posture, open body language and smile which was *matched* by the therapist's tone of voice in terms of intensity and the use of a light tone of voice *(both the therapist's and the child's exploratory systems are prominent).*



1.27

**Figure 40: Exploratory systems activated**

The therapist invited the child to lead by asking her which type of PBE the child wanted to do. The child responded with a high level of vitality shimmying her body from side to side, with a wide smile and full eye contact replied "a bit of both[218]". The therapist matched this affect with the intensity and tone of her voice, along with a wide smile, stating "you'd *like* to do a bit of both O::↑K"[219].

There was a *slight mismatch* in pace as the therapist put the miniature playroom away and the child focused on the phones. However, their affect *matched* and the therapist quickly re-engaged with the child by inviting her to make a name badge. Whilst the child made this name badge the therapist waited and was *responsive* to the child's slow

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[218] (line 52) Although Hannah suggested this at the start she later chose not to use the miniature playroom and used the 'Expert Show' only, with her own adaptations.

[219] (line 53)

pace. When the child completed her badge she suddenly sat forward displaying a high non-verbal *vitality affect*: puffing out her chest holding her hand to the badge on her chest with a wide open smile (see Figure 41). The therapist *matched* this high *vitality affect* sitting upright herself and the tone, shape, and intensity of her voice matched the shape of the child's body movement as the therapist stated "*Han↑nah* {smiles}".



4.01

**Figure 41: Matched high vitality affect**

At the end of this segment the child's confidence and engagement in the task continued to grow. Both the therapist's and the child's *exploratory systems* had been prominent for a sustained period. The therapist was *attuned* to this child's pace. The therapist again addressed the potential need for this child to be pleasing. The therapist made reflections about the process and the child's feelings. She structured the task by demonstrating how to engage with the 'audience'. The therapist again returned to *caregiving to acquiesce* the child's *careseeking system and allow her to explore*. The therapist held up the card to the camera and played out telling 'the audience' the number. The child then took the card from the therapist and imitated this (see Figure 42). Thus the therapist's *caregiving* had been successful in acquiescing the child's *careseeking system* and the child was again able to access her *exploratory system.*

4.52

**Figure 42 : Exploration active**

Throughout this segment the child took furtive anxious glances at the camera. At the end of this segment the child was able to look directly at the camera with open body language and was smiling.

**First Call** (6.59-8.59)

This segment began with a *misattunement* in pace. The therapist missed the child's non-verbal communication that she was answering the call. The therapist continued the call as a monologue not responding to the child. Thus the therapist's *pace* was too fast for child. Figure 43 illustrates the therapist being *preoccupied* with the task looking down at the interview schedule. (Notice the child was not within the therapist's peripheral vision). The child was looking at the therapist for cues *(the child's careseeking system remained highly activated as the therapist was mismatched and engaged in her exploratory system rather than caregiving).* The child became dis-orientated and confused.

299

7:00

**Figure 43: Missed careseeking cues**

There was a '*juncture point' (uncooperative)* as the child refused to take the call *(the child's defence system was activated)*. The therapist *repaired this rupture* by turning to face the child and was accepting of the child's lack of cooperation. She used a warm tone of voice. The therapist slowed the pace down, she commented on the process and allowed the child time to play with the phones (see Figure 44). Thus the therapist recognised the child's needs and accessed her *caregiving system*. This deactivated the child's *defence system* and the therapist responded to the child's *careseeking and own exploratory needs* as the child looked at the phones and sought the therapist's attention.

**Judy:** you're just having a look at the phone right yer

{looks at own phone}

**Hannah:** *they're real*

7.34

**Figure 44: Responsive caregiving deactivating child's defence system**

The therapist remained attuned to the child as she used a soft tone of voice to match the child's affect. At time marker 7.51 the therapist asked the child if she was ready for another call. The child indicated affirmation with a tiny head nod which the therapist immediately responded to. During the call the therapist was *responsive* in pace and both therapist and child shared lowered *vitality affects*. The therapist was aware of the child's *careseeking* need for face to face eye contact: she turned to the child *(therapist caregiving)* to repeat the callers question in the role as presenter. This meant the child did not have to respond over the telephone but directly to her therapist. At this point the child's *vitality affect* suddenly heightened. Her body became more upright, her face became slightly animated, she smiled and her tone of voice lilted. She shared her views of play therapy (*child's exploratory system activated).*

During the next call the therapist enacted a timid and softly spoken caller. This *matched* the child's own affect. The therapist switched to enacting the presenter and once again turned to the child and softly asked her if she wanted to take the call. The therapist was

*responsive* to the child's non-verbal communication of raising the phone near to her head. The therapist took this as an indication that the child was able to respond to the caller directly over the phone. The therapist checked with the child, who smiled and nodded in affirmation. The therapist provided a structuring encouraging comment for the child to go ahead and the child confidently answered the call with open body language and a smile. The therapist's sensitive *caregiving* here acquiesced the child's *careseeking system* and enabled her *exploratory system* to become prominent again.

**Break** 12.44 – 14.44 (30 seconds before break; 1 minute during break and 30 seconds after break)

This segment began with the child sharing her views about play therapy *(child's exploratory system activated)*. The therapist was responsive to the child's slow pace leaving pauses to allow the child 'space' to contribute her views. At time marker 13.12 there was a *'juncture point' (uncooperative)* as the child suddenly disengaged the call. She employed a sing song tone of voice *(careseeking)*. The therapist was responsive to this sudden change in pace and intensity. The therapist made an empathic reflection about the caller having had loads of questions *(caregiving)*. The child initiated a break and her false positive affect was heightened *(child's defence system activated, see Figure 45)*.



13.17

**Figure 45: False positive affect**

The therapist supported the child in addressing the audience. The therapist made an empathic reflection about the effort needed from the child *(therapist caregiving)*. She used a gentle tone of voice and had low facial affect, this was in contrast to the child's heightened affective state. This was a *purposeful misattunement*, and appeared to regulate the child: *affect regulation*. The child immediately engaged in colouring. The therapist relatively quickly moved back into the *exploratory system*: by asking the child questions, during this break, regarding the child's previous idea about having a website (time marker 13.30). At this point the child's *careseeking needs* had not been fully met. Her need to have a break from verbalisation and exploration of views to just play had been prematurely curtailed. Therefore this was a *misattunement* in terms of pace. This *rupture* was *repaired* by the child who was able to engage in this discussion. The therapist was attuned to the child's *vitality affects* as she explored and shared her views. The therapist smiled nodded and made vocalisations which *matched* the child's tone of voice.

At time marker 14.13 the child suddenly changed pace by pretending the phone was ringing. She made a ringing noise and looked at the therapist's phone. The therapist was *responsive* to this non-verbal cue and picked up the phone. The child's heightened *vitality affect* in tone of vocalisation, excited bodily rocking movements and wide smile were *matched* by the therapist's vocalisation and verbal acknowledgement "*Oh↑:::there's another call coming in gr:::eat↑↑*".

Both therapist's and child's *exploratory system* remained prominent during this call: The child's body movements were *matched* by the shape of the therapist's vocalisation of "oh↑↑hh:::↓"[220], her wide smile and the raising of her eyebrows. The child then established face to face contact with the therapist whilst maintaining the conversation on the telephone (see Figure 46).

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[220] ↓↑ = intonation down/up :::=elongated communication

14.34

**Figure 46: Face to face communication**

**Concluding Segment** (31.50 – 36.50)

This segment began with the therapist patiently observing whilst the child completed a poster. As the child finished this task the therapist was attuned to the child and used a soft gentle voice. However, she provided structure for ending the session *(caregiving)*. This was *responsive* to the child finding the evaluation itself increasingly difficult, indicated by her frequent initiation of breaks, her need to engage in play and slightly chaotic behaviour. The child had been oscillating between her *defence and careseeking systems*. The therapist gave the child a choice of how to end. The therapist was accepting of the child wanting to end the session with her own play about a play therapy museum.

The child became highly animated and engaged with the audience (see Figure 47). Her *exploratory system* was activated however this was not related to the evaluation task but therapeutic exploration (The *intrapersonal system* was mainly active here*).* However, the child frequently returned to look at the therapist or tell the therapist what she had done: interest sharing directly with the therapist and seeking care by way of reassurance (see Figure 48*).* The therapist was *attuned* to this and was warm and accepting. This represents a *'juncture point' (contentious topic/uncooperative)* as the child was engaging in exploration of issues outside of the evaluation task. The therapist was

304

initially accepting and the child continued exploring different roles and developing her play.



32.33

**Figure 47: Engagement with the 'audience'**



32.40

**Figure 48: 'Checking in' with Judy**

However there was a *mismatch* and rupture in the *attunement* as the therapist tried to lead the child back to exploring views of play therapy. The child tried to integrate this but became *dysregulated* and distanced herself from the therapist *(child's defence*

*system activated)*. The child engaged with the audience only (30 seconds). She then faced the therapist again to tell her what she was doing *(careseeking)*. The therapist repaired the *rupture* by attuning to the child's process. The therapist smiled openly had an animated facial expression which *matched* the child's high *vitality affect*. The shape, tone, and intensity of the therapist's vocalisation was also *attuned*. The therapist's vitality affect were a little lower than the child's *(a further example of purposeful misattunement and affect regulation)*. The child then enacted being a police woman and sent 'Hannah' (the child) to jail. The therapist was *responsive* to this play and congruently addressed the child's potential need to please and the symbolic assertion that Hannah should be punished, possibly for not completing the task. The therapist emphasised how surprised she was that Hannah was being punished and shared her own view that Hannah had engaged well in the task. This is a further example of *purposeful misattunement* by this therapist *(caregiving)* to address the child's emotional needs *(careseeking/defence system)*.

The child then engaged in a role play of 'strictly come dancing'[221]. This was unrelated to the task: however her *careseeking and defence* systems had been acquiesced and her *exploratory system* was reactivated. The therapist was warm and attentive observing this play.

The therapist then put in place a clear and concrete structure indicating the end of the evaluation. She stated that she was going to put the interview schedule cards away and actively did this stating that she was not going to ask the child any more questions (time marker 36.11). The child's play had become dysregulated and disconnected from the therapist as she pretended to be a clown *(child's defence system activated)*. The therapist reflected the child's disengagement and commented on how different the process was to usual. The therapist said she was going to turn the camera off *(caregiving)*. This deactivated the *child's defence system*: the child verbally stated she did not want to do it anymore. The child walked up to the camera and said 'and::: cut!' making a strong firm action downward with her arm (see Figure 49).

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[221] TV show

36.50

**Figure 49: Cut!**

### Discussion of Pairing

**Summary of Interactions**

In this pairing a high level of attunement was evident in the first segment, despite the child's initial uncooperativeness. In the second segment the therapist was misattuned to the child but was able to repair the rupture. The third and fourth segments were characterised by purposeful misattunements and the child entering her careseeking and defence systems more frequently. The child's engagement with the task of sharing her views on play therapy greatly reduced halfway through the evaluation. She entered her exploratory system on a sporadic basis for the second half and not at all, in relation to her views of play therapy, in the concluding segment. A high number of cross-modally matched vitality affects and extended verbal reflections by the therapist have been described above. Furthermore purposeful misattunements to lower the child's affect and emotionally regulate the child have been highlighted in this pairing. In contrast to Bradley (described above) Hannah was able to use the therapist as a 'safe base' whom she frequently returned to when she was engaged in her own exploration in the concluding segment of the evaluation.

Returning to Koren-Karie's et. al. (2003) findings, this dyad fitted the emotionally matched category, similar to Polly and Herbert. However, there were elements of the unmatched, inconsistent dyad group, due to the therapist following a cooperative and

consistent way of relating, but the child blocking the dialogue and also demonstrating anger at times. The therapist certainly matched Gertsch-Betten et. al's (2003) description of optimally-regulating mothers, similar to Polly described in the first exemplar. Turning to McCluskey's (2005) patterns of interaction rather than fitting the first pattern, as Polly and Herbert did, this dyad matched the third effective caregiving pattern: pattern nine. In this pattern McCluskey (2005:225) describes the careseeker presenting as often highly aroused, giving an incoherent account of concerns involving a lot of seemingly unconnected detail (this is seen in Hannah's use of a museum, the enactment of a TV show and a role play in which Hannah is sent to prison). The caregiver responds verbally and non-verbally, confirming, containing and encouraging. The careseeker continues to expand and the caregiver continues to respond by matching vitality affects and verbally focusing containing and orienting the careseeking.

**Child Factors**

It is suggested that it was difficult for this child to maintain engagement in her exploratory system for several reasons. She was referred due to attachment difficulties therefore it is likely that this defensive careseeking was a generalised pattern for this child, the reader is again reminded of the need to take into consideration the careseekers IMER when assessing the interaction in a psychotherapy context (McCluskey, 2005). The therapist described the child relating in a defensive manner toward others, for instance people in the waiting room.

The child had a high number of presenting problems and the therapist reported that these had not been resolved in the short-term individual play therapy she had received. The plan was to transfer to filial play therapy to focus on attachment related issues with her mother. Therefore healthier patterns of relating were unlikely to have been established for this child and her therapeutic needs remained high. The therapist recognised her continued need for therapeutic exploration within the evaluation itself and allowed this.

**Therapist's Skill Level**

Initially this child was anxious and uncertain. This child used very small non-verbal cues which the therapist was alert and responsive to (e.g. time marker 0.12 and 7.51 described above). It is suggested that this therapist was able to attune to this child and repair ruptures in the attunement well due to a number of factors. First the therapist was

likely to be alert to this child's small cues due to their established relationship. The therapist recorded in her feedback questionnaire that the child's demeanour was similar in the intervention as it had been in the evaluation. The therapist recorded that the child used smiles to hide her underlying emotions in the evaluation and in play therapy. The physical hiding behind the chair was also a familiar experience. This child used to hide under her coat in the waiting room. Furthermore a strong play theme identified by the therapist during the intervention was control and power vs. powerlessness. Similarly the child took control in the evaluation by making up the questions, taking on the roles of both the callers and the expert, instructing the therapist, and introducing new elements. Thus the therapist's skill level at attuning to this child's unique careseeking needs, in addition to identifying and responding effectively to the child's defences seemed to have been developed during the intervention. Interestingly the researcher's detailed and immersed observational analysis corroborated with the therapist's own reflections about the child's process[222]. The therapist's natural aptitude cannot be measured but is likely to contribute to the careful observation of Hannah's careseeking cues and effective responsiveness.

Second, the therapist's skill level at the task itself was high. She did not have a high level of need to look at the interview schedule and was not preoccupied with the task. This could be due to her experience and familiarity with the process of PBE's and/or her natural aptitude. She was able to focus on the child, and for the majority of the time identify and respond to both verbal and non-verbal cues from this child, even when they were difficult to read. It is worthy of note that the researcher missed many of this child's cues the first, second and third time of viewing and transcribing this tape. Only through complete immersion, and at points frame by frame analysis were some of the non-verbal cues identified. Although this was the case with most of the participants in this study, it was a more prominent and recorded element of the analytic process with this case.

The therapist's skill at the task not only enabled her to identify and respond to the child's cues but also enabled her to provide the child with information she needed, in the format she needed and at the right pace to facilitate this child's engagement. The therapist used rehearsal several times to scaffold for the child and provide her with the

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[222] The reader is reminded that the researcher had remained blind to the therapists perspective, see chapter six.

support she needed to engage in the task. The therapist invited the child to lead frequently and addressed her need to please.

Whilst this child was able to access her exploratory system throughout this evaluation she did not share a high number of views (40). However, the views expressed were personal to Hannah's own experience and concerns. For instance, the reader may remember from chapter seven, Hannah discussed age and gender appropriate toys being available. Issues regarding gender identity and developmental stage were features of Hannah's therapy. She also described being frozen in the first session. In addition there was not a high degree of repetition, thus the 'quality' of Hannah's views could be described as high. It is suggested that a combination of these sensitive caregiving factors quietened this child's defensive and careseeking systems and enabled her to access her exploratory system as frequently as possible.

The frequent disengagements and activation of the defence and careseeking system did present a challenge for the therapist. Whilst this did lead to some misattunements the therapist was skilled in repairing these ruptures. This therapist scored highly on the combined skill level codes, it was striking that when this grouping was broken down the therapist scored very highly (third highest dyad scoring) on the 'follows child's lead' group of codes[223].  It is suggested that this therapist's approach and depth of skill in NDPT enabled her to effectively support this child's engagement with the PBE. It is important to note that not only was this therapist accepting and able to demonstrate flexibility in her approach, she also utilised purposeful misattunement and employed congruence. Following Hannah's role play where, in role as a policeman, she sends herself to prison, the therapist appropriately responded with congruence. This is a good example of the therapist appropriately using her feelings to meet the child's therapeutic needs, as described by Ryan and Courtney (2009). Thus the therapist was not simply passive but highly active in her employment of 'non-directive' skills.

This child instigated seven breaks[224] throughout the evaluation session, indicating her difficulty in sustained engagement in the task. The therapist frequently provided structure following these disruptions. This child introduced several unique ways of engaging in the evaluation task which the therapist incorporated into the show

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[223] This group consists of therapist is accepting; permissive and flexible.
[224] Average number of breaks was one.

demonstrating the therapist's flexibility and adaptability. These included the child becoming both the 'child callers' and the 'expert' answering the questions. The child instructed the therapist what the next questions would be and the therapist had to adapt the interview schedule to play a child who asked these questions. As detailed above, the child also initiated the incorporation of a website and a museum of play therapy.

Both Schore (2003a) and Fonagy et al (2004) agree that playfulness is a key aspect of the regulating therapeutic relationship. Further Schore stresses the need for spontaneity, nurture and support balanced with challenge and stimulation, as the optimal conditions of the regulatory dyad (2003a:40). This dyad seem to represent a good example of this balance being achieved.

**Conclusion**

Schore proposes that the significance of the therapeutic process is in the ability of the therapist to offer emotional regulation to their client through their relationship drawing on Stern's notion of attunement and interactive repair (2003a:51). This was highly evident in the interaction between Judy and Hannah.

**Conclusions and Implications for Practice**

Whilst these dyads are only drawn from a small number of cases and therefore cannot be generalised, the in-depth analysis of these pairings and application of Heard and Lake's attachment dynamic arguably deepen our understanding of interactions between therapists and children in PBEs. Furthermore the analysis points to facilitating factors which enable children to access their exploratory systems and share their views as fully as possible. Application of McCluskey's (2005) patterns of interacting associated with effective and ineffective caregiving seemed useful. It is suggested that application of this model and the patterns, developed by McCluskey, to NDPT sessions more generally is warranted. Incorporating Koren-Karie et. al.'s (2003) and Gertsch-Betten et.al. (2003) descriptions helped to maintain the focus on adult-child dyads.

Utilisation of the dynamics of attachment to understand difficult sessions and complex cases in NDPT was suggested by Ryan (2004). This study supports this assertion. Therapists' using the model, alongside consideration of 'juncture points' in clinical supervision to reflect upon and understand the processes occurring within their interactions with children is indicated for both NDPT in general and specifically with

PBEs. This could help therapists make clearer decisions in future evaluation sessions regarding contra-indications and also their ability within the evaluation session to achieve an effective balance in attuning to the child and promoting the exploratory system.

It is suggested that attention to the attunement within the interaction is needed to promote a child's exploratory system, and in this context, facilitate the expression of their views of play therapy. This seems to be particularly important with children who are 'difficult to engage'. In cases where the therapy is ending prematurely or is still in progress, these examples seem to indicate that prioritisation of the therapeutic needs of the child and promoting an attuned interaction in the evaluation session is central. In these cases the child may have a greater need than others to explore intra-personal issues. Therefore therapists need to be prepared for this eventuality[225]. In cases where therapeutic resolution has been achieved flexibility is still needed but structure, and guidance toward exploring issues related to therapy, without rupturing the attuned relationship seems easier. Furthermore the need for optimally attuned interactions appears to be less significant in these cases, (see exemplar three, Cathy and Lucy). However, when the child does experience an optimal regulatory relationship it seems to promote their exploratory system (see exemplar one, Herbert and Polly).  As stated above, this is a small sample and further study into the interactions occurring in PBE's is needed. These exemplars indicate that attunement is an important factor in facilitating children's expression of their views.

In the next chapter I turn to a broader discussion on the process issues evident in PBEs and draw upon data from the whole cohort of participants in this study.

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[225] Contra-indicators to PBEs are discussed in the next chapter.

# CHAPTER NINE
## THE USE OF PBE TECHNIQUES: ATTENDING TO THE PROCESS

**Introduction**

In this chapter I intend to answer the research questions posed regarding the techniques developed and utilised in this study: 'Are PBE techniques useful ways of ascertaining children's views?' and are they 'accessible to all children?' I return to the question 'Do Play Therapists' views differ from children's views of play therapy?' and address the discrepancies between therapists' and children's accounts alongside the ways in which they support and enhance one another. I draw together four bodies of evidence:

- The children's views (as presented in chapter seven).
- The analysis of the therapists' and children's process
- The analysis of the therapists' views (drawn from questionnaire data)
- A broad analysis of the interaction between the therapist and child.

Similar to the previous chapters, I present the findings in one area and then turn to a discussion of related literature, implications of the findings and future areas of study, before proceeding to present the findings in the next main area. I consider the strengths and weaknesses of the techniques. I discuss in full the contra-indicators to undertaking PBEs. Next I explore whether or not PBEs are 'suitable for all'. In this discussion I take into consideration, age, gender, ethnicity and disability. I conclude the chapter by reflecting upon the power and consent issues evident.

**Children's Views Expressed During PBE's**

As demonstrated in chapter seven children were able to express a wide range of views using PBEs. In particular they expressed a wide range of feelings, which is arguably missed or confused when using child-friendly questionnaires. Such questionnaires often utilise smiley faces for a positive score and sad faces for a negative score. However, in therapy children experience and express a whole range of emotions and this was captured by the PBE techniques[226]. They did this through communicating with callers, discussing memories directly with their therapists, acting and using figures in the miniature playroom and introducing their own unique ways to explore their experiences of play therapy. Importantly children were able to share positive and more difficult experiences. Their therapists corroborated that many of the views articulated, and the

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[226] The reader is also directed to appendix 19 a matrix of the wide range of feelings on different issues expressed by the children.

play enacted, directly represented their experience of play therapy.

However, there were also times that children played or talked about experiences that therapists did not think matched the child's experience. For example, as reported in chapter seven, Lee (8.7yrs) enacted the child figure in the 'Miniature Playroom' having a nanny. The therapist reported that Lee did not have a grandmother but highlighted that it was quite possible that Lee and his mother wished they did have this extended family. Having the therapists' views, to provide the contextual information about the child and the intervention, assists us in determining which views may be direct experiences and which may be indirect or possibly reflective of a generalised personal issue for that child. The analysis of children's views reflecting their 'real lived' experience or their fantasised 'wished for' experience is presented below. As highlighted in chapter three such an analysis has been limited or lacking in previous studies of children's views of play therapy. In this section I consider the specific strengths and weaknesses of the two play-based techniques used by therapists in this study, the 'Miniature Playroom' and the 'Expert Show', to ascertain children's views.

**Specific Strengths and Weaknesses of the 'Miniature Playroom' Technique**

Using the 'Miniature Playroom' enabled some children[227] to enact their experiences of play therapy without a high reliance on language. An example of this was the demonstration of basic reciprocal play between children and their therapists. Both Lee and Emma (8.11yrs) enacted a child and therapist figure playing together:

> **Lee:** umm {protrudes lips} Billy[228] goes in the car↑ {younger tone of voice} and he drives it all: the way to Trudy↑[229]
>
> **Judy:** Umm {looks at Lee laughs}
>
> **Lee:** Brum brum↑ brumm brumm brum↑ brum {manipulates toy} so Trudy drives it back brum brum brumm [brum brum brum
>
> **Judy:**                              [{looks at child} oh so she's playing Trudy's playing with him …
>
> **Lee:** So Billy↑ goes and gets the ball {lilting tone of voice} *I've*↑ got the

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[227] The reader is reminded that only two children used the miniature playroom exclusively and five further children used it in combination with the 'Expert Show'.
[228] Name given by Lee to the child figure.
[229] Name given by Lee to the therapist figure.

ball↑ let's kick it to each other {younger tone of voice} [kick curly wurly

**Judy:**                                                    [ohh

**Lee:** {enacts ball play between child figure & therapist figure} wurly wup

whee::↑ catch Billy whee (.) [I got it whee kick it back

**Judy:**                              [{looks at child smiles laughs} he caught

the ball[230]

The use of the 'Miniature Playroom' enabled children to demonstrate concepts such as reciprocal play which are arguably more difficult to explain verbally. Interestingly both Rob and Lee were reluctant to give the child protagonist and therapist figure pseudonyms and wanted to use their own names, making a more direct link to their own lives. These two children, and Marble, also appeared to greatly enjoy using the technique and were delighted by the similarity between the miniature playroom and the real playroom. Eddie and Elizabeth also seemed highly engaged in the technique, whereas Emma and Susie appeared more ambivalent.

A second advantage of the 'Miniature Playroom' technique was that it did not rely on children looking at a camera. The 'relationship' children had with the camera was different when comparing the two techniques. When using the 'Miniature Playroom' technique children were focused on the camera recording their story rather than engaging with the camera as a 'third eye'. This is explored in relation to the 'Expert Show', further below.

A third advantage of the 'Miniature Playroom' was the use of props to stimulate children's memories. Judy (therapist) made a miniature puppet theatre for use within her 'Miniature Playroom' kit. This helped to stimulate Elizabeth's (8.7yrs) memories (described below under combining techniques). The inclusion of plasticine for children to make their own props which were not directly represented by the props available seemed helpful. For instance Lee wanted to enact playing with puppets. He noted that there were no puppets in the miniature playroom for him to share his story. He was about to integrate this feature of things being missing into the story itself, arguably creating new elements in his story of play therapy based on the *here* and *now* rather than

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[230] (248:266)  ↑=intonation up (.) = a noticeable pause too short to measure *italicised text* = emphasis

his *actual* experience of the intervention. Judy (therapist) reminded him that they could pretend the puppets he needed or make them out of the plasticine. Lee easily incorporated pretend puppets into his story which enabled him to elaborate on his real experiences of puppet play.

*Fantasy or Reality?*

Whilst the approach taken by Judy compensates for props or toys that children need not being available, it is more difficult to compensate for the potential impact of the presence of 'new toys'. It is likely that the miniature nature of the toys means they are appealing to children. Furthermore they do not necessarily directly replicate the toys in the room. Therefore a weakness of the 'Miniature Playroom' technique was the difficulty in distinguishing whether or not some play was just a reflection of the child's interest in the 'new' toys. Playing with certain toys may have been a reflection of their play in the here and now of the evaluation session, rather than a recreation of their play therapy experience. For example Rob made a 'pancake' to show the audience. He seemed absorbed in the activity of making and this element was not well integrated into a story. Therefore it was likely that this play was unrelated to his views. However, the triangulation of therapists' views in this study helped in making sense of this.

Observational data was also drawn upon to make sense of whether the play was likely to be a reflection of new play being created or rather play experiences being remembered. There were occasions where the interactions enacted in the miniature playroom were mirrored by the interaction observed via video of the actual session. For instance Rob demonstrated the therapist figure in the miniature playroom giving the child the lead in the interaction by asking him 'what would you like to do?'. In the actual observed interaction the therapist, Judy, was clearly following Rob's lead in the interaction. She did this both verbally, for example making accepting comments regarding the child's behaviour, and non-verbally with her eye gaze tracking the child's movement.

Sometimes children themselves made direct links between what they enacted in the 'Miniature Playroom' and what happened in 'reality'. For instance, Lee enacted the child figure painting. Judy asked him what the therapist figure was doing[231]. Lee replied "Watching, like you do".[232]

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[231] She pointed at the therapist figure in the miniature playroom as she said this.
[232] (109)

*'Here and Now' Reality or 'Mirrored' Reality?*

Sometimes it was not clear whether the child's *non-verbal communication* was mirroring their experience of the topic being asked about, or whether it was related to their feelings about the evaluation session in the 'here and now'. For example, as briefly mentioned in chapter seven, Emma had difficulty completing the first story stem. She initially engaged in the task (see Figure 50) but then withdrew and appeared anxious (see Figure 51).



**Figure 50: Initial engagement**



**Figure 51: Withdrawal**

She moved from sitting on the floor next to her therapist, by the miniature playroom, to sitting up on a chair. She looked down at her hands in her lap and communicated non-verbally with head shakes that she did not know what should happen next.

This was repeated in the second story. In later stories Emma continued to display anxiety. However, she also showed bursts of confidence. This was a significant process issue highlighted in the observational analysis. It seemed possible that Emma's anxiety and withdrawal mirrored the feelings she had when she first met the therapist. However, an alternative explanation was that she was anxious and preoccupied with the evaluation session itself at this point. Drawing on the therapist's views provided further data to suggest that both processes may be at play. The therapist, Judy, noted that Emma was not as confident as usual. She was reportedly more anxious and "tongue tied" than in her therapy sessions. However, the therapist later noted that it was interesting that the evaluation process had uncovered Emma's characteristic way of responding: with timidity followed by bursts of confidence which mirrored the process of the actual intervention.

**Specific Strengths and Weaknesses of the 'Expert Show' Technique**

Children quickly picked up the TV format of the 'Expert Show' and demonstrated that they were the 'experts of play' by easily getting into role, sometimes more adeptly than the therapists. One of the strengths of the 'Expert Show' was children's enjoyment of the technique. The two eldest children, Sarah and Bob, appeared slightly embarrassed about engaging in role play initially. However, Judy in particular managed this sensitively with Bob and he seemed to enjoy the process. Most of the children remained engaged in exploring their views using this technique for a significant period of time (mean 34 minutes). The non-verbal analysis, therapist report and comments from children themselves all corroborate this finding. The technique seemed to appeal to a wide age range from 8-13. The youngest child (6.1yrs) who engaged in the 'Expert Show' seemed to struggle with the concept and format. This is discussed further in the section on 'Suitable for all?' below. Children made good use of the ground rules set up at the beginning of the show (see power and consent section below) and several children were able to incorporate their own ideas into the 'Expert Show' format.

A weakness of the 'Expert Show' was the dependence on language. This not only has implications for younger children (see below for a discussion) but also the *type* of

information gained. The dependence on language means that cognitive functions are being primarily accessed, rather than affective states.

*The Relationship with the Camera*

Most children appeared to enjoy the filming aspect of the 'Expert Show'. Some children were excited about the prospect of seeing themselves on film and wanted to watch part of their tape directly after the session. In general terms children looked at the camera more when the 'Expert Show' technique was used. Billy, Leanne, Martin, Lee, Rob, Herbert, Gabriella and Cathy seemed to particularly like the fact the session was being filmed. They either dramatised their roles or made media references throughout the show. For instance, Martin pretended to take the microphone and walk around the 'studio' giving a 'moral message' to the audience. He encouraged his therapist Nick to cheer for him, akin to American chat shows. Others, for example Bob, Cathy and L-man grew in confidence at addressing the audience. The camera appeared to help most children enter the role play and 'speak to the callers'.

Eddie appeared to be particularly immersed in the role play and used the camera as a 'third eye'. During the 'Expert Show' phase of his evaluation session he appeared to be truly speaking to the child who was calling in. At other times he appeared nervous, often biting his lip, and aware of being on a 'TV show'. His therapist helped him with his feelings of unfamiliarity and as the session progressed he appeared to enjoy this element of 'being filmed'. Lastly, when he was feeling low, despondent, and nervous, the camera appeared to be something he could focus on, rather than look at his therapist who he was so sad to lose.

In contrast Hannah, Emma and Bradley all seemed particularly concerned about the camera. Hannah appeared ambivalent about the camera. At the beginning of the session she seemed to be anxious and preoccupied with being filmed. At other times she seemed to enjoy performing specifically for the camera and 'the audience'. Toward the end of the session Hannah demonstrated her anger toward the camera by pretending to punch it. Whilst Hannah's communications could be due to the impact of the research, it is also possible that the presence of a camera per se, and the 'performance' element of being on TV were difficult for her. Emma and Bradley's comments seemed to suggest that their concerns were about the research element rather than the PBE itself.

*Fantasy or Reality?*

Similar to the direct references between the play enacted and what 'really happened' in the 'Miniature Playroom' technique, children made direct personal links during the 'Expert Show'. For example, Judy (in role as a child caller) asked Elizabeth what it would be like returning to the playroom for visits. Elizabeth replied by directly drawing on her own experience stating "when *I* had visits it was the best thing"[233].

Children's need to please and reassure the 'child caller's was hypothesised to be a potential weakness of the 'Expert Show'. In this study one child, Leanne, seemed to be overly focused on reassuring and helping callers. Some of the older children commented on being unable to tell the callers how they would feel because they did not know the child and going to play therapy would be different for everyone. These children were often encouraged to draw on their own experiences to answer the questions, thus directly addressing the issue of giving 'real' responses rather than ones made up based on the role they were taking. For instance, Billy told a caller he could only tell them what Judy, his own play therapist, would have done in particular circumstances. Encouraging children to draw on their own experiences, and addressing their need to please, seemed to facilitate them sharing their 'real' experience of play therapy.

One of the strengths of the 'Expert Show' was the incorporation of the 'chat show' phase. During this phase children were asked if the information they gave to the callers was the same or different to their own experience. Whilst children in this study did at times provide 'fantastical' responses, in the main what they told the callers whilst in role as 'the expert' was reported to be the same as their own experience when they were asked during the 'chat show' phase. At this point children were arguably back to being themselves rather than deeply 'in role'. During this 'chat show' phase children pointed out the answers which were particularly poignant to their own experiences. For instance, as noted in chapter eight, Cathy pinpointed her responses to the child caller Amelia as particularly reflective of her own experience.

The contextual information supplied by the therapist, along with careful study of the child's non-verbal communication, enabled assessment of the most likely interpretation of the child's view, expressed within dramatic roles. The following exemplars will

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[233] (395)

demonstrate the process in which information was drawn upon to establish the most likely interpretation of the data.

As noted in chapter seven Billy said that his first session was 'bad', that he was 'shocked' and that he 'hated the first session'. When interpreting this view it was important to note that this child was referring to the assessment by the generic service before attending play therapy. Billy was highly dramatic in his approach to the 'Expert Show'. When he made this comment he used a mock tone of voice which conveyed shock and yet his affect when he talked about this assessment was one of enjoyment. This mismatch in Billy's communication highlighted the possibility that this view was an over-dramatisation. It is, of course, possible that Billy genuinely did feel scared and his jovial manner was a defence against these difficult feelings. There may have been an element of anxiety which he experienced at the beginning of play therapy which he could joke about, by the time of the evaluation, due to his increased confidence. However, it is also likely that he was enjoying the role of *being an expert* and used the word 'scared' and matching actions to enhance his dramatic performance, see Figure 52:

**Billy:** {looks downward} =Well the very first time that I go::

**Judy:** yeah:::

**Billy:** I went it wasum::: ba:::d {mock trembling voice stands up and grabs a tissue from the table}

**Judy:** oh:::

**Billy:** because it was so scary {mock trembling voice}

**Judy:** it was bad and scary the first time umm

**Billy:** {sits down holding tissue frowning as if crying} But the second time after

**Judy:** yeah:::

**Billy:** {wipes face slightly with tissue raises eyebrows} I went it was a lot better {nods head}[234]

**Figure 52: Dramatised emotion**

Whilst it is probable that his initial experience of the service was difficult, it is unlikely that it was as extreme as his words alone suggest. It is useful to compare his verbal and non-verbal expressions with Susie's and Hannah's. As noted in chapter seven, both Susie and Hannah described feeling scared the first time they went to play therapy.

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[234] (73:85)  ::: = elongated communication = = No discernible interval between adjacent utterances

Susie hugged a teddy whilst she told the therapist, in a younger tone of voice, that the child figure felt scared, see Figure 53 below.



**Figure 53: Feeling Scared**

Hannah described being frozen in her first session. Her manner and affect whilst she gave this response suggested that the first session was a particularly difficult experience. She looked downward, used a serious tone of voice and stood behind the chair in the room, see Figure 54. Her non-verbal cues and verbal comments were in synchrony. Furthermore her comment regarding how she experienced the first session was spontaneous rather than in response to a direct question.



**Figure 54: Being Frozen**

Thus Hannah's and Susie's non-verbal cues of anxiety appeared genuine and congruent with their verbal statements, whereas Billy's non-verbal cues appeared to be a dramatised version of anxiety.

Billy's therapist allowed Billy to express himself in this way. In his evaluation there was a mixture of over-dramatised responses and more considered serious responses. Other therapists tried to curtail children's expression of fantastical elements of play therapy. For instance, the reader may remember from chapter seven that Martin said the playroom had chandeliers. It is somewhat doubtful that the playroom had actual chandeliers. This child seemed to struggle to find the words to describe what the room was like. It is possible that he experienced it as a very light room or possibly a luxurious room and wanted to convey this in some way. This child had experienced neglect so the possibility of him finding the playroom with all the toys and resources, including the therapist, available to him alone a luxurious experience is quite possible. Alternatively he may have liked teasing his therapist and enjoyed this aspect of the interpersonal relationship. This is particularly suggested as there were a few times in this child's evaluation session where he suggested something which appeared to be fantastical. For instance, that the playroom housed a PS2 computer. Here his primary motivation appeared to be eliciting attention from his therapist.

Martin's non-verbal communication of heightened arousal and contextual information about play therapy suggested that these accounts were unlikely events in 'reality'. Martin's therapist curtailed Martin's exploration and told Martin to stick to what 'really happened'. This appeared to slightly dampen Martin's enjoyment of the session and made him more concerned about providing 'right' or 'wrong' answers.

**Combining the Miniature Playroom and the Expert Show**

Remaining flexible regarding which type of PBE was used seemed helpful. A combination of the two main techniques the 'Expert Show' and the 'Miniature Playroom' was used with five children in this study. For four of these children (Emma, Rob, Eddie and Marble) one technique was used in isolation first. Then the therapist switched to the other technique. Rob began with the 'Miniature Playroom' and progressed onto the 'Expert Show'. Arguably his enactment of the first session in the 'Miniature Playroom' enabled him to articulate this experience during the 'Expert Show'. The response he gave during the play enactment indicated his enjoyment of play

therapy in the first session. This was then corroborated in his verbal statements on the 'Expert Show'. This provided evidence regarding the validity of his play in the 'Miniature Playroom' as a representation of his 'real' feelings about play therapy.

As the 'Expert Show' proceeded, and moved onto areas Rob had not covered in the 'Miniature Playroom', Rob appeared to struggle with providing a response. It may be that he had become tired. However, it seems likely that using his 'right brain processes'[235] in the 'Miniature Playroom' first enabled him to access his 'left brain processes' shortly after. When Rob engaged in the 'Expert Show' only (without prior exploration of the topics using the 'Miniature Playroom') the heavy reliance on language production led to difficulty in accessing his memories. Arguably introducing the miniature playroom onto the TV set, as Judy did in a later evaluation with Elizabeth, would have enhanced Rob's abilities.

In Judy's ninth evaluation she invited Elizabeth to use the miniature playroom whilst *on* the Expert Show[236]. This seemed to work particularly well in terms of Elizabeth accessing emotionally important memories. When Elizabeth was asked, by a child caller on the 'Expert Show', "what happens if a child feels sad in the playroom?" she began answering by verbally articulating what would happen. She then turned to the miniature playroom (on the 'Expert Show' TV set) to pick up the miniature puppet theatre. This visual representation appeared to help her to provide more detail about this emotion-laden memory.

The reader may remember from chapter seven that Elizabeth recounted going inside the puppet theatre when she was sad, to have a think, and then enact a puppet show for her therapist. In other parts of the session Elizabeth was overly polite or dramatic as she verbally articulated her views. However, when she described and showed 'the audience' the miniature puppet theatre she was not hyper-aroused and was able to express her views in greater depth.

**Therapeutic Encounters**

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[235] As mentioned in chapter three the right hemisphere of the brain is thought to dominate in processing visual emotional affective communications and the left hemisphere is thought to dominate cognitive verbal language processes (Schore, 2003).

[236] This was suggested as a possibility during the training and therapists were advised to utilise this when they felt comfortable and confident with both techniques.

A further advantage of both the 'Miniature Playroom' technique and the 'Expert Show' was evidence of therapeutic encounters during the actual sessions. Distinct therapeutic encounters were coded for ten children in this study. I detail three here which highlight different processes. Lee prepared paper for painting and divided one piece to share between him and his therapist Judy. He stated:

> **Lee:** Because there's some for me::: and you so that you can remember me and I can remember you
> **Judy:** Right↑ oh I'll *definitely* remember you[237]

Nick was able to facilitate Martin's exploration of Nick's dual role as therapist and social worker. Martin had told one of the callers that his therapist might turn out to be a social worker who might take him away. Nick returned to this comment when they sat at the sofa area at the end of 'the Expert Show' and asked Martin if that was something he worried might happen when they had been having play therapy together. Martin affirmed this with a head nod. Nick noted in the post-evaluation questionnaire: "His (Martin's) anxieties about being removed from home again has been a dominant element, and one of the reasons for ending the work. I was astonished about how openly he admitted this in role…I am impressed by how powerful a tool this is." Martin's session appeared to be empowering for him and enable him to create a narrative about his experience of play therapy Nick stated: "I was surprised how much it meant to him to be the expert…also that he made comments about feeling strange about the ending of our work – this is the first time he has made any comments and shown appropriate sadness about the end".

A third example is drawn from another therapist's questionnaire. Lucy (therapist) noted the change in Cathy's ability to "speak up" which Lucy felt was clearly demonstrated in the PBE session. She stated: "Her capability and confidence in completing the evaluation was a fantastic move forward for her."

## Discussion and Implications
### The Miniature Playroom

Landreth (1993:52) states "…toys are like words to children in their efforts to

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[237] (570:571) ::: = elongated communication ↑ = intonation up *italicised text* = emphasis

communicate their experiences". As presented above, the use of toys in the 'Miniature Playroom' certainly enabled children to communicate about their experiences of play therapy. However, as Landreth (1993) points out the meaning of children's play is at best a difficult process. In this study triangulating the therapists' views with the children's account assisted the meaning-making process. This supports the argument that therapists themselves should undertake the evaluation, or be consulted regarding the potential meanings of a child's communications within a PBE.

The findings from this study suggest that props and toys in play therapy evaluation interviews with children enhanced their accounts. In Säljö's study (1997, cited in Westcott and Littleton, 2005) a globe was used as a visual referent to prompt children's discussion of astronomy. Reportedly this dramatically improved the process of joint meaning-making. I suggest that the use of props and toys in PBEs, which *directly* represent objects the child has had direct personal experience of in play therapy sessions, enhances the process of joint meaning-making further. The miniaturised puppet theatre used by Elizabeth enabled her to share her views more fully. This was a unique addition to the 'Miniature Playroom' kit which Elizabeth's therapist, Judy, had made to replicate equipment in Elizabeth's real playroom. Investigations into doll play assessment techniques have revealed that close replication of the child's 'real world' produced more identificatory themes (Woolgar, 1999). It is also likely that closer replication of the real toys reduces the effect of children being interested in the novelty of toys in the 'Miniature Playroom' kit. In the training, for practical reasons, therapists were not asked to replicate their real playrooms. However, the findings of this study suggest that closer replication of the real playroom is warranted. Comparisons between a more general kit and one which has a high similarity to the therapists' own playrooms in future research would be useful.

Hodges, et. al.'s (2003) recommendation to use displacement, during story stem assessments, led me to incorporate the use of pseudonyms for the characters in the 'Miniature Playroom'. This had seemed particularly necessary with two children in the pilot research, discussed in chapter four, who needed to use figures with differing characteristics than me, their therapist, or animal figures. Hodges et. al.'s (2003:245) rationale for the displacement used in story stems is due to the finding that some children can become inhibited if a researcher makes direct identifications. In story stem narratives the aim is to make the technique less anxiety provoking so the stories, which

are designed to be emotionally charged, are not 'near the bone.' However, the children in the current study were keen to use their own names and identify directly with the characters. Arguably the children in the pilot study were displaying a higher degree of anxiety. There were certainly indications that these children would benefit from further therapeutic input. The findings in this main study suggest that children should be offered choice regarding this issue. If the child wants to, and appears comfortable using his/her own name, then this should be used. It is likely that this will promote more direct identification and make the meaning-making process easier. If the child prefers to create further distance, it is suggested that this should be offered. It is hypothesised that this would enable the child to engage rather than insist on direct identification. Similar to principles advocated in NDPT (see Wilson and Ryan, 2005) adapting this aspect of the technique to the individual child's needs is indicated.

Limitations of the current study include the small sample size, particularly regarding use of the 'Miniature Playroom', and the difficulty in observing the action taking place in the miniature playroom. The use of two cameras in future research of the 'Miniature Playroom' is indicated, one to record the interaction between therapist and child and one to record the enactments in the playroom. Whilst this may be intrusive there are indicators from the children themselves that they wanted to ensure their stories were fully captured.

**The 'Expert Show'**

Most children were easily able to immerse themselves in imaginative role play in the 'Expert Show'. Arguably this affords them the emotional distance needed to explore emotionally laden memories. In fact children were more adept at role play than their therapists at times. This is unsurprising given children's natural tendency to "…engage in spontaneous dramatic play during their early years, this mode of expression is natural and comfortable for most, providing the safety of disguise along with the pleasure of play" (Irwin and Curry, 1993:167). This is not as common for older children, and certainly the eldest children in this study, Bob and Sarah appeared slightly embarrassed about acting. It is likely that several of the children will have experienced dramatic play with their therapists during the intervention itself. Again this argues for children's own therapists' undertaking the evaluation session. Helping older children to engage in the role play is one of the skills therapists need in order to deliver PBEs. These findings

also indicate that for older children adaptations may be needed. This is discussed in the section 'Suitable for all?' below.

Although the use of role play has been criticised for making it more difficult to extrapolate 'fantasy from reality' (Mitchell and West, 1996) the findings from this research demonstrate that triangulation, attention to process issues and children's non-verbal communication along with the de-briefing stage during the 'chat show' phase, reduce these difficulties. It is important to recognise that there are many layers of meaning in children's communications. Some of the children's 'fantastical' responses may well have symbolic meaning, as suggested above. There is much interest in this area within the play and drama therapy literature. Some have used terms such as 'dramatic reality' (Pendzik, 2006) 'fantastic reality' (Lahad, 2000) and the 'fictional present' (including the past and present, the real and the symbolic; Courtney in Cattanach, 1994b). It seems that the therapist/interviewer role is to enter this playspace and be open to all of the child's 'realities'. Allowing children's 'fantastical' responses seems the most helpful way to facilitate a child's exploration as Billy's therapist did. Billy remained highly engaged in the process and expressed a large number of views some of which were detailed and in depth. In contrast Martin was curtailed in his 'fantastical' responses and later was more reluctant to share his views. A possible way of achieving a balance with regard to this issue may be the use of congruence (see Ryan and Courtney, 2009). The therapist might reflect in role that they did not think there would be 'chandeliers or a PS2' (for instance) in the playroom but maybe this is something children wish for. Another possibility would be to reflect the therapist's uncertainty about what the child means. Again this might take place in role. For instance reflecting that they are wondering if this means the child thinks the room will be really light or have expensive or pretty things in it. Caution is needed to ensure therapists do not overly lead children. Ensuring that a position of curious naivety is followed and the child's 'expert' status is maintained seems essential. Furthermore the need to provide options is clearly necessary, and following Kvale's (1996) advice, the least likely option should be suggested first. Further training in how to respond to 'fantastical responses' during PBEs is indicated.

The high reliance on language in the 'Expert Show' technique promotes left brain processing. If successful therapy is thought to be a right brain to right brain process (Schore, 2003) then thought is needed on how to incorporate more action-orientated

elements into the 'Expert Show'. This would arguably allow children greater access to their affective states (right hemisphere dominant activity), as demonstrated by Elizabeth's use of the puppet theatre. The findings of this main study, along with my own continued clinical experience of using PBEs, indicate that offering a combination of techniques to children is helpful. Furthermore, integration of other methods during the 'Expert Show' such as drawing, or photos of the real playroom and toys is indicated[238].  Arguably this would enable greater access to right hemisphere dominant processing. It would also allow a greater degree of choice within the *framework* of the 'Expert Show' which would mirror children's experiences of NDPT sessions more closely. Thus here again it seems offering variety within a framework will be of value. However, a high level of familiarity and skill in administering both techniques is needed in order for the therapist to manage the differing demands of both techniques. Furthermore for some children, particularly younger children or those with cognitive impairments, combining both techniques is likely to be overwhelming. For these children the 'Miniature Playroom' seems best suited to their needs, certainly in the first instance. The suitability of PBEs with regard to children's ages is discussed further below.

Children displayed a strong relationship and knowledge of media and technology in this study (Livingstone and Bovill, 2001; Jensen-Arnett, 2007[239]). Along with the use of play, in the 'Expert Show', the link with technology also seems to meet children in 'their world', their culture (see Davis 1998 for a discussion on the interaction between researcher's and participant's cultures). Such techniques have been utilised in therapeutic contexts to connect with children and adolescents (Kaduson, 2001; Gallo-Lopez, 2001; Guldner, 1991; Rose, 1995 and most recently Rubin's edited book, 2008). This has led to consideration of the way in which the findings of this study are fed back to the participants in this study. It seems fitting to utilise technology and send the children a video in response.

In this study, one child expressed hostility toward the camera, pretending to punch it, and another behaved in a provocative manner toward the camera. In both instances sensitive management of the situation and considered judgement about the potential

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[238] Current piloting and future research plans in this regard are discussed in chapter ten.
[239] With regard to the discourses on the impact of Talk Shows (as replicated by Martin) the interested reader is directed to Tolson (2001).

distress the camera may be causing was needed by the therapists. As Banks (2007) highlights, using video for research purposes can be experienced negatively for some participants and may be met with hostility. Similar to the considerations of video taping therapy sessions, Banks (2007) points out that some participants may associate filming with danger or control. This is a particularly important consideration in the therapy context (Wilson and Ryan, 2005) and a substitute camera or alternative approach to the 'Expert Show' is advocated in such circumstances.

**Therapeutic Encounters**

The findings of this study suggest that PBEs are in themselves therapeutic. Several therapists commented that the session enabled children to narrate their experience of play therapy. Their comments suggested that children were able to put into words or otherwise express feelings and processes which they had not previously been able or had opportunity to do. The PBE provided a space to build and share a narrative of children's experience of play therapy. The benefits of constructing a narrative of one's life experiences are well known in both the therapy and research literature (see Cattanach, 1997). It seems important to provide children with this space to reflect upon and make sense of their experience of play therapy, in order to support them in coherently integrating this experience into their 'life story'. It also seemed that the status of being an 'expert' gave some children further confidence and perhaps enhanced their self-esteem; this seemed particularly true of Herbert, Billy and Cathy.

**<u>Contra-indicators for the use of PBE's</u>**

As highlighted in chapter six, five of the twenty children in this study were ending prematurely due to funding or service constraints. One was ending prematurely due to the family disengaging and two were moving onto filial play therapy. Consideration regarding the appropriateness of using a PBE in these circumstances is given here.

**Premature Endings**

Rob, Eddie, Martin, Leanne, Susie and Bradley were all ending their interventions prematurely. As detailed in chapter seven, the decision to end Eddie's play therapy was based on the parents' needing support. A strong sense of sadness was evoked in Eddie's PBE. On the one hand the evaluation session seemed to compound these feelings for Eddie, on the other it seemed that the evaluation session enabled him and his therapist to construct a narrative of the important experience they had shared. It provided an

opportunity for Eddie to process some of his difficult feelings. As noted above despite therapy ending prematurely for Martin, the PBE session appeared to be therapeutic and provided him with a space to make sense of his experience.

In contrast Leanne tried to avoid how difficult ending prematurely was for her by being overly positive and cheerful. Later in the evaluation session she was more explicit about her difficult feelings and informed her therapist that she continued to feel unsafe. However, she felt that if she was a helper (on the TV show) she *should* be happy. She clearly stated to Lucy (therapist) that inside she was not happy. Lucy was at first responsive and soft in her tone of voice. However she quickly told Leanne that they could discuss those things later. Lucy returned to being a cheerful up-beat presenter. This led Leanne to return to her previous stance of being overly positive and cheerful.

It is likely that Leanne's expression of her views were more positive than her true feelings. It is suggested that Lucy was not able to respond and contain Leanne's difficult feelings in the evaluation session itself, possibly due to Lucy's own difficult feelings about having to end the intervention. Lucy showed awareness of Leanne's process in her post-evaluation questionnaire stating that Leanne was 'jollying herself along to make everyone else feel better'. Furthermore Lucy believed Leanne would manage the ending because she 'had no other choice' and expressed strong feelings about Leanne's continued needs. It is suggested that the therapist may have found it too painful to think about things still being scary for Leanne. This was likely to be compounded by the therapist feeling that she was powerless and had no control over changing the decision to terminate therapy prematurely – a decision made due to funding constraints.

**Transferring to a Different Therapy Intervention**

Two children in this study, Hannah and Gabriella, were transferring from individual play therapy sessions to filial play therapy sessions. The fact that the therapy was continuing indicates that these children continued to have a relatively high level of therapeutic need. Both children were assessed to be difficult to engage (see explanation in chapter eight). Judy and Polly had to provide a high level of permissiveness and flexibility to engage these children. Both children were highly controlling and Gabriella seemed to find the process particularly difficult.

**Discussion and Implications**

It is important to hear and represent the views of *all* children and not exclude children purely because the therapy has been 'unsuccessful' or remains 'unresolved'. If all children who were finishing their therapy prematurely were excluded a skewed picture of children's views would be presented. It seems important to hear about and learn from cases, which have been 'unsuccessful', from both the therapists' perspective (as presented in Ryan, 2004) and the child's. Furthermore it is important to hear the views of children who experience their therapeutic intervention being curtailed due to funding issues or other reasons for drop out such as disengagement of the family. Understanding how these processes affect children and their views on why children may finish prematurely or drop out of therapy are important to add to our current understanding (for a review on reasons for drop-out in play therapy see Campbell, 2000 and in child therapy generally Kazdin and Mazurick, 1994). Furthermore, providing children with a space to explore process and narrate their experience when the therapy intervention is ending prematurely *can* be therapeutic. Eddie and Martin's sessions detailed above clearly demonstrate this. However, other examples from this study illustrate the need to make a careful assessment of the child's needs when considering PBEs.

Where the adults need for evaluative information overrides the child's therapeutic or emotional needs, the child's best interests are not at the fore. Similar to the legitimate reasons highlighted by professionals for withholding consent for children to take part in research in general (Murray, 2005) there are legitimate reasons for children not to take part in evaluation sessions. Flick (2007) reviews the potential impact of striving for quality in research on ethical standards. She points to examples of narrative and life story interviews becoming overwhelming for some vulnerable participants. Similarly when conducting PBEs, 'therapist interviewers' need to remain mindful of the balance between quality and ethics. Whilst PBEs are being integrated into therapists' usual practice[240] and therefore a part of the therapy intervention, an element of participant research remains. Seen in this light such considerations are highly relevant.

At times gatekeepers can make decisions to withhold consent for spurious reasons. Similarly it is important that therapists do not fall into this trap when assessing the suitability of PBEs. Therapists are familiar with making difficult and complex

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[240] As reported by 100% of therapist participants in this study, in their follow-up questionnaires.

decisions regarding setting up therapy interventions. As Ryan and Wilson (1995) explore, careful consideration regarding the stability of the child's home environment needs to be undertaken to ensure that the child can make good enough use of therapy. Similarly therapists need to employ these assessment skills at the end of the intervention and assess each case on an individual basis. It is suggested that this process should not only take into account child factors but also the therapist's level of skill and experience with PBEs.

The data from this study suggests that the demands on therapists' skills are higher when they first undertake PBEs. At this time they are less likely to be able to adapt the protocol to suit individual needs. If the child is easy to engage this small sample suggests that PBEs are effective and the therapists' provide 'good enough' conditions to facilitate the child's views. However, if the child is highly anxious, demanding and/or controlling, it is less likely that the PBE will be effective with a therapist newly trained in PBEs. Furthermore if a child is finishing their therapy prematurely either because they are transferring to another type of therapy intervention with the same therapist, or particularly if they are prematurely ending therapy altogether, the PBE is likely to be more challenging. This is suggested due to it being more likely that the child will have unresolved difficulties. In addition it has been argued that the therapist may be more likely to have strong feelings in these circumstances (see Leanne's case above).

In such circumstances it is important that the therapist is experienced and accesses supervision where therapists' own feelings can be processed (see Bratton, et.al. 2008). Self-awareness is a key aspect of clinical supervision. The aim is to ensure that therapists do not engage in similar defence strategies as their young clients, in this case avoidance of negative feelings regarding the ending. If the intervention has been particularly difficult, or strong feelings are evoked in the therapist regarding the ending, it may be advisable to consult with a trainer in PBEs and consider the possibility of an outside evaluator to undertake the PBE. Of course, this may not be feasible, particularly at this stage as there are so few therapists trained in the technique. If this is the case an alternative evaluation method would be indicated. In a small number of cases it is suggested that it would not be in the child's best interest to undertake any form of evaluation due to their therapeutic and emotional needs needing prioritisation. For instance those children, like Bradley, who have a high level of unresolved issues and/or where their home situation has become unstable.

In all cases where there is a premature ending it is advocated here that therapists are particularly mindful of the child's therapeutic needs *during* the evaluation session and ensure that they provide flexibility, remain highly responsive to children's cues that they need a break, or need to stop or need to play for a short time. If, as was the case with Susie, the need to play is so strong that it overrides any engagement in the evaluation task, it is suggested that this should be permitted but after a period of ten minutes should be acknowledged and the evaluation task explicitly abandoned. A good example of reading these cues was seen with Hannah and Judy (a dyad discussed in depth in the previous chapter).

For children transferring to another intervention it seems counterintuitive to postpone the evaluation until the second intervention is complete. Postponing the evaluation would have negative implications for children's ability to remember the details of the first individual intervention. The evaluation interview schedule would become too complex for both the child and the therapist to manage due to the need to cover a wide range of different processes.

### Are PBE Techniques Suitable for All?

In this section I consider the evaluation sessions in terms of their accessibility to different groups of children. I consider diversity factors such as age, gender, ethnicity and disability. I draw on examples to demonstrate the strengths and limitations of PBEs in meeting the needs of all children and young people. It is not possible to fully explore some areas due to some children being under-represented in this sample, for example d/Deaf or blind children. However, my own continued clinical experience is drawn upon to comment on these issues.

#### Age

As detailed in chapter six, children in this study ranged in age from 5 years and 6 months to 13 years and 9 months. The average age was 9 years 1 month. Susie (5.6yrs) and Jack (6.1yrs) were the youngest children in this study. Susie's therapist Lucy used the 'Miniature Playroom' and Jack's therapist, Polly used the 'Expert Show'. In terms of the number of views they expressed Jack and Susie were both in the lowest group.

It could be argued that PBEs were not suitable for these children due to their age.

However, in Susie's case there were moments of engagement with the task and this girl's ability to play symbolically was evident in the alternative play she chose. Her therapy was ending prematurely and it seems most likely that her therapeutic needs overrode her engagement with the task. Interestingly her therapist stated that she felt she "saw more of the 'real Susie' and her feelings in the evaluation". Her therapist felt that Susie had not previously shared any negative feelings about ending. However, the evaluation highlighted these to the therapist.

In contrast Jack's understanding of the technique was questionable. He passed a high number of times (10; range 0-10; average 3) often saying he didn't know or was unsure. Some of his responses were repetitive. He appeared eager to engage in the session but his comprehension of the task seemed limited.

His therapist later reflected in the follow-up questionnaire that she felt this evaluation had been unhelpful. She asserted that therapists need to consider the child's developmental level with regards to play when delivering PBEs. Although she had once observed Jack engage in role play in the school setting, she reported that he never engaged in this play during his sessions. She reported that he needed to regress and engage in younger play in therapy and offering him the 'Expert Show' was subsequently incongruous. She had reported that Jack engaged in projective symbolic play and subsequently suggested in the follow-up questionnaire that the 'Miniature Playroom' or using puppets may have been more appropriate. It is not possible to comment on whether the 'Miniature Playroom' or puppet play may have facilitated Jack's engagement with the evaluation. However, it was clear that the 'Expert Show' did not meet his needs and this was not attributable to the therapy ending prematurely nor the therapist's skill level (see Table ii appendix 25).

At the older end of the age range were Bob (13.9 yrs) and Sarah, (11.6yrs).  Whilst Bob was in the mid-low group for number of views expressed (31-40) the range of questions he answered was high and he gave detailed responses. Bob's therapist commented that Bob had suffered from low self-esteem, was withdrawn and had low confidence. He was referred due to experiencing emotional, physical and sexual abuse and neglect. She reflected that the process of the evaluation mirrored that of the therapy intervention. Bob began quietly and was withdrawn with closed body language, gave minimal responses and little eye contact. He appeared nervous and slightly embarrassed as the

therapist played out child callers to the camera to begin with. However, his confidence grew over the twenty-five minute session and his therapist commented on being surprised at how well he had managed the session, noting his confidence at the end. Bob had spontaneously suggested that *he* would welcome the audience back after the advert break. Thus, although Bob appeared initially self-conscious and perhaps embarrassed about role playing, particularly in front of the camera, he engaged in the task and was able to share his views. His therapist appeared to be sensitive and responsive to his embarrassment and used older age-appropriate language during the evaluation and established a collaborative approach. Bob asked to watch some of the video when they finished the evaluation. This arguably indicated his enjoyment of the task. This example suggests that PBEs can be suitable for older children, if managed sensitively by their therapists.

Sarah was the second eldest and was in the high group for number of views expressed (61-70). She provided in-depth responses over a wide range of areas. Again some embarrassment regarding her therapist role-playing younger children calling in was evident on observing the tape. However, in the main, her therapist was mindful of using age appropriate language and explanations. This mirrored Sarah's shared view that her therapist used age-appropriate language that she could understand during the intervention.

**Gender**

There was a fairly even spread across the child participants in this study between the genders: 11 boys and 9 girls. In terms of the number of views expressed there was an even spread across the low, medium, and high categories. Thus in this small sample gender did not seem to correlate with the accessibility of the evaluation methods.

One child, Lee, made a comment that the figures he had to choose from all looked 'a bit too girly' for him. This highlights the need to ensure that the props and figures provided to children convey a wide range. This seems particularly important in terms of the 'Miniature Playroom' being accessible to boys and girls. Whilst this was encouraged in the training, it was not possible to tell from the video recording what the range of toys and props available to each child were.

**Ethnicity**

The data regarding ethnicity is limited to the terms used by the therapists, which were sometimes ambiguous, these are detailed in chapter six Table 3. No specific differences, nor particular adaptations made by therapists were identified when analysing the data with regard to the child's ethnicity. However, Lucy's interpretation of the views expressed by Leanne was influenced by her understanding of Leanne's ethnicity, culture and religion. In addition, power issues were prominent in one dyad where the therapist was White British and the child was mixed race, namely Bradley (discussed below).

**Disability**

Six children in this study were reported to have a disability. As detailed in chapter six, three of these were non-specific low level 'special needs', two were children with an educational statement for 'emotional and behavioural' problems. One child had a diagnosis of ADHD.

With one child, Marble, it was possible that her low level learning difficulty had an impact on some of her responses. For instance, as noted in chapter seven, when she was asked what it would be like if the child had a 'man play therapist', Marble replied 'it would be exactly the same' and then highlighted that there would be a physical difference. She commented that the man would be "twice as taller" {looking upward smiling}.[241] Her response was literal and focused on concrete physical attributes. Her therapist accepted her view rather than trying to shape Marble's response to a less literal interpretation of the question.

With another child, Martin, it appeared that his therapist was unsure whether or not he would understand the concept of a pretend TV show to ascertain his views. This led the therapist to check Martin's understanding of the concepts introduced repeatedly. Arguably this therapist's lower expectations of Martin's ability affected their attunement as the therapist appeared pre-occupied with checking that Martin understood.

The child with a diagnosis of ADHD, Lee, used the 'Miniature Playroom' to share his views. This seemed to meet his need to be active and physically play out scenarios in

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[241] (425)

the playroom. The therapist also permitted him to actively recreate what happened in the playroom by allowing him to use the miniature paints to actually create paintings during the session. Lee moved around during the story-telling and his attention was sometimes suddenly distracted by other things. His therapist, Judy, responded in an accepting manner. Lee initiated a break stating he was going to walk around the room. He moved to a separate area and engaged in creating a larger painting before returning again to the task. The 'Miniature Playroom' seemed to be a suitable way for Lee to share his views. He was in the highest group for number of views expressed (70+). Whilst this example cannot be generalised to other cases, it provides a good example of PBEs delivered by a responsive therapist being accessible to a child with ADHD.

## **Discussion and Implications**

It is essential to take issues of gender, race, disability and culture into account when understanding the ways children reconstruct meaning. As described in chapter five these were considered when the evaluation interviews were developed.

For the youngest children in this study it is questionable whether or not PBEs met their needs. Other factors such as the therapy ending prematurely need to be considered. Whilst these results are not generalisable to other young children, it does suggest that for young children whose language comprehension may be more limited, the 'Expert show' technique maybe less appropriate. Furthermore this technique requires sophisticated role play, including several role-shifts, for younger children and those with developmental delay this may be confusing. This points to therapists' needing to use the more concrete techniques of the 'Miniature Playroom' technique or the puppet technique with these children. As previously noted, none of the therapists utilised the large dolls/puppet technique in this study, and most focused on the 'Expert Show'. This may be due to the training being primarily focused on the 'Expert Show' and only minimally covering the puppets technique. There were five children aged 5-7 in the pilot study and PBE's have been used with a further five children in my own clinical practice and other research projects. These further interviews indicate that PBEs are suitable for children in this age group. However, a high degree of flexibility and the use of more than one technique are often, although not always, necessary. Further research regarding the appropriateness of play-based techniques with regards to young children is needed.

The element of flexibility and the need to respond to individual children's differences in terms of their communication, but also the things they would need to communicate, was a motivation for developing the three techniques. In the training offered to play therapists, flexibility and adapting the techniques to suit children's individual needs is emphasised. As mentioned in chapter five, in both the 'Miniature Playroom' and puppets technique, children are asked to choose the child and the therapist who will be having special play times together. Therapists are encouraged to offer children a choice from a wide range of figures/puppets, including both child and adult figures of both genders and figures with different skin tones. Therapists are also encouraged to provide toy wheelchairs, hearing aids, glasses, and crutches in the kits so children can use these to express themselves. As stated above it was not clear from the video tapes whether or not therapists in this study provided this wide range. One child made his view clear that the figures were too 'girly'. This highlights the need to ensure that a range is offered to children. The use of toys such as wheelchairs seems particularly important if the child, therapist or parent themselves use a wheelchair. Whilst it is known that none of the children or therapists used a wheelchair in this study, it is not known whether or not other important figures in the child participants' lives were wheelchair users. The lack of information regarding the actual props used by therapists is a limitation of this study.

The addition of cues regarding the identity of the therapist and the child in the PBE schedules would be useful. However, it is also possible that this is one area where it is more difficult for the child to provide 'honest' answers directly to their own therapist. The identity of any 'outside' interviewer is also likely to have an impact on the child's response. How culturally appropriate, accessible and representative of the child's own world the play therapy environment and materials are is another area where further cues in the interview schedule could be developed. Consultation with children and young people to find ways of having these questions making sense to children seems important.

With regard to children who have a level of cognitive delay, a balance between checking children's understanding of the process, adapting the language used during PBE's, and accepting the way in which different children with varying abilities see the world, is needed. This is highlighted in the consultation literature with disabled children (Marchant, 1999). Flexibility appeared to be particularly important in meeting the needs of children with ADHD. Whilst there was only one child in this study who was

diagnosed with ADHD, the techniques have been used with two other children with ADHD in my own clinical practice. The findings indicate that promoting breaks, not requiring the child to be seated for the interview, being highly responsive to the child's need to play, and subsequently providing structure to enable the child to re-focus on the task, are facilitative factors with these children (see Kaduson, 1997; 2006, for a review of using play therapy techniques with children who have ADHD).

There were no D/deaf, hard of hearing, blind or partially sighted children recruited to this study. Therefore use of interpreters or adaptations to the 'Expert Show' schedule promoted in the training, such as using text messages, e-mail or webcam conversations in replacement of telephone calls were not used. Having the choice of a small miniature play set and a larger doll set arguably helps to have a more accessible option for children with partial sight. In the research methods literature Davis (1998) highlights that children will have varying degrees of expertise in the methods employed by researchers to facilitate their views. He asserts that this is largely dependent on the child's culture. In Deaf culture, historically, TV has not been as prolific as it has been in the 'hearing culture' due to accessibility issues which are slowly being addressed (Ladd, 2003). Therefore utilising methods which are more reliant on visual communication and less emphasis on being on a TV show is indicated. The potential use of a framework incorporating webcam is being developed, as this new medium is being utilised by Deaf children more frequently (Beresford, 2008; Harkins, and Bakke, 2003).

In my own clinical practice the use of text messages instead of telephone calls and delivering the interview questions in BSL[242] has been successful in one case with a Deaf child. Other adaptations of PBEs have been developed to meet the needs of D/deaf children and adolescents including 'The Expert Show board game' and the 'The Expert Art Gallery'. Whilst one deaf adolescent has been invited to take part using these visually based techniques he declined participation in any type of evaluation, including a paper-based option. Further discussion of these methods is beyond the scope of this dissertation.

Further research is needed to further evidence whether or not PBEs are suitable for all. However, there are indicators that they are highly adaptable techniques which have the

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[242] The author is trained in BSL, British Sign Language (NVQ level 3 receptive level 2 productive).

potential for meeting a wide range of different needs (see appendix 30).

## Power and Consent Issues

I argued in chapter five that PBEs were likely to reduce the power imbalance between research and child. The pilot research indicated that creative use of ground rules in PBEs enabled children to participate as much or as little as they wanted. In this section I return to this issue and I present the findings from the main study regarding the child's need to please and how this was responded to within PBE's. I describe the use of ground rules and therapists' response to these. I conclude by presenting a theme arising from the data on 'powerful roles' expressed in PBE's.

### The Child's Need to Please

A need to please adults was coded frequently for some children in this study. This was indicated by the children's comments and/or behaviour. Therapists addressed this need to please in varying degrees. In general therapists addressed the child's need to please more frequently than the child indicated this need. There were four exceptions to this: Bradley (8.5yrs), Leanne (9yrs), Jack (6.1yrs), and Eddie (9.3yrs). All four of these children expressed a high need to please adults, particularly Bradley.

There were twelve quotes coded as the child expressing a need to please in Leanne's evaluation. As described above, these centred on being 'good' and 'helpful' to the child callers who rang in, and remaining positive to help them. Leanne also displayed sexualised body movements; she had an effusive manner and frequently used a pleasing tone of voice. It is suggested that Leanne's need to please adults was an established pattern of relating to others. It was hypothesised that this may, in part, have developed as a result of sexual abuse. On reading the therapist's pre-evaluation questionnaire it was confirmed that Leanne had experienced sexual abuse and there were also confusing cultural norms and expectations on her as a female to be pleasing to males. As suggested above, the therapist seemed to find it difficult to respond to Leanne's need to please and they both wanted to focus on the positive aspects of the intervention, rather than the impact of the premature ending. The therapist addressing the child's need to please was only coded once during this evaluation session.

Jack made four comments which were coded as expressing a need to please. These were all positive affirmations to the therapist's questions. It seemed likely that these were

comments driven by his need to please adults rather than conscious thought out responses. The reasons for this assertion are as follows. They were all positive affirmations and Jack was not able to expand on any of these minimal answers; as stated above his cognitive comprehension of the task was questionable. He appeared to be checking his therapist's responses, both verbally and non-verbally at these times. This suggested that he was seeking a social referent to affirm he was providing the right answers. Jack's need to please may have been compounded by the fact that the session was held in a school setting where children experience testing, and may be more likely to be concerned about giving the 'right' answer. His therapist, Polly, was gentle and soft in her approach. She accepted his statements and often sought further information. This helped to identify the possibility that Jack's responses were driven by a need to please. However, Polly did not explicitly address his need to please during the process. On reflection in the post-evaluation questionnaire she highlighted her awareness of his potential need to please, and this being a driver for his responses. Subsequently she improved her practice in this area with another child (namely Herbert presented in detail in the previous two chapters).

Interestingly, as briefly mentioned in chapter eight,  through the process of agreeing the ground rules, Herbert was able to acknowledge that it was "kind of hard" to let Polly (therapist) know if he didn't want to take one of the calls. He stated: "sometimes when I don't want to take calls I usually just speak".[243] Thus the process of agreeing the ground rules enabled Herbert to explore his natural tendency to please others and provide an habitual response. Herbert had a high level of energy and there were indications that he found it difficult to slow down and take a break when needed. Polly was mindful of this and initiated the break herself, demonstrating attunement and responsiveness to the child's need. Indeed there was no further indication in Herbert's session that a need to please was a driver for his responses.

Similar to Herbert, Eddie was able to explore his need to please with his therapist, Rachel. Toward the end of his evaluation session, Rachel asked him if he'd like to join her on the sofa area for the chat show phase. Eddie whispered: "I'll do anything really"[244]. Rachel overtly responded to this by stating: "and maybe you really want to

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[243] (89)
[244] (1013)

do whatever I ask but you don't have to"[245]. It is suggested that Eddie was able to acknowledge this due to Rachel's consistent messages throughout the session regarding Eddie's potential need to please. Rachel had added more detail and clarification when she set up ground rules with Eddie. Twenty quotes were coded as examples of her addressing Eddie's need to please. Rachel addressed this need well before there were indications from Eddie that this drove his behaviour or responses. She frequently gave two options regarding the process and stated that either option was OK to choose. She used asides in the middle of calls to remind Eddie that he did not have to answer the questions. Eddie explicitly expressed a need to please eight times. For instance, he asked if Rachel knew where to put things in the 'Miniature Playroom' and after enacting a story he asked how long you have to play the story for. Each time, Rachel explicitly addressed his need to please which appeared to relieve him and enable him to make his own choices. It is suggested that through their established therapeutic relationship Rachel was aware of Eddie's internal driver to please adults and could effectively address this which enabled Eddie to respond more freely to the task. She was not inhibited by a preoccupation with the task, nor overwhelmed by her own feelings about the endings. Arguably she was also a highly adept therapist.

**Informed Consent as an Ongoing Process**

*Therapist Initiated Consent Checks*

Most therapists initiated consent checks with children throughout the course of the evaluation session or initiated the use of a ground rule, for instance initiating a break or explicitly offering to stop the session. This was sometimes in response to children's non-verbal communication, for instance a child appearing restless and tired. Judy commented to Hannah (8.5yrs)[246] toward the end of the evaluation session: "I think the TV show is about to finish soon so you can decide how you'd like to finish it, either with another call or two, or some questions you'd like to make up. It's up to you[247]."

Similarly Judy provided Elizabeth (8.7yrs) with choice regarding the process. There were three outstanding questions on the schedule and Judy gave Elizabeth the choice of which question to take. Judy remained in role as the presenter. She told Elizabeth that her 'producer' had just told her who was about to ring in and what they wanted to ask.

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[245] (1014)
[246] This dyad was also considered in detail in the previous chapter.
[247] (581-3)

Judy read out the three question topics. Interestingly Elizabeth seemed to make her decision based on *who* the call was from rather than *what* they were going to ask her. She chose to speak to the child rather than the adult callers. Indeed several children appeared uncertain about taking calls from a 'parent' or a 'trainee therapist':

A further interesting example of a therapist incorporating a consent check into the PBE was Judy's session with Bob (13.9yrs). In role as a child caller she asked if she could ask Bob a question. Bob looked downward and rubbed his neck with his hand. Judy then switched roles and became the presenter who told the 'child caller' that she could ask him a question but Bob would decide himself whether or not he wanted to answer it. Judy stated that if Bob didn't want to answer it the caller could go to the advice line. Here it was as if Judy, in her role as presenter, took the role as therapist or protector of Bob. She set out the limits and structure of emotional safety to enable Bob to make use of the agreed ground rules.

Some children seemed to suggest that they wanted to keep some of their information confidential. Their therapists helped to manage this confidentiality. Judy turned the camera off when Elizabeth switched to using the 'Miniature Playroom' as she did not want it recorded. Judy asked Bob whether or not he wanted the camera off during the break. Lucy (therapist) turned the camera off during the break for Cathy as did Sonia (therapist) for L-man. This demonstrates children and therapists taking control of the camera thereby reducing the impact of the research.

In two cases, Leanne (9yrs) and Susie (5.6yrs), this code - therapist initiated consent check - was not present at all. Particularly with Susie, it is suggested that if the therapist had initiated a consent check this may have facilitated Susie's overall engagement with the evaluation session. Likewise with Leanne, a child with a high need to please, implementation of the ground rules by the therapist and some 'consent checks' may have helped to address her need to please. This would arguably have facilitated a more open environment in which to express a wider range of views.

*Child Initiated Ground Rule*
Children themselves used the concept of ground rules and initiated them frequently in the session. Table iv (appendix 29) details the type of ground rule used. Every child in this study, except Lee, initiated a ground rule at least once. The most frequent use of

ground rules was made by Bradley who initiated a ground rule twenty-five times during the session, followed by Gabriella (sixteen times) and Hannah (eleven times).

The ways in which therapists responded to the child's use of ground rules differed. Therapists overall were accepting of the child's use of a ground rule and often made explicitly accepting comments. However there were four cases where the therapist overrode the child's use of a ground rule. This happened once with Hannah. As discussed in the previous chapter this rupture in the attunement was repaired by the therapist. It is therefore unlikely that this had a negative impact on her engagement. Similarly Sonia (therapist) overrode L-man's (10.10yrs) assertion that she should take the next call. However, she responded to this quickly on L-man's second request. Nick (therapist) overrode Martin's (11.1yrs) wish to disengage two of the calls and persisted with questions.

In Bradley's case, presented in detail in the previous chapter, the therapist overrode his use of ground rules a high number of times (22, median=0). This raised ethical concerns for me as a researcher and trainer, discussed below. At times Emily (therapist) accepted Bradley's use of the ground rules. However, she often subsequently contradicted her acceptance resulting in Bradley receiving mixed messages.

**'Powerful Roles'**

Other power issues also manifested themselves during role play in Bradley and Emily's session. Emily pretended that the camera was voice activated. When Bradley questioned her on this Emily embellished the 'story' by telling Bradley that the camera only responded to her voice. One could argue that the therapist was being playful here and using a fantastical response to enhance the dramatic nature of the 'Expert Show'. However, Bradley seemed genuinely confused by this and returned to this several times during the evaluation. Emily responded by maintaining the fantasy that the camera was voice activated, telling Bradley in a serious tone of voice that the camera was very clever and it only responded to her voice, not his. The therapist did not recognise and respond to Bradley's confusion. Cognitively Bradley did not appear able to process this information and he took the therapist's explanation literally. The therapist's serious tone of voice and manner suggested that this part of the role play was not playful but a way of controlling the situation.

This therapist also communicated a position of power and control through her non-verbal communication. As mentioned in chapter eight the therapist sometimes used a cajoling tone of voice. At other times she switched to a serious tone of voice. Her bodily posture was sometimes rigid and slightly leaning over the child looking down at him, other times she touched the child's arm to encourage him to sit back in his seat.

This case example was an exception in the cohort. Similar to the pilot research there were many examples of the children appearing to feel empowered through the process of the 'Expert Show'. The child feeling empowered was coded fifty times across the twenty children.  In contrast to Bradley, Herbert enjoyed and was permitted by his therapist to take control of the cameraman. He used an authoritative tone of voice and assertive body language whilst telling the cameraman to 'hit it' (meaning start; see figure He10, chapter eight). Similarly Billy, Martin, Gabriella, Leanne and Charlie took on roles where they interacted directly with the audience and took control of the show at times. The reader may remember from chapter seven that Billy ran his own competition on the show inviting 'the audience' to participate. Martin walked around the room with a 'microphone' pressing home his message to all parents 'out there'. Gabriella took on the roles of her favoured film stars and directed the show. Leanne introduced her own song and dance routine for the audience as an ending. The song she chose was about no-one being perfect and the importance of trying again and again. Charlie sat upright and organised the papers on the desk whilst telling the callers how much fun play therapy was. He suggested that child callers would be sent a limousine to transport them to the studio. He smiled and pointed to the badge on his chest in a proud fashion, stating that he worked at the helpline service.  He chose to put the callers on speaker phone and sat looking down at the phone with an air of authority. He turned to ask his therapist, Judy, if there was another clipboard which he could have. Judy deferred to Charlie and allowed him to take her clipboard. Figure 55 below shows 'Mr. Charlie Daniels' enjoying being the expert, with his clipboard and speaker phone, on the audience's "favourite show":

**Figure 55: The Expert**

## Discussion and Implications

As highlighted in chapter five, Westcott and Littleton (2005) note that although agreeing ground rules has been shown to be beneficial in conducting forensic interviews, it is not clear to what extent researchers employ such techniques. Here clear presentation of both the techniques and the range of strategies therapists employed in responding to children's use of ground rules has been detailed. Rachel and Judy's examples show how sophisticated implementation of PBE techniques enables therapists to truly promote the notion of informed consent being an ongoing process. Most therapists were able to employ the use of ground rules without breaking the rules of imaginative play. Arguably this is an area play therapists are highly skilled at. Therapists are trained to employ similar strategies when making congruent statements to children during role play enactments in therapy (see Ryan and Courtney, 2009).

However, it has been argued that several factors can intrude on therapists' ability to address the child's need to please. These include therapists' preoccupation with task, therapists feeling overwhelmed regarding unsatisfactory endings and the inappropriate use of the 'Expert Show' with a young child (discussed above). The need for therapists' to rehearse the technique well and to concentrate on therapists' skills at addressing the child's need to please in the training is indicated.

The interaction between Bradley and Emily has been analysed in detail in the previous chapter. However, here I intend to address the power and consent issues apparent in this dyad and the dilemmas I faced as a trainer/researcher. Emily's fictitious response, regarding the voice activated camera, arguably resulted in an elevation of the therapist's status and power over the child. This undermined the premise of the 'Expert Show' which endeavours to maintain the child in the role of expert and therefore redress the power imbalance inherent in adult-child relationships. Furthermore in this case there was the compounding power dynamic of a white British therapist and a mixed race looked after child[248]. It is suggested that the therapist taking a position of control may have been influenced by being overwhelmed by the task and the child's challenging responses. This suggests that therapists need to ensure that they are very familiar with the demands of the task. Practice with children who are less demanding to build up confidence is indicated.

The use of touch during this session is worthy of comment here. Whilst touch per se does not necessarily communicate an imbalance of power, consideration of who initiated the touch and the purpose of the touch are of importance in therapeutic encounters (McNeil-Haber, 2004). In response to the touch instigated by his therapist Bradley often became passive. McNeil-Haber (2004:130) cites Geib's (1998) study on adult perceptions of touch in psychotherapy. Geib found that the central factor related to touch in psychotherapy being positively or negatively experienced was whether or not the client felt in control of the touch. McNeil-Haber asserts that "…it is extremely important for therapists to consider the message that their child-patients maybe receiving. Children should not infer that they have no control over when they are touched or that they must participate in touch to take care of the clinician" (2004:130). Further she highlights the need to be cautious of replaying power dynamics, particularly when the child has experienced abuse. This highlights the need for therapists to be aware of their non-verbal communication during child evaluations and other therapeutic encounters and the need to allow children to move around during the session rather than trying to maintain their seated position. As Butler and Williamson, (1994:46 in Shaw, 1999:150) assert: "Children jump around and researchers have to jump with them". The use of video can be helpful in increasing therapist's self awareness of their bodily

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[248] See Malcolm, 2003, unpublished for a review of the literature relating to NDPT and the needs of ethnic minority children and McLeod, 2007 regarding power dynamics in interviews with looked after children.

posture and non-verbal communication. Indeed one therapist, Polly, commented on the usefulness of viewing the video and noticing her non-verbal communication. This was the first time she had used video as it had not been a requirement during her play therapy training. The use of video in not only PBEs but play therapy training in general is indicated[249]. It is also suggested that increasing therapists' body awareness through the use of techniques such as those described by Rothschild (2000:102-3) may be helpful to their practice. These include simple concentration exercises on body sensations and processes whilst sitting, encompassing awareness of tension, temperature, breathing, position etc. This concentrated exercise can help to make therapists more aware of their movements and body communications.

McNeil-Haber (2004) points out that there is currently no published research on children's perceptions of touch in psychotherapy. This continues to be an area for further research. Again careful consideration regarding how to integrate questions regarding touch into the PBE schedules is needed.

The training and research procedures meant that there was a considerable amount of responsibility on therapists to gain the consent of the children and families involved, including during the evaluation session itself. As detailed in chapter six this seemed necessary and appropriate rather than my meeting the children and families directly and explaining the research procedure. However, as the researcher I held overall responsibility for this process and had agreed to adhere to the ethical standards set by the NHS MREC[250]. This included both consent issues and maintaining therapists' and children's anonymity.

In Bradley's case I felt that ethical guidelines regarding ongoing informed consent had been contravened. As a researcher I felt a responsibility for the child's welfare. Furthermore as the developer and trainer of these PBE techniques, I felt a further responsibility to ensure good practice and to support the therapist in her administration of the techniques. I experienced a mixture of conflicting feelings. I had to analyse the influence and responsibilities of my dual role. In consultation with my supervisor, it was agreed that the child had not experienced significant harm during the evaluation session.

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[249] This has become a requirement on most play therapy courses in recent years.
[250] Multi-site Research Ethics Committee

I recognised that I had a responsibility to support the therapist in gaining informed consent in the future and using the PBEs in an ethical manner. Whilst I had tried to ensure that I did not influence the research process, particularly the therapist participant's own progression and learning in administering the techniques, the issues raised in this evaluation were significant enough to warrant my contacting this therapist. I did this as a researcher foremost, but also as a trainer to offer individualised feedback regarding the session. This feedback focused on the power and consent issues which were raised by this evaluation session.

As Davis (1998:330) highlights children are the ultimate gatekeepers to their internal world. He asserts that "if the adult researcher oversteps the bounds of what a child believes to be appropriate the child will resist through silence, humour, conflict or by shutting the gates to their world." This is reflective of Bradley's evaluation session. He tried various strategies, including some of the agreed ground rules, to stop the session. Unfortunately his therapist overrode these. Bradley shared the least number of views out of all the children in the study, and ultimately in this session at least did not allow his therapist into his internal world.

It was clear that this therapist felt that Bradley was capable of sharing his views more fully. However, she accepted and subsequently advocated the need to prioritise the child being in control of their contribution. This process enabled me to develop clearer more sophisticated advice regarding responding to power and consent issues, and the importance of prioritising the child's needs over the research at all times. This will now be incorporated into the training in PBEs in the future.

Whilst it is argued that the 'Expert Show' provides therapists with an opportunity to redress the power imbalance inherent in adult-child relationships, it is also acknowledged that adults *can* be drawn to intensifying the power imbalance when they take on a 'role', particularly with children who engage in dominant/submissive patterns of relating (Heard and Lake, 1997). Even low levels of coercion or 'cajolement' present significant difficulties for children, particularly those who are vulnerable and specifically those who have been forced or coerced inappropriately in the past. However, in this study this was the exception rather than the rule. In general children appeared to find PBEs an empowering process and their therapists facilitated this well. Children were able to utilise the format of the 'Expert Show' to incorporate their own

unique creative expressions. Museums, American chat shows, film stars, competitions, limousines, tours, songs and dances were all integrated into the 'Expert Show' by individual children. Children were able to add their own props into the 'Miniature Playroom' and direct the therapist as cameraman to record their story as they wished. Children also found creative ways to develop their own individual ground rules. These included various gestures, use of props, making the telephone lines in the 'Expert Show' go dead, and introducing their own callers, stories and questions. Thus children were enabled to take the lead and feel in control of many elements of the PBE sessions.

## Conclusion

In this chapter I have presented and discussed the findings related to the process of PBEs in several different areas. I have highlighted the strengths and weaknesses of each technique. I have indicated adaptations to improve each PBE method. Overall it is suggested that PBEs are useful and important new ways of ascertaining children's views using their language – play. Engel (2005:206) asserts that: "The characteristics of a child's story must be understood in terms of the context in which the story is created. A challenge in good narrative analysis is to apply at least two levels of analysis". It has been demonstrated here that thorough systematic analysis utilising triangulation of data sources and methods, has provided a detailed and comprehensive picture of the children's views and enhanced the validity of the findings. Such analysis helps us to make meaning of the child's communications as expressed in 'fantastic reality'. There is some evidence to support the assertion that PBEs are accessible to all groups of children. However, the importance of flexibility, adaptability and the combination of more than one technique has been put forward. The incorporation of the miniature playroom, or other visual and/or action orientated methods, *on* the 'Expert Show' has also been highlighted. It has been suggested that this would promote activation of differing brain processes which seems important when researching an action-oriented modality such as play therapy. Further research utilising PBEs, particularly with younger children is indicated.

**PART FOUR:**
**CONCLUSIONS**

# CHAPTER TEN

## Conclusions and Future directions

### Introduction

In this final chapter I return to consider my original aims and consider the contribution this study has made to the field of play therapy. I begin by reviewing my starting proposition that participatory activity, while inherent in non-directive play therapy (NDPT) practice during therapy interventions, has been lacking at the end of the intervention. In other areas consulting children on the services they have received has been mushrooming. However, the challenge to develop methods which were congruent with NDPT practice remained. The need to embed this ethos of participation and consultation into therapists' practice is considered here. Future plans to support and sustain this participatory activity are detailed. Next I turn to the recorded views of children in this study. I summarise the main themes and highlight the importance of play-based evaluations having enabled children to express themselves in both symbolic and non-verbal ways. I reflect upon the importance of developing analyses and presentation methods to 'hear' and convey these communications more fully to the reader. I return to a theme which has been central to my thinking and has repeatedly arisen throughout the lifetime of this project: the purpose of play-based evaluations. This leads me to consider the importance of therapists having a clear understanding and commitment to enabling children to explore the 'narrative truth' rather than becoming overly focused on eliciting an 'accurate account'. I argue that the latter approach leads the therapist to abandon NDPT values and negates the premise that play-based evaluations are congruent with a NDPT intervention. Lastly I detail the dissemination activity taking place and future areas of research, before making concluding remarks.

### Promoting participatory activity in NDPT practice

In this thesis I have argued that previous research into children's views of play therapy has been very limited. Interest in this area is just beginning to emerge. Evaluations of therapy services in clinical practice are often incongruous with NDPT sessions which utilise play in an highly individualised way to meet children's needs. The rationale for consulting children about their experiences has been detailed in many settings and children have consistently shown that they are the experts of their own experience. I set out strong arguments for developing *play*-based techniques to ascertain children's views which have a high level of salience with the *play* therapy intervention children have experienced. These arguments included that: a) the likelihood that children would

engage in such techniques more easily due to the methods being familiar to them b) that props and visual referents enhance children's accounts (based on the findings from the research on facilitating children's memories) and c) that it is important to maintain NDPT values throughout the intervention. I argued that whilst children's participation rights are highly valued in NDPT, and many parallels can be drawn between children's rights and the NDPT perspective, incongruously there is little focus on the consultation of children at the end of play therapy interventions themselves.

As described in chapter one, I set out to develop techniques which would be congruent with the NDPT approach and could be integrated into practitioners' everyday practice, rather than simply developing child-centred research methods for use in a one off research project. I have presented both the advantages and disadvantages of therapists' undertaking evaluation interviews with children in their own clinical practice. In the main I have argued for therapists themselves conducting these evaluations, due to their unique knowledge of, and relationship to, the child. When therapists conduct their own evaluations there is the benefit of participatory activity continuing beyond the lifetime of a research project. The findings of each evaluation interview can inform individual practice, and can be fed back to each therapist's local service. It is also possible that data collected can be utilised in a larger research project at a later date[251].

As briefly mentioned in chapter six, findings from this study suggested that during the lifetime of the project therapist participants tended to conceptualise the play-based evaluation (PBE) session as synonymous with the research. This pointed to therapists' seeing the PBEs as part of research rather than an integral part of their practice. However, the follow-up questionnaires revealed that all the therapist participants involved in the study intended to continue using PBEs in their own practice. Two therapists commented that PBEs are "really powerful" tools and two stated that they are a good/great tool to find out children's views. All the therapists made a comment about children enjoying, loving, or engaging well with the PBEs. This reportedly provided them with motivation to use PBEs regularly. Thus my aim of developing techniques which could be integrated into practitioners' everyday practice has been 'confirmed' by these therapists.

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[251] Providing the necessary consents are obtained.

However, the voices of therapists who chose not to adopt PBE techniques following the training phase and those who chose not to take part in the research are missing in this study. It would have been interesting to follow up their views of the techniques as they would be key informants (Miles and Huberman, 1994) regarding potential negative views or experiences of using the techniques. This is recognised as a limitation of this study.

As highlighted in chapter three, Kirby et. al. (2003)  assert that participatory activity needs to be sustained, embedded into practice, meaningful to children and effective in bringing about change. Whilst therapist participants expressed their commitment to sustain this participatory activity, there was some indication from therapists' comments that further support and encouragement is needed in order to truly embed the work into practice. This is unsurprising as many play therapists are lone workers or the only play therapist in their team. However, it indicates that therapists themselves need to intrinsically value undertaking PBEs and be supplied with sound arguments to advocate for their use as an integrated part of practice so that they are valued by others, including other team members, managers and commissioners.

The reader may remember from chapter six that three of the potential therapist participants were thwarted by their managers withholding consent for them to take part in the research, and in two of these cases to undertake PBEs at all. To reduce this in the future, providing therapists with an information sheet on PBEs that summarises the rationale and arguments made in this thesis for the incorporation of participatory practice in play therapy interventions is planned. It is hoped that the dissemination materials and activity, detailed below, will lend therapists further support and encouragement to continue using PBEs in their practice.

A further benefit of play therapists maintaining this participatory activity is the potential for cascading their findings from PBEs to others; for instance the wider child therapy community through therapists presenting case examples both in training sessions and in written format in journal articles. Two therapist participants from this study have already reported that they have presented case examples to other professionals. Sometimes issues are raised by children in PBEs which have wider implications beyond play therapists' own practice. Thus raising these issues within the therapist's wider team, including members of management teams, seems important. Furthermore play

therapists may have an important role in advocating and advancing the participatory activity which takes place in their teams. Presenting findings from PBE sessions is one way of galvanising more interest, and possible activity, in ascertaining children's views of therapy.

Following my own short presentations and workshops on the techniques there has been international interest in PBEs from therapists in the UK, Ireland, Holland, Australia and the US. Many of these play therapists have requested full training in the techniques. Interest from other child therapists has also been expressed, following both short presentations and also e-mail correspondence in response to the article published on the pilot study. Therefore further training events are planned, thereby increasing the cohort of therapists offering PBEs. This will hopefully increase the momentum and enthusiasm to embed PBEs into clinical practice.

With regard to making effective changes following PBEs, therapists recorded that there were no changes made at a service level. From my analysis of the children's views in this study, the only service level issue which was identified was the need for longer term work to be permissible in some cases. One therapist reported that she took this issue to the managers and commissioners of her service but the children were "not listened to by the hierarchy". All the therapists highlighted that they understood the child's feelings or communications more through undertaking the PBE. In several cases it had confirmed a decision they had made. In two cases the PBE made the therapists reflect upon the need to talk to the child's parents further about particular issues which arose during the PBE session. Ensuring a forum for discussing potential changes to practice on an individual or service level following children's evaluations and a place to pull together a record of these changes may help to add value to these comments and motivate therapists to see through these changes. Utilising a web-based forum and blog on the members' area of the BAPT website is planned. In this way it is hoped that PBEs will not only be embedded into practice but also bring about positive changes advocated by child clients.

A further issue is therapists themselves undertaking the analysis of the evaluation interviews and summarising the children's views for each session. Thus far this aspect has remained in the research domain. However, therapist participants have requested guidance on undertaking their own analysis of the child's view. It seems that the

motivation and interest in undertaking this part of the process exists and would arguably contribute to therapists reflecting upon the child's communications at a deeper level. Arguably this would make changes being made to practice both more likely and considered. One therapist, Polly, provided a lot of extra detail regarding her thoughts on the children's communications and had reviewed each video tape herself before sending it to me for analysis. Therefore she had independently begun an analysis process of her own and it seemed that this led to her reflecting on her clinical practice and potential changes she could make. Simplified analysis matrices drawn from the findings of this project have been developed. These focus on the two main strands of this research, the child's stated views and the impact of process issues. These have been piloted in my own clinical practice. Further piloting by other therapists is planned before dissemination of these tools. Again it is hoped that the incorporation of this recording tool will further embed PBE's in practice and focus therapists on issues of importance. It may also help to address managers' accountability concerns as this would enable more objective and accessible presentation of the findings. Using such a tool will also ensure that a coherent record of the PBE is held on the individual child's file which could prove useful should that child return to the therapy service at a later date.

**Recording the children's views of play therapy**

As set out in chapter one I intended to record the children's views of play therapy which had been expressed in PBE interviews in NDPT practice. I detailed the communications of children in this study in chapter seven recording their important memories of play therapy and their recommendations for clinical practice. I argued in the previous chapter that PBEs are useful and important ways of ascertaining children's views of play therapy. The use of play, toys and props within an established therapeutic relationship all seemed to enhance children's abilities to share their views more fully. Here I summarise the main themes arising from the children's expressed views. I proceed by detailing two essential parts of the analytic process: making sense of the symbolic play and non-verbal communications expressed by children in PBE sessions. Analysing these communications was fundamental in recording the children's views more fully.

The main themes were as follows. The involvement of parents and carers in play therapy interventions was experienced, by the children, as positive. The importance of children being able to express themselves using a wide range of toys and activities, including those which were age and gender appropriate was highlighted. In the main the

playroom was experienced as a fun, safe place where children could choose. Non-directive play therapists were described as active observers, rather than passive onlookers who would help children when they needed it, cheer them up and calm them down. Some children described or demonstrated the therapist using congruence. A central finding was the importance of the therapeutic relationship, which was referred to as a friendship "hardening" and "a bond" developing. Advice regarding going at the child's own pace was given by one older child and was clearly experienced by many others. In the main positive changes were described as the outcome of play therapy, particularly in regard to inner feeling states. Children also communicated how difficult it was for them when therapy ended prematurely. It is not known how representative the sample of children participants in this study is of the wider population of children who attend play therapy. It is quite possible that those children and/or families with the most negative views declined participation in the research. The sample was small and cannot be generalised. However, these themes and the learning gained from children's expressed views appear to be 'transferable' (Fook, 2001) to NDPT more widely.

As stated above, in the thematic analysis I paid attention to the potential symbolic meanings expressed by the children in this study. With this smaller sample I have been able to analyse the children's communications in depth. I have provided the reader with the context and evidence I have drawn upon when suggesting symbolic meanings. Engel (2005) advocates intercoder reliability to enhance the validity of interpretations of children's stories. I concur with her view that ignoring or avoiding underlying meanings leaves us with an incomplete understanding of the child's communication. In this study triangulation of data from the therapists contributed to making sense of the varying layers of meaning in children's narratives. In particular, remaining blind to the therapists' own interpretations and knowledge of the child's history enabled incorporation of a second view. This approach was limited to the issues the therapists chose to detail in the pre- and post-questionnaires. Some therapists provided very thorough analysis of each individual call and story the child told; others provided minimal responses. Some compensation was made for this by undertaking member checks. I asked therapists to make further comment on the potential meanings of children's communication by reviewing and commenting upon sections of my analysis. In some respects the use of the therapists in this way as second 'meaning-makers' provides stronger evidence than two 'outsiders' being used to achieve intercoder reliability. The therapists contributed their 'inside' knowledge of the child and I, as

researcher, contributed my 'outside' more objective perspective, initially blind to information regarding the children, to make sense of the child's communications. Incorporating an explicit question on how witnessing/hearing the story made the therapist feel and what they felt the child's purpose was during the evaluation would have further enhanced the data received. A checklist including Engel's (2005) suggestions regarding the child's purpose may be useful for therapists to apply to each call/story (e.g. whether they were primarily ordering experience or making upsetting material feel safer).

In addition to making sense of the symbolic meanings of children's play and interactions I have also argued that intensive attention to children's non-verbal communication, both in terms of facial expression, body language and gestures and their play behaviour, was essential. The immersion into the child's world in this analysis enabled me to experience and record their views in greater depth. The focus on non-verbal communication of their views of play therapy was seen in Axline's early work. Following the interviews Axline noted her observations of the child's facial expressions and body language. The use of video-recordings has enabled a sophisticated return to this focus. Advances in technology allow for more intensive study of non-verbal communication and greater access to the child's inner world. In particular the interactions occurring between therapist and child and inferences about the quality of the relationship can be accessed. This is of course limited by the 2D image which is not a 'real' replication of what happens between two humans. However, the profound effects that viewing the tapes had on me as the researcher on an affectual level point to video being an effective tool which enables partial access to the affective communication that occurs. As previously noted a further limitation of this study was the poor camerawork, particularly during the 'Miniature Playroom' interviews. Therefore my recording of these children's views was somewhat compromised. This points to the need for two cameras and/or the therapist making a detailed record of the miniature toys picked out by the children.

Paralleling the technological advances in actual recording the interviews, advances in 3-D imaging have allowed me to replicate the child's non-verbal communications and grant the reader greater access to this essential information. This is an exciting and innovative new use of technology. It has enabled the presentation of human interaction in child therapy in a way that respects participants' right to anonymity. The level of

detail and accuracy which can be achieved with regard to body positioning, eye gaze and facial expression is superior to other methods previously utilised (e.g. simple line drawing or real photos manipulated with posterisation and cut out techniques, see Prosser, 2009). This is a strength of the study which could usefully be employed in a number of studies across disciplines, particularly those which focus on human interaction.

## A Question of Purpose

A theme arising throughout the lifetime of this research project was the way in which researching children's views is conceptualised. In other words what is the underlying *purpose* or motivation for ascertaining/eliciting children's views of services in child therapy? In other areas where children's accounts are sought, such as children's testimonials, the purpose is clear. It is necessary to gain an accurate recall of events, or the 'historical truth'. In the field of evaluating children's services, potential aims might be based on adults' needs to validate the approach they use of the service they offer, particularly in these times when the model of evidence-based practice dominates (Gilroy 2006). The interactions observed in this study took place in the therapeutic relationship. However, the 'task' in hand was different to usual interactions between these dyads. It seemed that therapist participants in this study were unsure about their role and the purpose of the evaluation. It seemed difficult for therapists to determine whether they were primarily therapists, interviewers, or 'research informants'. It became clear that I needed to consider the therapists' purpose during the PBE interaction.

It seemed that, like the over-regulating mothers in Gertsch-Betten et. al.'s (2003[252]) study there were therapists who placed emphasis on facts. In the context of PBEs this appeared to be motivated by a desire to provide 'useful data' which was 'easy to analyse'. These therapists also appeared to miss the affective core of the narrative at times. The second style - under-regulated mothers - was characterised by passivity. This style was not overly pronounced in any of the dyads in the current study. However, it was evident in some training tapes, where therapists asked questions and kept dialogue to a minimum, in fear of 'contaminating' the child's views. The therapists who were identified as being highly attuned to the children seemed to parallel the third pattern of

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[252] Reviewed in chapter four and drawn upon in the analysis of dyads in chapter eight.

optimally-regulating mothers. These therapists focused on coherency and emotional content.

It seems that the first two patterns are somewhat reflective of a positivist point of view, focusing on facts for research or the 'historical truth', whereas the third pattern is most similar to the values underpinning NDPT practice. Here the purpose is to facilitate the sharing of 'narrative truth' and to promote therapeutic benefits. It is suggested that whilst the first pattern of relating was associated with 'accurate accounts' (in Gertsch-Betten et. al.'s 2003 study) the third pattern of optimal-regulation is most desirable not only in child therapy sessions but in PBE sessions also. As stated in the previous chapter, the therapeutic benefits possible in PBE sessions include processing the end of therapy and integrating the child's play therapy experience into their life story in a coherent and meaningful way. Focusing on the 'narrative truth' in PBE sessions is likely to enable therapists to facilitate these benefits. To ascertain a full picture of child therapy, interventions where negative/difficult emotions are experienced, and hopefully processed, an interview style which focuses on affective states including negative/difficult emotions is desirable.

A training need regarding the role and purpose of the therapist in PBEs was indicated. This issue, along with an exploration of other skills needed by therapists and the implications for play therapy and PBE training are discussed in the next section.

**Therapists' Skills: implications for play therapy training**

It is important to acknowledge here that a limitation of the study is the potential impact the research component had on therapists. Some therapists had not used video in their practice before. Therefore this created an extra demand on the therapist and potentially further anxiety about the equipment itself. A further stress was the fact that these tapes would be sent to me, the researcher, developer and trainer of the techniques. Furthermore I was a peer to, and in some cases a previous lecturer for, some of the therapists which may have added to their anxieties. Therapists were aware that taking part in the research would necessarily involve scrutiny of their practice which caused anxiety about 'getting things right'. This was particularly evident with regard to therapists allowing themselves to be flexible with the techniques. This requires veering away from the interview schedule: potentially 'displeasing' me. In addition most of the therapists had agreed to their tapes being used for training purposes in the future. Thus

they were aware that other professionals, and the play therapy community, may view excerpts of the tape[253]. Furthermore most therapists made a verbal comment or written statement that they were concerned to provide me with 'useful data' for my project, which was 'easy to analyse'.

The need for play therapists to have a greater understanding of the strategies for promoting validity within qualitative research was indicated. This may have reduced therapists' anxieties regarding collecting 'hard' evidence and 'good enough' data. Making training on research methods and the conduct of research more accessible to all play therapists is indicated. The importance of having a good understanding of research in general should be promoted to encourage therapists who choose to take part in research to attend such training, rather than only those who are interested in conducting research themselves. However, it is also needed in terms of undertaking PBEs with children in therapists' own practice that is not part of a large research project.

The findings presented in chapters seven through to nine have demonstrated the skills needed to fully facilitate the child's exploration. The sample size, in this study, is too small to draw any firm conclusions regarding the therapists' skill development. Furthermore therapists were new to the techniques and the development over time was not possible to ascertain. Variables such as the therapists' natural aptitude are impossible to determine, particularly with no other observational data to draw comparisons. However, the most striking finding from the exploratory analysis seemed to be that responsive therapists did integrate their NDPT skills into the directive framework of the PBE.

Yin (2003) suggests a number of skills (highlighted in italics below) which are essential to being a good case study investigator. These skills can usefully be applied to the 'therapist/interviewer' role during PBEs. Importantly NDPT and research interview skills do not need to be mutually exclusive:

*To be a good listener:* Hill (1997) argues that while research interviews are not therapy, the skills are directly transferable. Non-directive play therapists are trained in listening to children on all channels (i.e. verbal, non-verbal, on a motor level, affect level,

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[253] It was agreed with therapists' that I would let them know which excerpts specifically I planned to use in this way and they could withdraw their consent to this at any time.

symbolic level, see Wilson and Ryan, 2005). Emphasis on listening on all of these levels *during* PBEs will be made in future PBE training.

*Ask good questions:* Here the question of whether the therapist is a therapist or an interviewer during PBE's arises most strongly. As a non-directive play therapist it is second nature to comment on feelings children express through their play and facial expressions. In contrast in the role as interviewer it can be somewhat alien to therapists to ask a child how certain characters feel, or indeed to be asking questions at all, a practice avoided by most non-directive therapists. During the pilot studies I had noticed my own strong drive to 'help' children understand and process their feelings. Using core Rogerian skills to reflect the feelings evident to myself would be on some level interpretative. It was important to recognise this and understand the differences and 'limitations' of this new role and to become questioning in a wholly different way. Some of the therapists in this study achieved a good balance of asking questions whilst integrating their skills of reflecting, thus avoiding the trap of becoming passive or over-regulating and only focusing on the facts.

*To be Adaptive and Flexible:* The highly individualised nature of NDPT means this is an area play therapists are usually good at. However, this is within the structure and framework of the NDPT session where, aside from setting therapeutic limits and structuring the beginning and ending of the sessions, the therapist is free to flexibly adapt to the child's agenda. Within PBE's the agenda is rather more structured. However, as argued above, once this is conceptualised as a framework within which the therapist can be flexible and adapt to the child's needs, a successful symbiosis seemed to occur for some therapists.

*Have a firm grasp of the issues studied:* As noted elsewhere, the ability to respond to children flexibly only seems to take place when the therapist has a good degree of familiarity with the techniques and interview schedules. This high level of familiarity is also needed in order to effectively incorporate the role play involved in the 'Expert Show'. As Landy (1991:36) asserts: "In many ways, the aim is to become the consummate repertory player, a juggler of roles, a one-person masquerade." Toward the end of the 'Expert Show' when the therapist introduces the chat show element the therapist's role is to "facilitate the passage between realities" (Pendzik, 2006:277), from immersion in role, to a more direct discussion and finally ending the session back in

reality. Arguably whilst play therapists employ such strategies, there is limited emphasis on these aspects of dramatic play in most play therapy training. This study indicates that further training in this would be beneficial.

*Someone who is unbiased by preconceived notion:* It seemed evident to me that we all *do* have biases and preconceived ideas about what we are doing and why. What seems to be the key is rather than being unbiased, we should strive to be alert to our biases, recognise these and consider their impact on the interview process. As stated above, this is a process familiar to therapists, who use clinical supervision and their own personal therapy to achieve this awareness. Importantly therapists need to be aware of possible preconceived notions about what makes 'good research data'. Focusing on facilitating the 'narrative truth' rather than trying to elicit 'accurate accounts' should help therapists to remain accepting and possibly promote greater attunement in the therapist-child interaction during PBEs.

**Empathic Attunement**

McCluskey (cited in Heard and Lake 2001a) reported that participants who were securely attached themselves were able to be more empathically attuned to clients (in an experimental counselling situation) than those with insecure attachments. It was not the aim of this study to reliably measure the therapists' attachment style. However, the findings from Rubino et. al.'s (2000) study are of relevance here. Their study pointed to therapists' awareness of their own attachment style mitigating against reaffirmation of the client's internal working models. As Mc McCluskey argues:

> "Attachment theory provides a framework *for monitoring the interaction process itself* between the careseeker and caregiver" (2005:88).

Applying the 'dynamics of attachment model' (Heard and Lake, 1997), along with consideration of juncture points and Koren-Karie et. al's categories, to the PBE sessions proved useful in analysing the therapist-child interaction. Applying these attachment concepts to therapists own cases would arguably heighten therapists' awareness of their own dynamics. This would provide valuable insight which would enable them to support children during both PBEs and child therapy sessions more effectively. I am not suggesting that play therapists undertake the type of detailed analysis presented in this study. However, selecting segments of video, 2-5 minutes in length at the beginning,

end and a mid point of a play therapy session to watch and verbally review in training or supervision is likely to be beneficial. Specifically focusing on vitality affects to indicate juncture points and misattunements would help therapists process the interaction. Possibly an assignment focusing on this could be incorporated during a play therapy practicum in the final year of training. At this stage of training more sophisticated understanding of the interaction is needed. For qualified therapists, who undertake further training in PBEs, this process could also be applied to the PBE session itself within follow up PBE training and/or in supervision.

It is suggested that it takes practice and experience with PBEs to establish the most effective balance in ensuring that one does not overly influence the child whilst maintaining a responsiveness which is encouraging and genuine in the interaction. All the therapists who undertook the training in PBEs stated that a one day training event was not enough to cover all the issues raised in enough depth. Therefore the training in PBEs will be extended to a two day event including individualised feedback and a follow-up day available.

**Dissemination of findings**

Gilroy (2006:40) advocates using visual research methods to not only collect and analyse research data but also to present our research. She asserts that:

> "…inviting clients into the heart of the research process and privileging user voices, will also enable us to convey the particular sensibilities, properties and underlying culture of our practice that differentiates it from the mainstream of care, and from other psychological therapies."

In this thesis, children's 'voices' have taken centre stage, not only their verbalisations but their non-verbal communications and play have been shared with the reader. Unique visual reconstructions have brought the therapist-child interactions to life and enabled greater engagement with the detailed analyses undertaken.

Interesting interactive presentations of findings have been reported in the arena of art-based interventions (see Gilroy 2006:98). Presentations have reportedly incorporated performance, music and visual displays to communicate the findings of their research. Gilroy provides a full description of Bagley's interactive experiential exploration of his research on the Sure Start scheme. The theme of social deprivation was re-created by constructing a theatre set for conference delegates to explore. This included dark places

strewn with nappies whilst the smell of burnt toast exuded from a toaster. Gilroy argues that this made the research accessible in a wholly different way to the traditional dissemination methods of the written word and statistical tables. Rather it was "…an experience that stimulated thought and affect. A million miles from EBP[254] you might say, but this risky representation illustrates how affect-laden, visual and other kinds of research material can be conveyed to audiences in ways that are neither dry nor distant" (2006:98).

As Gilroy asserts we must all find approaches and methods which are appropriate to our disciplines. Playful ways to disseminate the findings of the pilot study and the initial findings of the main study have already been employed. During presentations a TV studio has been created and seminar participants have become the TV audience whilst I have acted the part of TV presenter introducing the techniques as part of the 'Expert Show'. It is planned that this format will be used in further seminars and talks when disseminating the results. Adapting Hannah's (child participant) idea of creating a play therapy museum to present the findings in an interactive format at conferences and training events is also being developed.

A series of booklets for children, parents, therapists and other interested professionals is being produced. These reports incorporate visual images and a small selection of the 3-D images presented in this thesis. As stated earlier making a video to send to children is under development. The main findings will be presented as a series of stories using the miniature playroom and additional scale models. A second version utilising the 'Expert Show' format in which I act as a presenter reporting on twenty experts' views of play therapy is also underway.

**<u>Future studies and other applications</u>**

Several suggestions regarding further research into PBEs have been made throughout this thesis. Here I focus on specific projects which have utilised PBEs and the main applications of PBEs to the wider arena of child research and practice.

As highlighted in chapter one PBEs have been used in a project comparing and contrasting two parenting group programmes: filial play therapy and the Incredible

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[254] Evidence-based practice

Years programme. The interview schedules were adapted to follow the process of these two group interventions. The data collection period of this project is complete and the analysis of the PBEs along with analysis of parents' views and quantitative measures is in progress[255].

The interview schedules have also been adapted for individual filial play therapy and are being implemented in therapists' clinical practice. A study reviewing the use of these schedules specifically is indicated.

Use of PBEs in a mixed method study on individual play therapy is planned within my own, and a colleagues', clinical practice. This will include administering the CBCL[256] before and after the intervention, and a review of the therapists' process notes possibly following a specific recording format of play themes such as those in development by Ryan and Edge. Further studies following a similar design would be useful.

Requests for interview schedules which follow the process of Theraplay and other therapeutic interventions have also been received. The use of PBEs to evaluate other creative therapies is indicated. Some adaptation to questions in the schedules will be needed and in some cases adaptation of the method employed is indicated. Consultation with an art therapist led to the development of 'The Expert Art Gallery' technique to be used in evaluating art therapy. It is suggested that in addition to the two-day training aimed at play therapists a pre-training session for other professionals would be needed. This would focus on basic play therapy skills and particularly practice in engaging in role-play and the importance of maintaining the metaphor in symbolic play.

Beyond the world of child therapy the framework of PBEs may be used to research or ascertain the views of children regarding therapeutic or mental health interventions, through to their experience of social services interventions. The techniques could be adapted to ascertain the views of Looked After Children for their reviews, rather than, or in addition to, the current paper-based consultation papers. They could be adapted as playful ways to conduct therapeutic life story work. One therapist participant suggested their adaptation for use in educational reviews in an EBD[257] school. Thus PBEs have a

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[255] By the author and her supervisor Dr. Virgina Ryan.
[256] Child Behaviour Checklist (Achenbach, 1991)
[257] Emotional and behavioural difficulties.

wide application to a diverse range of settings and professional groups. However, as stated above pre-requisite training in basic play therapy skills along with consultation and supervision with an experienced play therapist is indicated (as previously advocated in Jäger and Ryan, 2007). As noted earlier, the findings of this main study highlight that even experienced play therapists trained to develop emotionally open, non-defensive and responsive relationships with children, need in depth training, feedback, supervision and practice in effectively delivering these techniques.

## Concluding Remarks

My main motivation for developing PBEs was a desire to see the values of NDPT realised at the end of play therapy interventions. In addition I was motivated to truly seek children's views in meaningful ways rather than following an adult agenda of consultation designed to meet political targets. The findings of the study have shown that PBEs are innovative, fun, enjoyable and therapeutic methods. They are child-centred techniques which are highly adaptable and congruent with a play-based action-orientated modality such as NDPT. When they are delivered by child-centred responsive and flexible therapists they allow the child to construct meaningful narratives of their play therapy experience.

PBEs provided an environment in which to study therapeutic encounters in detail. Micro-analysis of four therapist-child dyadic interactions undertaken in this study has provided an in-depth accessible understanding of therapeutic interactions. Use of new technology has enabled the reader to visually engage with the material represented without compromising anonymity. This study has taken the first known steps in analysing observed interactions in therapist-client encounters in *child* therapy applying attachment theory to increase our understanding of inhibitive and facilitative factors during the process of therapy.

In this study children emphasised that play therapists both listen and play with children and importantly offer them choice. PBEs have enabled play therapists to extend these attributes to the very end of play therapy, making the NDPT intervention truly child-centred and focused on the child's 'voice' from beginning to end. The evaluation sessions utilise the child's language, namely play. Thus children are enabled to draw upon their expertise in play to express themselves more fully and ensure that their 'voice' is truly heard.