

Counselor Trainees' Development Throughout an
Introductory Play Therapy Experience

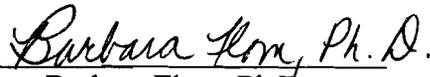
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ABSTRACT

The purpose of this study was to evaluate and analyze the experiences of one set of graduate students enrolled in an introductory play therapy course at a public Midwestern university in the summer of 2006. This study was done with the following question as its foundation: What is the developmental journey of graduate level counselor trainees as they progress through an introductory play therapy experience? This study was designed to provide interpersonal perspectives from the participants to determine if themes and patterns could be observed.

The research regarding counselor development proposes counselor identity models of development; however, there is little research that speaks to students' experience of becoming a play therapist. A phenomenological methodology was used to explore participants' journeys as they progressed through a play therapy course. Each of the nine participants was interviewed individually twice and then collectively once in a

focus group format. Data analysis involved coding transcripts of the individual and focus group interviews looking for emerging and distinct themes in the participants' experiences. Three divergent phases emerged. The phases presented in this study are: Mistrust/Doubt, Skills Acquisition, and Theory Integration. Recommendations are presented for counselor educators as well as researchers who may seek to replicate the study.

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Chapter I: Introduction

As graduate level counseling students progress through a training program, a majority of the skills and techniques learned to counsel children are modified versions of adult based helping techniques (Landreth, 2002). Piaget (1962) concluded that most children below the age of eleven lack a fully developed capacity for abstract thought, which is a prerequisite to meaningful verbal expression and understanding of complex issues, motives, and feelings. Play therapy is one of the few therapy/counseling styles designed initially for children and is widely used to treat children's emotional and behavioral problems because of its responsiveness to their unique and varied developmental needs.

Unlike adults who communicate naturally through words, children more naturally express themselves through the concrete world of play and activity. In play therapy, play is viewed as the vehicle for communication between the child and the therapist on the assumption that children will use play materials to directly or symbolically act out feelings, thoughts, and experiences that they are not able to meaningfully express through words (Jones & Rubin, 2005).

Play has been acknowledged as significant since the time of Plato. It has been reported that he observed, "You can discover more about a person in an hour of play than in a year of conversation." In the eighteenth century Rousseau wrote in his text *On Education* about the importance of observing play as a means to learn about and understand children (Rousseau & Payne, 2003). Froebel, in his book *The Education of Man*, emphasized the significance of imagery in play. He wrote, "...play is the highest development in childhood, for it alone is the free expression of what is in the child's

soul... children's play is not mere sport. It is full of meaning and import" (1903, p. 22).

The first recognized case describing the therapeutic use of play was in 1909 when Sigmund Freud published his work with Little Hans. Little Hans was a five-year-old child who was suffering from an irrational fear. Freud saw him once and recommended that his father take note of Hans' play to provide insights that might assist the child.

In 1919, Melanie Klein implemented the technique of using play as a way of analyzing children under the age of six (Ginott, 1959). She believed that a child's play was essentially the same as free association used with adults, and that as such, it provided access to the child's unconscious. Hermine Hug-Hellmuth formalized the play therapy process by providing children with play materials to express themselves and emphasized the use of the play to analyze the child. Anna Freud utilized play as a means to facilitate positive attachment to the therapist and gain access to the child's inner life (Ginott & Lebo, 1961).

In the 1930's David Levy created a technique he called release therapy (Ginott & Lebo, 1961). His technique emphasized a structured approach. A child who had experienced a stressful situation would be allowed to engage in free play. Subsequently, the therapist would introduce play materials related to the stress-evoking situation allowing the child to reenact the traumatic event and release the related emotions. In 1955, Gove Hambidge expanded on Levy's work emphasizing a "Structured Play Therapy" model, which was more direct in introducing situations (Moustakas, 1953). The format of the approach was to establish rapport, recreate the stress-evoking situation, play out the situation and then free play to recover.

Carl Rogers extended the work of the relationship therapist and developed nondirective therapy (Rogers, 1951). Virginia Axline (1947) added to Rogers' concepts and summarized her concept of play therapy stating, "A play experience is therapeutic because it provides a secure relationship between the child and the adult, so that the child has 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" (p. 68).

Filial therapy was a new innovation introduced to play therapy during the 1960's (Guerney, 1983). This technique emphasizes an ordered curriculum for parents were they learn how to make use of child-centered play therapy techniques at home (Guerney, 1983). In the 1960's, with the introduction of school counselors, school-based play therapy began to move from the private sector to a place in the mainstream counseling culture.

In 1982, the Association for Play Therapy (APT) was formed, marking the desire not only to promote the advancement of play therapy, but to acknowledge its extensive growth. Presently, the APT has almost 5,000 members in twenty-six countries (2004). Play therapy training is made available, according to a survey conducted by the Center for Play Therapy at the University of North Texas (2004), by 185 universities and colleges all over the United States.

As a student in a play therapy course I found myself struggling with learning how to use play therapy techniques in a way that had not been experienced to that point in my graduate program. Upon discussing these struggles in class with fellow graduate students, it was made clear that a majority of my cohort were on a similar journey with comparable trials and struggles. It seemed as though there was a progression through

similar phases as the course evolved. This experience was the catalyst for this study; what is it like for a group of individuals to learn how to conduct play therapy and be with a child in a way that was unfamiliar to all those taking the course?

Statement of Research Problem and Purpose of Study

This study was done with the following question as its basis: What is the developmental journey of graduate level counselor trainees as they progress through an introductory play therapy experience? The purpose of this study was to qualitatively evaluate and analyze the experience of one set of graduate students enrolled in an introductory play therapy course at a public mid-western university in the summer of 2006. The study was designed to provide the researcher with interpersonal perspectives from the participants to determine if themes and patterns could be observed.

Definition of Terms

The following definitions have been established in order to assure complete comprehension of the methodology and results of this study:

Counselor trainee- A graduate student pursuing a graduate or professional degree in a counseling or psychological field. A counselor trainee is in the process of obtaining a Master's Degree but has yet to do so.

Play Therapy- Play therapy is a structured, theoretically based approach to therapy that builds on the normal communicative and learning processes of children. Therapists strategically utilize play therapy to help children express what is troubling them when they do not have the verbal language to express their thoughts and feelings.

Assumptions and Limitations

This study assumed that all participants shared their experiences truthfully and without consequence for doing so. It was also assumed that participants did not attempt to impress the researcher with their knowledge of play therapy techniques and theory and with their success, or lack thereof, with their client.

Limitations of the study included that participant feedback may have been falsified, unintentionally or due to human error, and consequently presented misleading information during coding. The fact that the researcher was the only coder of the participants' interviews presents an added limitation. Additionally this study used one class of students from one university taught by one professor during one point in time, thus making generalizations from this study unwarranted.

Chapter II: Literature Review

This chapter will present information on child-centered play therapy, a discussion of literature pertaining to counselor trainee development, and the implications for play therapist development and training. A summary of the literature review will be presented along with the need for this study.

Child-Centered Play Therapy

Virginia Axline, first a student under Carl Rogers and then his colleague, translated the philosophy and principles of Rogers's nondirective counseling approach to work with children in her definitive play therapy text, *Play Therapy: The Inner Dynamics of Childhood* (Axline, 1947). Rogers's approach was later referred to as client-centered therapy, and today as person-centered therapy. The person-centered, or, with children, child-centered, approach makes no effort to control or change the child and is based on the theory that the child's behavior is at all times caused by the drive for complete self-realization. To understand the child-centered play therapy approach it is necessary to first understand the meaning of play in children's lives.

In play therapy, toys are viewed as the child's words, and play as the child's language, a language of activity which may contain more meaningful material than verbalized words (Landreth, 2002). Play therapy is to children what counseling is to adults. In play therapy, it is the symbolic function of play that is so important, providing children with a means of expressing their inner world. For children, emotionally significant experiences can be more comfortably and safely expressed through the symbolic representation that the toys provide.

Given the opportunity, children will play out their feelings and needs in a manner that is similar to that of adults (Landreth & Sweeney, 1997). The dynamics of expression and the medium for communication are different for children, but the expressions are comparable to those of adults. Children may have substantial difficulty in trying to tell what they feel or how they have been affected by what they have experienced. However, if permitted, in the presence of a caring, sensitive, and empathetic therapist, they will reveal inner feelings in their choice of toys and materials, in what they do with and to the materials, and in the story acted out (Landreth & Sweeney, 1997). Children's play is meaningful and significant to them, for through their play they extend themselves into areas that they would have difficulty entering verbally.

Because the child's world is one of action, and play is the child's natural means of communication, play therapy provides the child with a safe haven in which to act out a wide range of experiences and feelings (Moustakas, 1953). In the moment of play, the child lives out past experiences and feelings and is not restricted to discussing what happened. If the reason for referral of a child to the therapist is aggressive behavior, for example, the therapist is provided with an opportunity not only to experience the aggression firsthand as the child bangs on the bop bag but also to help the child learn self-control by responding with appropriate therapeutic limit-setting procedures (Landreth & Sweeney, 2001).

If play materials were not a part of the therapeutic experience, the therapist could only discuss with the child the details and possible reactions to the aggressive behavior the child exhibited yesterday or last week. In play therapy the therapist has the chance to experience and actively deal with that problem in the propinquity of the child's

experiencing. In the context of the sharing of experiences, play therapy becomes a living relationship (Landreth, 2002). Axline (1947) viewed this method as one in which the children play out their feelings, bringing them to the surface, getting them out in the open, facing them, and either learning to manage them or discarding them when appropriate.

For a majority of children, the play therapy rapport is like no other they have experienced. It is one in which they are fully accepted and valued for the persons they are. The play therapist preserves and conveys a constant regard and respect for children despite their actions. Even during the setting of limits on a child as they attempt to break items, the person of the child is more important than the behavior (Landreth & Wright, 1997).

In the beginning, the play therapy relationship is structured by how the therapist introduces the child to the playroom (Landreth & Sweeny, 2001). According to these authors, spoken communication should be kept to a minimum at this point. No words can communicate to the child that this is a safe place; the child learns this through experience. Words should be chosen cautiously to communicate to the child autonomy, self-direction, and the limitations of the relationship (Rhoden, Kranz, & Lund, 1981). The therapist might say something like, "Sara, this is our playroom, and this is a place where you can play with the toys in a lot of the ways you would like." This statement is freeing in that it expresses to the child accountability for direction. Boundaries on freedom are conveyed by the phrase "in a lot of the ways," which in effect communicates limits on behavior. Guerney (1983, p. 339) added to this statement, "and if there is anything you are not supposed to do, I will tell you." Although the playroom is not a place of absolute

freedom where children can do anything they want, the initial introduction to the experience jointly is not the time to articulate all the possible needed limitations on behavior; to do so would unnecessarily inhibit the child's exploration and expression.

The natural response of many adults to children is to question, provide answers, and solve their problems for them. The child-centered, or non-directive, play therapist believes that children are able to figure things out for themselves, within developmental boundaries (Guernsey, 1983). From this perspective, children are viewed as capable, creative, resilient, and responsible. Responding to children in a way that communicates compassion, understanding, and approval and that conveys choice and accountability even when dealing with antagonistic acts requires a radical shift in outlook and a reformation of responses for most therapists as they learn to respond therapeutically to children. As with other therapeutic approaches, the approach of the therapist is paramount in conveying to children that they are understood and accepted (Guernsey, 1983).

Facilitative responses return responsibility for direction and resolution to the child and allow the child to direct the content and focus. Allowing a child the freedom to engage in the process of decision making enables the child to struggle with ownership and accountability. When a child asks, "Can I make a monster with this Play- Dough?" the therapist can respond, "In here, you can decide." In the process of returning responsibility, the child learns self-direction and develops creative resiliency (Landreth & Wright, 1997). The intentionality of the play therapist to see, hear, feel, and experience with the child in a non-evaluative relationship is communicated to the child at all times through the following four messages the play therapist lives out in the relationship:

- I AM HERE. Nothing will distract me. I will be fully present physically, mentally, and emotionally. I am here for the child.
- I HEAR YOU. I will listen fully with my ears and eyes to everything about the child, what is expressed and what is not expressed. I want to hear the child completely.
- I UNDERSTAND YOU. I want the child to know I understand what he or she is communicating, feeling, experiencing, and playing, and will work hard to communicate that understanding to the child.
- I CARE ABOUT YOU. I really do care about this little person, and I want the child to know that. If I am successful in communicating fully the first three messages, the child will know I care (Landreth, 2001, p. 97).

In child-centered play therapy, the therapist is highly interactive verbally and is so actively responsive to the child that the child feels at all times as though the therapist is a part of whatever the child is engaged in at the moment, even though the therapist may not be physically participating. The play therapist is never an observer but is always an emotional and verbal participant. Learning to be this type of therapist can prove to be stressful, anxiety introducing, and all too often overwhelming (Ray, 2004). Through these struggles comes the reality of what being fully engaged with a child means and therefore increases the therapist's effectiveness as a helper.

Play Therapist Training

The need for adequately trained play therapists has increased considerably in the last ten years as mental health agencies, psychiatric hospitals, and elementary schools have acknowledged the distinctive mental health needs of children (Jones & Rubin,

2005). This increased demand has fashioned a need for improved procedures in training play therapists to be fully prepared to work with the variety of populations of children needing therapy (Bratton, Landreth & Homeyer, 1993). The skilled play therapist must have more than clinical skills. According to Landreth (2002) play therapists also need to have insight and understanding of the child and themselves throughout the therapeutic process.

Many university departments of counseling, psychology, and social work have recognized the benefits of play therapy and have implemented programs and courses to provide the necessary training. These training programs are highlighted in the 2003 Edition of the *Directory of Play Therapy Training* (Landreth, Joiner, & Solt, 2003), which lists 185 universities that offer play therapy curriculum in the form of courses or a unit in a course. One hundred and nine universities offer one or more full semester courses in play therapy.

Kranz, Lund, and Kottman (1996) acknowledged several indicators of the reappearance of the use of play therapy in counseling with children since the 1960s when guidance and counseling programs were established in elementary schools. These indicators include increased membership of the Association for Play Therapy (1136 members in 1991 to over 4600 members in 2004), an increase in the number of play therapists seeking registration credentials, and an increase in continuing education providers and workshops. This increase in the use of play therapy in counseling with children has increased the need for suitable preparation. Regrettably, the number of trained play therapists and experienced supervisors needed to educate and supervise beginning play therapists is inadequate (Bratton, Landreth, & Homeyer, 1993).

Publications within the past ten years have acknowledged the discrepancy in training facilities and have indicated a need for the development of criteria for play therapy training in counselor education, psychology, and social work programs (Kao & Landreth, 1997; Kranz & Lund, 1993; Tanner & Mathis, 1995). Ryan, Gomory, and Lacasse (2002) surveyed 891 members of the Association for Play Therapy (APT) and reported 13% of the members of the Association for Play Therapy were registered play therapists, and 16% of the members were registered play therapy supervisors. Only 41% of the members of APT had completed a university graduate course in play therapy and 38% of the members had a play therapy practicum experience at a university. The results of this survey indicated the bulk of APT members are gaining play therapy training through workshops rather than taking a formal graduate level class in play therapy.

The Association for Play Therapy (2004) revised basic requirements for registered play therapists to include a Master's degree in a mental health field from an accredited university; license/certification in a medical or mental health profession; 2000 hours of direct contact clinical experience hours related to the area in which the applicant received a Master's degree; 150 clock hours of play therapy instruction consisting of the following content areas: history, theory, techniques/methods, and applications to special settings or populations; and 500 direct contact hours of play therapy under supervision. The Association for Play Therapy (2004) reported that 914 play therapists have met the requirements to become a registered play therapist and/or registered play therapy supervisor.

Little research has been conducted to determine and define the minimum cognitive and experiential education needed to sufficiently train a play therapist. A

convergence of knowledge from play therapy experts and university professors is needed to determine a recommended training model that encompasses didactic training and practicum experience to train beginning play therapists (Kranz, Kottman, & Lund, 1998).

Counselor Trainee Development

Through their research Skovholt and Ronnestad (1992) identified twenty themes of therapist-counselor development. Four of these twenty themes have been selected to provide a theoretical framework for this study. The first of these themes is “there is an external and rigid orientation in role, working style, and conceptualizing issues increases throughout training, then declines continuously” (Skovholt & Ronnestad, 1992, p. 507). For developing play therapists the orientation of the instructor is more often than not the theoretical orientation the student adopts throughout and immediately following the course. As the therapist becomes more comfortable with the process, purpose, and play therapy clientele, the therapist begins to develop an integrated and eclectic approach to therapy that aligns more closely to the ‘truths’ the therapist holds about therapy and the therapeutic process.

Secondly, “development is influenced by multiple sources that are experienced in both common and unique ways” (Skovholt & Ronnestad, 1992, p. 511). By the time graduate students take their first class they have had a lifetime worth of experiences that have helped shape their world view up until that point. Undergraduate education, past and present employment, as well as the culture a student was and is a part of all enter into the classroom on day one. Throughout the pursuit of higher education the student’s past comes face to face with the student’s present, and what results is a new world view that now includes the student’s formal education. In the context of play therapy, the way the

therapist views play and its role in a child's life directly influences the therapist's effectiveness in working with children via this modality.

The third theme directly relevant to this study is "clients are a continuous major source of influence and serve as primary teachers" (Skovholt & Ronnestad, 1992, p. 512). Counselors report that at all levels of experience and education their clients have a powerful impact on their professional functioning. Through the close interpersonal contact between the client and counselor, the latter is continually receiving feedback on him or herself as a person. A frequent crisis for a professional involves a lack of client improvement when the practitioner uses a theoretical approach that the practitioner had worked hard to master because of its supposed effectiveness. This often brings on a searching process for the practitioner regarding the cause of the failure. For a student learning play therapy the effectiveness of the field itself is often brought into question along with one's own doubts and insecurities.

The final theme pertaining to this study is "...for the practitioner there is a realignment from a narcissistic position to a therapeutic position" (Skovholt & Ronnestad, 1992, p. 513). The beginning counselor most often believes that he or she is responsible for any and all failures that occur in work with clients. In play therapy, the researcher has generalized this theme as, "The success of this child's time in play therapy is solely based on my skills as a therapist. If the child does well it is because I performed the techniques perfectly, if they fail it was my fault and I should have done something differently." The narcissistic position often involves a partially understood pull to the therapist/counselor role due to an assumption that the role is influential: one has power to help people, cure, and lessen dis-ease and anxiety; therefore, acting as a practitioner and

helping others can increase one's own self-esteem and competency (Skovholt & Ronnestad, 1992). The therapeutic position involves less performance anxiety and a less pretentious sense of self as a curative agent. The shift involves repositioning from a position of practitioner power to client power.

The literature surrounding play therapy focuses largely on background/history, techniques, and current training practices. There exists a perceivable void when one looks for information on the trainee's perspective on the process of becoming a play therapist. This study was designed to provide voice to trainees and their experiences as they first encounter formal play therapy training.

Chapter III: Methodology

This study used the experiences of a set of graduate students taking a play therapy course to gather information about their journey to better understand the process from their perspective. Through individual and focus group interviews, information was collected, coded, and interpreted to determine if the students had a shared sense of their experience.

Participants

In a study such as this it was necessary to identify and solicit a certain population (Creswell, 2003); in this case graduate students enrolled in an introductory play therapy course at a Midwestern comprehensive state university. The researcher obtained permission from the instructor to solicit participants from a section of an introductory play therapy course. During the class' first meeting, the researcher presented the research question along with the methodology, including the time commitment, to the twelve students enrolled in the class. It was made clear that participation, or lack thereof, in the study would have no direct impact upon the grade the student would receive in the course. A copy of the participant consent form can be found in Appendix A.

Of the twelve students solicited, nine volunteered to be participants in the study. Of the nine participants, seven were female and two were male. Six of the nine participants were enrolled in the Guidance and Counseling program, one was enrolled in the Marriage and Family Therapy program, one was enrolled in the School Psychology program, and one was enrolled in the Mental Health Counseling program.

Data Collection Procedures

After reviewing each participant's demographic information, the researcher assigned each participant an identifier to ensure that all participants' personal information was kept confidential. The information necessary to link participants to their identifier was accessible only to the researcher.

The researcher contacted each participant to schedule the initial interview that took place after at least two lecture based classes but before the student had begun conducting play therapy with a child in a laboratory setting. These audio recorded interviews took place outside of class time and were between thirty and sixty minutes in length. The initial interview was used to gain background information on the participant as well as the participant's thoughts and feelings about and expectations of learning how to conduct play therapy. The questions asked during the first interview can be found in Appendix B.

After all participants had completed the initial interview, the constant comparison method (Silverman, 2004) was used to identify themes that arose from this set of interviews. To perform a constant comparison analysis, the researcher first read through the entire set of data. After doing so, the researcher collected the data into smaller meaningful parts. The researcher then labeled each of the smaller parts with a descriptive title or "code." The researcher took pains to compare each new section of data with previous codes, so similar sections would be labeled with the same code.

A second interview was scheduled, again outside of class time, with each participant at the midpoint of the semester before the participant's mid-semester evaluation with the instructor. It was the thought of the researcher that the interview may

be adversely influenced by instructor feedback if the interview was conducted after the participant/instructor meeting. This interview focused on growth, perceived change in style and approach, what the participant found challenging and enjoyed about play therapy, and how the participant's expectations were holding up. The questions asked during the second interview can be found in Appendix C. Again these interviews were audio recorded and coded using the constant comparisons method upon the completion of the interview by all participants.

The final interview took place during class time during the final class meeting. This interview involved all participants present in the form of a focus group (Silverman, 2004). This interview took place during the first hour of a two hour class where the instructor was not present and the researcher served as group moderator; the remainder of the class conducted a reflection activity with the professor in a separate location. The interview covered topics such as participants' understanding and use of play therapy in addition to revisiting expectations that had been discussed throughout the semester. The questions asked during the focus group interview can be found in Appendix D. The interview was audio recorded for coding purposes. The feedback was coded for similarities again using the constant comparison method.

Data Analysis

Upon the completion of all three sets of interviews, the researcher began to chart the journey of the participants using the coding from each set of interviews. After all the data had been coded, the codes were grouped by similarity, and a theme was identified and documented based on each grouping. The researcher then wrote the first draft of the 'results' based on all data collected. The draft of the results was then e-mailed to each

participant for review to improve the internal validity of the study (Creswell, 2003).

Upon receiving participant feedback on the researcher's conclusions, the researcher then made necessary improvements, if necessary, to the conclusions before publishing final results.

Assumptions and Limitations

This study assumed that all participants shared their experiences truthfully and without consequence for doing so. It was also assumed that participants did not attempt to impress the researcher with their knowledge of play therapy techniques and theory and with their success, or lack thereof, with their client.

Limitations of the study included that participant feedback may have been falsified, unintentionally or due to human error, and consequently presented misleading information during coding. The fact that the researcher was the only coder of the participants' interviews presents an added limitation. Additionally this study used one class of students from one university taught by one professor during one point in time, thus making generalizations from this study unwarranted.

Chapter IV: Results

This chapter will address the results of the following research question: What is the developmental journey of graduate level counselor trainees as they progress through an introductory play therapy experience? Participants were solicited from a graduate level introductory play therapy course; nine of the twelve students asked to take part agreed to be participants in the study. Each participant agreed to be a part of two individual interviews as well as a collaborative focus group interview with all participants. The information from those interviews was coded and categorized into development phases with supporting themes.

Data Analysis

Upon the completion of all three interviews outlined in the methodology section of the study, the researcher began to chart the journey of the participants using the coding from each set of interviews. The researcher compared each section of data with previous codes, so similar sections would be labeled with the same code. After all the data had been coded, the codes were grouped by similarity, and a theme was identified and documented based on each grouping. The researcher was able to cluster these experiences into three major phases with supporting developmental themes for each phase.

The method used to indicated the representativeness of the results was to indicate whether each finding was general (applied to all nine cases), typical (applied to six to eight cases), or variant (applied to two to five cases) (Hill, Thompson, & Williams, 1997). Any result that applied to only one case was not reported as it was considered idiosyncratic and not representative of the sample.

Uncertainty/doubt phase. Each participant entered into the play therapy experience with a preexisting world view that may or may not have involved working with children in a therapeutic way. These world views assisted the participants in making meaning of their experiences and education. When a new idea, such as play therapy, is introduced the world view acts as a filter by which information is deemed relevant or inconsequential. A typical statement ($n = 8$) was that play therapy was not what participants initially thought it would be upon registering for the course. Participant 4 states, "I thought it would be a bunch of techniques that I could use while talking with a child, what toys are best to have in my office and such." Participant 7 reports, "I had no idea that it was this involved and even that there was an organized group surrounding it [*Association for Play Therapy*]. I am worried that I don't think I am as gung hoe about learning how to do it as I think I should be; I have children and I know how to talk to them... why reinvent the wheel?"

A typical finding ($n = 8$) was that participants reported that they understood what the assigned text was saying while over half ($n = 6$) reported that they felt they would be able perform the techniques with little practice. A general theme ($n = 9$) was that the participants felt as though "just sitting there and saying what the child is doing" would not be enough for a therapeutic result to occur. There was a typical response ($n = 7$) that the developing of the child/adult relationship, which Landreth (2002) considers paramount, would be a result of time spent together rather than effort made on the participant's part. A typical response from participants ($n = 6$) was that the success of the play therapy relationship rested in the amount and quality of work that the therapist did as

opposed to the 'work' that the client completed during the session. A variant finding ($n = 3$) suggested that the relationship was largely facilitated by the child's 'like' of the therapist.

One theme that emerged in the uncertainty/doubt phase was the fact that there existed a mistrust of the nondirective techniques. Child centered play therapy requires that the therapist be able to present in the play room with no other agenda than to be present and with the child (Landreth, 2002). Techniques used to facilitate this process often put the therapist in the background allowing the child and her play to unfold with little to no direction or input from the adult therapist. Most ($n = 7$) of the participants in this study had formal undergraduate training in traditional pedagogy which often places the teacher in the lead directing the experiences around them. A typical response throughout the interviews was that the participants expressed a need for active techniques which had a beginning, middle, and end with a measurable outcome (i.e. the child learned how to do something) rather than abstract techniques that left the therapist wondering if anything had been accomplished in their time together.

Participant 1 reported, "I just don't see how doing nothing can be helpful for the child. I mean, I have read what I am supposed to do, but I really don't see it working in real life. Children want adults to tell them they are doing a good job, but I can't in play therapy and I think that it may be more harmful than helpful." Participant 7 shared similar concerns highlighting concern as a student, "I am concerned that I will not do enough in the sessions to get a good grade on my tape review. Telling my client 'you put that there' hardly seems like 'A' material." Reporting that they felt as though they would not be of benefit to their client was a typical response ($n = 7$) among participants. Where

no one reported they felt that the non-directive technique would seriously harm a child a typical response ($n = 7$) was that they doubted the benefit.

Another theme that was present in the uncertainty/doubt phase was the weight that participants gave parent satisfaction when evaluating their effectiveness as therapists. Joiner and Landreth (2005) stated that working with children requires an ability to also work with the adults in their lives, most often parents and guardians. Play therapy students learn how to join with parents during the intake to gather information necessary for the therapist to place the child's play in context and for the parents to understand the process of play therapy.

Participants in this study were assigned a family who self referred their family, specifically their child (ren), to partake in play therapy. Participants were responsible for setting up initial contact with the families to complete an assigned intake and to receive permission, via a parental consent form, to work with the child therapeutically. Eight participants reported that taking the lead on setting up the initial meeting produced anxiety. Participant 3 stated that, "It felt like I was calling these parents and saying, 'Hey can I use your kid in my science experiment?'" Although all nine participants saw play therapy as a benefit to their clients, they would have preferred the parent to have made the initial contact with the therapist.

A general response ($n = 9$) pertaining to parents was that participants had a fear of disappointing the parents during the play therapy process. Over half ($n = 6$) reported that the parents had an identified issue that they wanted the therapist to address during the play therapy sessions. Participant 9 commented, "...she told me that her son hit his younger brothers to hard, too aggressive you know. She then asked how I could help

with that in play therapy and I was at a complete loss as what to say. I had no idea how to tell her about what I was supposed to do, and I had no idea how to help this kid with hitting without just telling him to stop.” A variant response ($n = 3$) was that the participants wanted to feel as though they contributed to their client’s perceived improvement by the end of their relationship. A general finding ($n = 9$) was that participants reported that thinking about the parents influenced the way they conducted therapy with the child. Participant 3 reported, “...and sometimes I would do or say something in the session just so I could tell her parents that I did it...I guess I did it just to make the adults in the process happy, myself included.”

Skills acquisition phase. As the participants progressed through the course they were exposed to advanced play therapy techniques and theories all the while being encouraged and instructed to use the basic skills learned within the first few class meetings. Information gathered from the second interview suggested that a typical response ($n = 7$) from the participants was that they were starting to feel comfortable with the process of play therapy. Although over half of the participants ($n = 5$) reported that they were doubtful of the effectiveness of the process, this number of doubtful responses was significantly less than the number of positive responses in response suggests that a

Counselor Trainees’ Development Throughout an
Introductory Play Therapy Experience

by

Adam Carter

A Research Paper
Submitted in Partial Fulfillment

A theme that emerged in the skill acquisition phase was that there existed a developing comfort in process by participants as the course progressed. Experience with the process, concluding that the techniques have merit, and perceived client satisfaction all contributed to a developing sense of comfort in the play therapy process. As participants logged play therapy hours, they typically reported that the anxiety they experienced previously had since dissipated. Participant 5 stated, "...being in the session is not so daunting now. I am finding that it almost has a flow to it, almost like a dance between [my client] and I." Participants stated that the trust in the process was complemented by the fact that they were developing a sense of confidence in the play therapy techniques. Over half of the participants ($n = 6$) reported that their faith in the non-directive play therapy techniques had increased as a result of using them consistently in their play therapy sessions.

Another typical response ($n = 7$) was that the client's perceived satisfaction in the process was a factor contributing to the developing sense of comfort in the process. A general response ($n = 9$) was that the clients were excited before their sessions and as Participant 6 said, "[My client] really seems to enjoy being there! He starts playing as soon as we get into the room, I mean *as soon as* we get into the room. I guess I thought there would be this awkward time where we would just be sitting there looking at each other but he seems to be enjoying himself and has a hard time leaving!" A typical response ($n = 8$) from participants was that they seemed to connect with their clients although they did not always understand their client's play.

An additional theme in the skills acquisition phase was that participants were developing an emerging confidence in themselves as play therapists. As the participants

developed proficiency in their play therapy techniques and comfort in the process an emerging sense of confidence in self became evident. A general response ($n = 9$) was that the feeling of anxiety that had been present when they started working with their client was either greatly reduced or no longer present. A frequent reason given for this change in feeling was that the participant now knew what to expect and felt confident that they could address issues as they arose. Participant 4 said, "Yeah, I think that I am little more at ease during my sessions...I don't doubt myself as much as I did and I surely don't think I am incompetent anymore." Participant 2 added, "The techniques are really starting to flow out of me now, I even use them at home with my children and then I catch myself and smile, I guess I do know what I am doing!"

Theory integration phase. The last few weeks of the participants' play therapy course allowed for participants to begin varying from basic techniques by adding advanced methods and experimentation. This section of the course allowed for theory integration to develop among all of the participants. All nine of the study's participants reported that they had taken some aspect of play therapy and had begun to integrate it into their personal counseling theory. Participant 1 stated, "It was a lot to take in for one class...and it had its ups and downs for sure. But even though I griped at first I really got something out of this class, I'm guessing that my client taught me more than I helped him!"

A typical response ($n = 7$) from participants was that they appreciated the process of non-directive play therapy but it was not going to be the type of play therapy they practiced. Participant 9 suggested a reason for this idea, "...I just feel that when a parent brings their child to me that they want me to work with the child. I know that being there

in the moment is work, but what results do the family members see immediately, usually none! What keeps them bringing them back if I am not even trying to address the behavior, or reason I guess that the child came in for in the first place?" Over half ($n = 6$) suggested that non-directive play therapy would take too long to complete to true fruition, but there were some techniques that could be gleaned and incorporated into a new world view.

A theme that supported the theory integration phase was that the participants were actively changing their world view. Participants repeatedly commented on the fact that by taking this course and working with a child in a laboratory setting that their view and understanding of children had changed. Participant 4 explained that "...this experience taught me how to counsel children, but I really think it helped me see them for the truly amazing thinkers that they are." A general response from participants was that the ways in which they are going to work with/counsel children in the future had been changed as a result of this experience. At the core of that change was the idea that children were not at a cognitively developmental place to verbally respond to therapist's questioning as evidenced by this excerpt from the focus group interview:

Participant 2: "I have worked with children before and they are VERY vocal when it comes to getting something that they want, at time too vocal if you know what I mean. I thought that is the way a counseling session would go as well, back and forth with a little extra prodding on my part."

Participant 4: "Me too. I thought that they would pick up a crayon

and start drawing out what was going on in their life like they do on Law and Order and shows like that.

(Laughter) I know it sounds corny but I thought I was going to be there to and listen to this child's story and they would tell me what was going on."

Participant 2: "I am guessing that did not happen."

Participant 4: "No it didn't."

Participant 8: "I agree with [you] about the 'ah-ha' moment let down, but I did get something out of my client's play. I am not saying that I was able to interpret it completely but I was able to at least see what he was doing and saying through the toys in the sand box. I did not feel as though I needed to tell him to stop hurting them or killing them, I was there to be a part of it."

Participant 5: "That is nice way of saying that. I was concerned that my client played with the same things in the same way for six sessions straight. I was a little bored too so I had a hard time focusing. It makes sense to me now that my reason for being there was to be a part of the play like you said and not to change it."

Summary

This study set out to explore the developmental journey of a set of graduate students as they completed an introductory play therapy course to determine if there was

a shared experience among the students as the course evolved. Using a set of two individual interviews and a focus group interview consisting of all participants, the participants' experiences were recorded and coded resulting in the identification of three phases of play therapy student development. Uncertainty/Doubt, skills acquisition, and theory integration were the phases that students experienced as they became more familiar with the field and practice of play therapy. A general theme through all of these phases was that the counselor's view of a child's play and the counselor's role in that play were paramount to the counselor's understanding and acceptance of play therapy theory and practice.

Chapter V: Discussion

This study attempted to determine if there existed a shared experience amongst graduate students enrolled in an introductory play therapy course. Where there are numerous sources that discuss the developmental process of counselor trainees, the point of view of the counselor trainee, particularly in regard to play therapy training, is often omitted. In an effort to provide voice to this population, this study interviewed nine graduate students enrolled in an introductory play therapy course affording them an opportunity to discuss their experience. From these interviews the researcher concluded that there were similar phases that the participants advanced through as the course progressed.

Conclusions

Skovholt and Ronnestad (2003) suggest that there exists a professional journey that counselors traverse as they progress from novice to experienced counselor. This study set out to specifically explore the developmental journey of a cohort of counseling students as they progressed through an introductory play therapy class. Participants individually reported experiences, that when analyzed in combination with the remainder of the participant interviews, resulted in the formation of three phases play therapy students progressed through.

Uncertainty/Doubt Phase. Students began in an area of doubt in both the theory and techniques of play therapy and in their ability to successfully conduct play therapy with a client. Skovholt and Ronnestad's research (1992) suggests that this doubt comes from the rigid orientation of the student in place before the play therapy class. The students had developed an understanding of how counseling children was to be

conducted, largely by adapting adult based techniques (Landreth, 2002), and the introduction of new information was viewed with hesitation. Play therapy and its techniques would have to 'prove' that this modality was effective before the students begin to accept it as valuable. After weeks of lecture based classes and play therapy laboratory time, participants progressed from mistrust/doubt to an area of skills acquisition.

Skills Acquisition Phase. During this phase doubt was reduce and replaced by an apparent eagerness to learn and practice non-directive play therapy techniques. This change in feeling was contributed largely to the responsiveness of the clients. The clients of the participants served as the catalyst for this growth and Skovholt and Ronnestad (2003) put forth that the clients actually served "as primary teacher" in this instance bringing to actuality the proposed effectiveness of play therapy. The participants reported that as they gained confidence in their ability to perform play therapy, the effectiveness of the technique became clearer. As participants gained comfort with the skills they had acquired they progressed to the third and final phase: theory integration.

Theory Integration Phase. In this phase participants were beginning to introduce play therapy theories and techniques into their personal counseling philosophy, subsequently changing their world view and professional opinion of children's mental health. Participants reported that they began to identify their role in the process, and to their surprise it was not one of dominance. Skovholt and Ronnestad (2003) identify this as the counselor realigning from a place of counselor authority to that of client control. The participants reported that although they would not likely practice non-directive play therapy in its entirety, they would most likely maintain the position that children should

take the lead in their counseling sessions. Participants reported that the skills learned in the course were valuable and would benefit them in their work with children.

Assumptions and Limitations

This study assumed that all participants shared their experiences truthfully and without consequence for doing so. It was also assumed that participants did not attempt to impress the researcher with their knowledge of play therapy techniques and theory and with their success, or lack thereof, with their client.

Limitations of the study included that participant feedback may have been falsified, unintentionally or due to human error, and consequently presented misleading information during coding. The fact that the researcher was the only coder of the participants' interviews presents an added limitation. Additionally this study used one class of students from one university taught by one teacher during one point in time, thus making generalizations from this study unwarranted.

Recommendations for Further Study

A limitation of this study rests in the fact that only one set of students were interviewed to reach these findings. A study that included a larger sample from different universities would provide the researcher a broader scope of experiences from which conclusions and recommendations could be made. From this larger sample another aspect of this experience, the way in which the counselor educator teaches the course, may be explored to investigate if there is a correlation between student experience and the educator's teaching technique. Another area for future consideration would be a study that uses the same format but focuses on the graduate program the students are enrolled in. Exploring questions such as how do students in the school counseling

program view this experience as compared to students in the mental health counseling program? This proposed format would allow for counselor educators to better reach individuals in these populations while they are enrolled in their courses.

Recommendations for Counselor Educators

Landreth (2002) suggests that play therapy is a way of viewing the adult/child therapeutic relationship rather than a series of techniques used to achieve favorable outcomes. With this in mind it is vital for play therapy educators to allow their students time to first identify and explore their view of the adult/child relationship and their role in a child's play. Introducing play therapy theory without allowing for adequate time for reflection and discussion on the aforementioned issues may foster confusion as the student attempts to merge what they knew as "true" with how they are being instructed to work with children in this modality. Allowing for self exploration at the onset of the course may help reduce or alleviate the sense of self doubt this study identifies as present in play therapy students during the first part of the experience.

Additional recommendations are presented for the group conversation that presumably takes place as part of the course and graduate experience. Counselor educators should allow for the voice of frustration and apprehension in groups discussion as students begin to incorporate play therapy into their counseling theory. Normalizing these feelings as part of a developmentally appropriate process may provide a sense of inclusion rather than having students who feel that they are "the only one who feels this way." Additional class discussions on how the students are beginning to incorporate play therapy into their current counseling theory will allow the students to feel empowered to

select favorable aspects of play therapy rather than feeling as though they must perform play therapy exactly as presented in class.

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Appendix A: Consent for Participation Form

CONSENT FOR PARTICIPATION

PROJECT TITLE:

Counselor Trainees' Development Throughout an Introductory Play Therapy Experience

INVESTIGATOR:

Adam Carter
Office: (xxx) xxx-xxxx
Home: (xxx) xxx-xxxx

RESEARCH SPONSER:

Barbara Flom, Ph.D., LPC
403 Education and Human Services Building,
(715) 232-1343

DESCRIPTION:

I am a Mental Health Counseling graduate student at the University of Wisconsin-Stout conducting a qualitative research study on the development of counselors in training as they progress through an introductory play therapy course. The goal of this study is to compare the experiences of several play therapy students for possible themes that may arise as the experience unfolds.

TIME COMMITMENT:

You are being asked to participate in two 45-60 minute interviews that will take place outside of the allotted Play Therapy course time. An hour long focus group discussion including all participants will conclude the interviewing process and will take place during course time.

BENEFITS and RISKS:

This study will allow you several opportunities throughout the semester to reflect on your learning as you progress through your play therapy experience. Metacognition, or "thinking about how a person thinks," is one of the most important tools for lifelong learning. People versed in metacognition understand the power of asking themselves "why" and will seek answers to that question in a multitude of scenarios. As with any reflection based activity, the risk of experiencing emotional discomfort may be present. If at any time you feel uncomfortable you may address these feelings with the investigator, University Counseling center, your Program Director, or you may withdraw from the study.

CONFIDENTIALITY OF RESPONSES:

Your answers are strictly confidential. Only the primary researcher will have access to the confidential raw data. No personal information will be included in the published results. You as a participant will be given the opportunity to review the preliminary results to remove any information that you feel may breach confidentiality. This informed consent will not be kept with any of the other documents completed with this project.

ACCESS TO COURSE WORK:

By agreeing to participate in this study your feedback forms (self-, partner, and instructor reported) will be accessible to the researcher. No other course work will be viewed by the researcher.

RIGHT TO WITHDRAW OR DECLINE TO PARTICIPATE:

Your participation in this study is entirely voluntary. You may choose not to participate without any adverse consequences to you. Should you choose to participate and later wish to withdraw from the study, you may discontinue your participation at that time without incurring adverse consequences.

IRB APPROVAL:

This study has been reviewed and approved by The University of Wisconsin-Stout's Institutional Review Board (IRB). The IRB has determined that this study meets the ethical obligations required by federal law and University policies. If you have questions or concerns regarding this study please contact the Investigator or Advisor. If you have any questions, concerns, or reports regarding your rights as a research subject, please contact the IRB Administrator.

Investigator:

Adam Carter

Office: (xxx) xxx-xxxx

Home: (xxx) xxx-xxxx

cartera@uwstout.edu**IRB Administrator**

Sue Foxwell, Director, Research Services

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Barbara Flom, Ph.D., LPC

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I attest that I have read and understand the above description, including potential risks, benefits, and my rights as a participant, and that all of my questions about the study have been answered to my satisfaction. I hereby give my informed consent to participate in the research study entitled *Counselor in Training Development Throughout an Introductory Play Therapy Course*.

 Printed Name of Participant

 Signature of Participant

 Date

Appendix C: Second Interview Questions

Participant Identifier: _____

QUESTIONS FOR PLAY THERAPIST INTERVIEWS SECOND INTERVIEW

1. How would you summarize your experience thus far?
2. What aspects of the experience are you enjoying?
3. Has this experience meet your expectations? How has it been different than what you'd expected?
4. How has your approach to play therapy changed since your first class session?

APPENDIX D: Focus Group Questions**FOCUS GROUP QUESTIONS**

Now that this play therapy experience is almost over:

1. What aspect(s) of this experience surprised you?
 2. How or in what ways was this course what you expected? How or in what ways was it different? Would you explain?
 3. What were the challenges you faced as a student in this course?
 4. How do you feel you have changed as this course unfolded?
 5. What are you going to take away with you from this course?
-