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I am delighted to be presenting a full and fascinating issue this year. I would like to offer my enthusiastic thanks to those contributors and referees from the Editorial Board (one of whom excelled herself by overlapping in both roles!) who have worked particularly hard to get this edition to print. There were considerable revisions made to most original submissions and the detailed constructive feedback from reviewers combined with the authors’ conscientious attention to responding to their suggestions, has yielded five varied high calibre papers.

Firstly Jessica Jäger feeds back on her pioneering doctoral research on how children perceive their participation in the process of their Play Therapy. Jäger devised creative, playful ways to elicit the views of children who had experienced a Play Therapy intervention and trained a team of Play Therapists as research participants in conducting these evaluation techniques. The findings provide a valuable insight into how our young clients feel about their involvement (or lack of it) in various stages of the process and there are important lessons to be learned for our clinical practice.

Kathryn Hunt’s paper, which evaluates the delivery of a brief Play Therapy training programme in three regions of Kenya, raises some interesting issues on the most helpful ways of increasing knowledge, skills and confidence in offering therapy to children, within developing countries. Hunt and her colleagues initiated a programme that has now been taken on and adapted by the Kenyan participants involved in the initial training: the ripples are making an impact in a country where the need is great but the resources scarce.

The next two papers exemplify the current high standard of student research in the BAPT-accredited Masters programmes. Linda St Louis’ paper is an abridged version of her dissertation case study, describing a collateral Play Therapy intervention with a mother and her son, both scarred in their different ways by the impact of domestic abuse. St Louis’ illustrated article powerfully conveys how both generations were helped, their resources strengthened and their mutual attachment consolidated by separate Play Therapy interventions running in parallel. This personally-based, qualitative piece of academic work is contrasted by the rigorously-analysed quantitative research conducted by Anastasia Petrakopoulou. Many of you may have been involved in this investigative study and will doubtless be intrigued to discover the results. Petrakopoulou’s detailed interviews of over fifty qualified Play Therapists in the UK, examined therapists’ perceptions on the use, role and effect of aggressive-release toys in play therapy, and whether such toys have any negative impact on children’s aggressive behaviour. Petrakopoulou concludes that aggressive toys could have a positive impact on the cathartic release of aggressive emotions, a thought-provoking finding which lends support to her catharsis hypothesis and may lead some Play Therapists to consider the inclusion of these types of toys in their tool kit, if they do not already do so. I fervently hope that recent graduates of the BAPT training courses will be encouraged and inspired by St Louis’ and Petrakopoulou’s examples and contemplate submitting their own research for publication in this Journal. There is a wealth of strong and significant work going on in our Universities that we all need to hear about and that can assist in providing a much needed evidence base to our clinical practice.

Finally another qualitative submission from Steve Harvey, who draws on his considerable experience as both a Play Therapist and Dance Therapist in New Zealand, to review a small case sample of ‘pivotal moments’ that represent significant moments of change for a child or family in expressive therapy interventions. The commonalities across disciplines and contexts are intriguing and point the way to further research.

I look forward to receiving a similarly varied and interesting selection of submissions for the 2012 issue.
CHILDREN’S PARTICIPATION IN THE THERAPY PROCESS:
A CHILD’S PERSPECTIVE

Jessica Jäger
CAMHS East Sussex, England

Abstract
Non-directive play therapy uses the child’s language of play to facilitate their expression and enable the child’s voice to come to the fore. Recently there has been renewed interest in children’s views of the therapy process itself, both in play therapy and wider afield. However, there has been little detailed exploration of children’s participation in the play therapy process and their views on their involvement in the decision making processes. This study aimed to capture children’s views of their involvement in the non-directive play therapy process using meaningful evaluation methods. Seven non-directive play therapists trained by the author in play-based evaluation techniques undertook qualitative evaluation interviews with twenty children (aged 5-13 years). A thematic analysis of these video-taped sessions revealed that children often appreciated the preparation provided by play therapists at their initial meetings. They commented on the non-verbal means of communication which the therapist brought to the meetings to familiarise the child with the therapy process. However, several children shared a lack of knowledge about progress/review meetings held about the therapy process. Some children had strong views about being included. The implications for play therapy practice are explored and a case example from the author’s own clinical practice is presented.

Key words: Play Therapy, Children’s views, play-based evaluation, involvement, reviews; participation, children’s rights

Introduction
The broad framework of participatory research with children within the historical and political context of the children’s rights movement will be outlined. Next, this brief review will turn to the level of participation afforded to children at various stages of play therapy. Detailed consideration of children’s meaningful participation at the end of therapy is presented. It is argued that there has been limited research into children’s views of the therapy process. Play-based evaluation methods were developed by the author to meet the challenge of accessing children’s views of child therapy in a meaningful way (Jäger and Ryan, 2007). It is argued that the use of play-based evaluation sessions enhances the child’s participation rights in the therapy process. Two of these techniques were utilised in the current study and are briefly described. The views expressed by the children in this study, pertaining to their participation in the decision making processes of play therapy, are presented. Suggested responses to the children’s expressed views, in terms of changes to clinical practice, are detailed.

Children’s Participation Rights: An Overview
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’ (Department of Health, 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 a stipulation for professionals to communicate directly with children and provide a service that 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 Child and Adolescent Mental Health Services (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).

Currently a national initiative, focusing on ‘Shared Decision Making’ with children and young people in CAMHS, is under way as part of a wider initiative focusing on increased participation and partnership working across the NHS (Closing the Gap: Health Foundation, 2010).

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; see Unicef, 2009) 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.

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, Holgate & Sigston, 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; See Franklin, 2002, for a review on the progress made in realising the ambitions of the UN Convention).

Children’s Involvement, Voices and Rights in Play Therapy

Due to the changes detailed above, 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. The author began delivering Children’s Rights training on one of the British Association of Play Therapists (BAPT) courses in 2004, the first known dedicated inclusion of this topic on a play therapy syllabus in the UK. Non-directive play therapy (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 lives. Therefore exploration of children's rights during their engagement in such a context seems warranted.

The UN Convention on the Rights of the Child broadly covers three main areas: Provision,
Protection and Participation (Franklin, 1995; 2002). This study specifically focuses on children's participation rights within play therapy. However, children's rights to be provided with a service and particularly their rights to protection need to be given due consideration in relation to the type and level of participation afforded to children within this context. This theme will be re-visited throughout this paper.

In general terms it seems that NDPT promotes children's participation within the actual play therapy sessions. Axline's third principle states a feeling of permissiveness should be established so that “the child feels free to express his feelings completely” and the fifth principle details deep respect for the child’s ability to make their own choices (Axline, 1947: 69). These two principles seem to particularly reflect the strong emphasis on promoting children's participation in the process. However, it is argued here that the level of participation afforded to children does vary throughout the process of play therapy. Malone and Hartung (2010) report that Hart’s ‘Ladder of children’s participation’ (1992) continues to be one of the most influential models informing practice in a wide range of disciplines. Applying Hart’s (1992) ladder seems helpful in conceptualising the variants over time. This was purposefully developed as a generic model to enable wide application by professional groups to rethink ways of engaging with children in particular contexts (Hart, 2008). The model has come under criticism due to its seemingly sequential nature (Reddy & Ratna, 2002 and Kirby & Woodhead, 2003 cited in Malone & Hartung, 2010). The metaphor of a ladder unfortunately does give the impression of a

<table>
<thead>
<tr>
<th>Steps</th>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Children and Young People in Charge</td>
<td>Children and young people decide what to do. Adults only get involved if children ask for help</td>
</tr>
<tr>
<td>9</td>
<td>Young People Lead With Help From Adults</td>
<td>Children and young people lead in deciding with help from adults.</td>
</tr>
<tr>
<td>8</td>
<td>Joint Decision Making</td>
<td>Adults and children decide things together.</td>
</tr>
<tr>
<td>7</td>
<td>Consultation</td>
<td>Adults consult with children and young people and consider their opinions carefully, and then adults decide taking all the options into account.</td>
</tr>
<tr>
<td>6</td>
<td>Invitation</td>
<td>Adults invite children's and young people's ideas, but they make the decisions on their own terms.</td>
</tr>
<tr>
<td>5</td>
<td>Tokenism</td>
<td>Adults decide what to do, but children and young people are allowed to decide some minor aspects</td>
</tr>
<tr>
<td>4</td>
<td>Decoration</td>
<td>Adults decide what to do, but children and young people just participate by being there.</td>
</tr>
<tr>
<td>3</td>
<td>Manipulation</td>
<td>Adults decide what to do and ask children and young people if they agree.</td>
</tr>
<tr>
<td>2</td>
<td>Adults Rule Kindly</td>
<td>Adults make all the decisions. Children are told what to do and are given reasons and explanations.</td>
</tr>
<tr>
<td>1</td>
<td>Adults Rule</td>
<td>Adults make all the decisions. Children are told nothing except what they must do.</td>
</tr>
<tr>
<td>0</td>
<td>No Participation</td>
<td>Children and young people are not given any help or consideration at all. They are ignored.</td>
</tr>
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hierarchical system whereby the ‘top rung’ is the most desirable. However, Hart argues that the intention is to promote a graduated approach to conceptualising 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. A further criticism by Hart himself is cultural bias (the model was based on Hart’s experience in America and the UK: Hart, 2008). However, it is argued here that the model provides an opportunity to reflect upon NDPT practice through a different lens. I briefly outline the ten graduations in Table 1 and then relate them to the process of NDPT:

The beginning of the therapy process is the point of referral. As Brownlie (2006 unpublished: 6) highlights “…children rarely have any control or real level of consent” at this stage of the process. In Carroll’s (2002) research children reported that they did not even know why they were referred to play therapy. However, in the author’s own clinical practice and other therapists’ practice, self-referrals within school settings in the UK (Reyes & Asbrand, 2005) have been encouraged and do occasionally take place. However, it is noted that this may not be so in the US. A recent book on school-based play therapy detailed a range of adult referrers with no mention of the possibility of children referring themselves (Drewes & Schaefer, 2010). A further practice in the author’s and other therapists’ practice in the UK (including school; social services; CAMHS; private practice and voluntary settings), 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 seems to be 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. Therapists necessarily have to seek the consent of adults holding parental responsibility for children and a sense of shared decision making is necessary at this point. Furthermore in some cases ‘protection needs’ may take precedence. Careful decisions regarding the provision of therapy are necessarily advocated in statutory settings (see Wilson & 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. The complexities of listening to children’s views regarding provision of services, and what should happen during their engagement in services, including their level of vulnerability, individual circumstances, need for protection services and their attachment styles have been given some, but very limited, attention in the literature (see Schofield, 1998 on Making sense of the ascertainable wishes and feelings of insecurely attached children).

Farnfield and Kaszap (1998) highlighted in their research that 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. Sometimes children may voice a desire for a service where it is not possible for the service to meet the demand. However, rather than taking a position of not considering self-referrals due to a belief that ‘all the children would want to go’ a respectful position of responding to all self-referrals with clear age-appropriate explanations of what is possible - much the same as responses to adult referrers - is advocated here. Furthermore, a review of all referrals and due consideration of feedback from children and young people needs to be taken into account by managers and commissioners of services.

During the intervention itself it is suggested here that there ought to be a high level of child participation and the majority of the time is spent between graduations 7-10 in NDPT practice. All the key texts on NDPT practice provide plentiful examples of this (e.g. Axline, 1947; Axline, 1969; Landreth, 2001; Wilson & Ryan, 1995; VanFleet, Sywulak & Caparosa Sniscak, 2010 and Ray, 2011). However, during review or progress meetings, variation is again seen from graduation 2-8. Anecdotally the author is aware that some UK therapists, including the author, routinely invite
children and young people to attend at least part of the review. This has been advocated on BAPT training programmes for several years, although there is an emphasis on inviting older children (9 years plus). However, it appears, as reported by Brownlie (op.cit:77) that other UK based therapists do not. Previously there has been little mention of children’s involvement in play therapy review meetings in the literature. However, recently Ray (2011) reports a range of practices in the US. She states that:

“Traditionally, young children do not participate in parent consultations because consultations are verbally based and it would be developmentally inappropriate to ask a 3- to 6-year old to sit quietly as other people are talking about him. As children grow older, a play therapist might consider involving children in parent consultations, especially to participate in family problem solving or family therapeutic activities”.
(Ray, 2011: 145)

In addition reference is made to a number of adults being included in progress/review meetings, who are seen to be key figures in the child’s life (Ray, 2011). However, there is no mention of children influencing this part of the decision making process. This issue is re-visited in the discussion section of this paper below.

From the NDPT practice literature it is suggested here that it is at the end of therapy that once again there is potentially a lower level of participation. The prime indicators for terminating NDPT are reportedly: parental and other professional’s report, quantitative outcome measures, observation of behaviour and therapist’s assessment of the progress of themes emerging in children’s therapy (see Ray, 2011; VanFleet et al. 2010; Wilson & Ryan, 2005). However, Van Fleet et al (2010: 56-7) acknowledge that “In many cases, children let the therapist know when they are ready to terminate treatment. They may begin to ask the play therapist how many more times they need to come, or there may be a decline in their enthusiasm about going into the playroom.” Likewise Wilson and Ryan (1995) discuss the need to take into consideration the child’s view and make an assessment of the intensity of their communication to assist decision making regarding termination. Certainly on UK training courses and taking into account anecdotal evidence from several therapists’ clinical practice, the author is aware that such collaborative practice does take place in some cases. This practice may also include discussion about the frequency of the sessions, and the possible inclusion of a family member in part or all of the ending session(s). However, constraints on therapists’ practice and an emphasis on short-term time-limited interventions may make this difficult to achieve. It seems fair to conclude that a range between 2 and 8 reflects the variation in practice.

As mentioned above, children’s views of therapy after the intervention have rarely been sought. In most cases 0: i.e. no participation, would likely reflect practice. In others children are given a paper-based questionnaire to evaluate the service they have received and share their views. 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. Even within the research arena, following a promising early emphasis on children’s views of the therapy process by the founder of NDPT (Axtline, 1950) there has been an unfortunate diversion away from gaining children’s views of play therapy until recently (Cleveland & Landrath, 1997; Carroll, 2002; Green & Christensen, 2006; Brownlie, 2006 unpublished; Jäger & Ryan, 2007)

Applying Hart’s generic model of children’s participation to analyse the process of play therapy highlights the variance in practice, and particularly the lowered level of participation in review meetings and at the end of the intervention.

The Development of Play-based Evaluation Methods

The author’s interest in this area and desire to promote children’s meaningful involvement in evaluating their play therapy intervention led to the development of play-based evaluations (see Jäger & Ryan, 2007 for a full description of these
techniques). Briefly these included ‘The Expert Show’ (adapted from ‘Broadcast News’, Kaduson, 2001). In the ‘Expert Show’ the child is asked their views about play therapy from the position of being an expert on a TV show. The therapist pretends to be children and parents calling into the show for advice and follows a semi-structured interview schedule developed and refined by the author following pilot research. In the second technique ‘The Miniature Playroom’ the child is invited to complete stories, similar to the projective assessment technique ‘Story Stems’ (see Emde, Wolf & Oppenheim (Eds) 2003; Woolgar, 1999). In the evaluation interview the child is specifically asked about their experience of play therapy using miniature figures, props and furniture. Again therapists follow a semi-structured interview schedule guiding the child through the process of the therapeutic intervention. A substantive study was undertaken using play-based evaluations seeking the views of 20 children who had received NDPT. The general findings of this study are reported in Jäger (in preparation). The current paper specifically focuses on the views children expressed which pertain to their involvement in the play therapy process.

Method

A cross-sectional, multiple case study design utilising qualitative methods was employed. The research questions encompassed three areas: the children’s views, the play therapists’ views and the use of the techniques. For the purposes of this paper and brevity those pertaining to the children’s views are detailed below:

- What are children’s views of play therapy?
- What are children’s important memories of their play therapy sessions?

Participants

Seven qualified non-directive play therapists, who had undertaken additional training in play-based evaluations, participated in the study and recruited a total of thirty children, ten of whom were excluded due to poor video recording. Therefore the final cohort was comprised of twenty children: nine girls and eleven boys. The age range was 5-13 years. Fifteen of the children were White British. The other five were recorded by the therapists 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 Attention Deficit Hyperactivity Disorder (ADHD). Both the children’s and therapists’ anonymity have been maintained by the use of a pseudonym. The length of the interventions ranged from 8-40 sessions.

Data Collection

Interviews with the children took place 2-3 weeks after their final play therapy session. Video-recordings of the play-based evaluation sessions were sent to the author for analysis. The ‘Expert Show’ was used in 13 cases and ‘The Miniature Playroom’ in 2 cases. A combination of both of these techniques was used in the remaining 5 cases.

The therapists completed a pre- and post-evaluation session questionnaire. This provided information regarding the child, including reason for referral, length of intervention and demographic information, along with the therapist’s reflections on the intervention and their interpretation of the children’s expressed views during the evaluation.

Data Analysis

Following comprehensive transcription of the video tapes (involving six viewings and including both verbal and non-verbal transcription adapted from Heath and Hindmarsh, 2006) a thematic analysis of the children’s views was undertaken. Atlas-ti, a Computer assisted qualitative data analysis software (CAQDAS) package was utilised alongside visual methods and more traditional paper-based methods of analysis. The author remained blind to the therapists’ questionnaires until full transcription and initial analysis of the author’s own interpretations were complete. The children’s views were then compared and contrasted to the therapists’ views which provided contextual information and enabled the author to triangulate the child’s stated views and play behaviours, the
author’s interpretations of their meaning and those of the therapists. A variety of coding checks were undertaken to enhance internal validity (see Miles & Huberman, 1994).

Ethical Considerations

Unfortunately, due to lack of space full consideration of the ethical considerations during this study is not possible. However, here I provide a brief overview of the issues which are particularly pertinent to children’s participation rights; the subject of this paper. Full ethical approval was obtained from the National Health Service Multi-site Research Ethics Committee (MREC). Further approval was obtained from seven local site research and development committees in the NHS or social services and voluntary organisations where the therapists were based. The existing broad guidelines provided by Alderson (1995), Medical Research Council (MRC, 1991) and the National Children’s Bureau (NCB, 1993) were applied to this research. 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. The following areas were specifically considered in relation to this research:

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 used 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.

Informed Consent

There is much debate in the literature regarding children’s ability to give their informed consent (see Mahon, Glendinning, Clarke & Craig, 1996). There is concern that children either will not 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, children were given full and honest information about the research and guidance was given to therapists about obtaining children’s assent and ensuring they provided children with a number of opportunities to decline. Child-friendly assent forms were developed, augmenting writing with pictures and using developmentally appropriate language. The author was mainly reliant on therapists adequately assessing the child’s assent to take part and this was a disadvantage of this methodology. Written consent from the person with parental responsibility was also gained (see Daniel-McKeigue, 2007 for an overview of the debate on consent vs. assent issues).

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 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 & Ryan, 2005). Play-based methods were employed in this research.

Confidentiality and Anonymity

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 session itself.
Consultation

Before concluding this section it seems important to summarise the consultation processes which were undertaken with children specifically during the lifetime of this study. Consultation with children began at the initial stages of developing the techniques in the pilot study. Children were consulted about their experience of being interviewed using the techniques. Changes they recommended - including changes to questions, format, explanation of the techniques and additional questions they thought were important - were incorporated in the final interview schedules. 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 in which 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 (1995) 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 talents which they, as children, possess”


Findings and Discussion

The main findings of this study in relation to children’s levels of participation within the play therapy process included their expressed knowledge about why they attended play therapy. Interestingly this sometimes differed from the adults’ reasons for referral. There was a theme around the importance of therapists preparing children for play therapy, which included an exploration of home visits and emphasised the importance of communicating via non-verbal methods. A central theme in the data was children being afforded choice during play therapy sessions. Greater involvement in progress/review meetings was indicated. Experiences of collaboration regarding the termination of play therapy appeared to be important to children in this study. A detailed presentation of these findings and discussion follows.

Reason for Referral

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 (8yrs 11mnths) named anger, along with worry, due to loss and separation issues, as the reason children might go for play therapy:

Herbert: … if your [looks downward] dad or your mum split up and then you got dead angry: for stuff [leans back in seat rest head back looks upward] or it can it can worry y- it can you angry or worry you

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 Herbert named 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 “…aren’t nice probably”. 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.

Billy (10yrs 9mnths) 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 abuse 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 yrs 6 months) 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 abuse.

In response to being asked if she remembered anything special or important about her play therapy times, Cathy (9 yrs 1 month) explicitly identified her worries, particularly her fear of needles. For Leanne (9 yrs), 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 therapist’s follow-up information revealed that Leanne had been sexually abused by a male adult and an older teenage boy.

Martin (11 yrs 1 month) 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”. 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 abuse. Anger was also highlighted as a presenting problem.

Lastly, Jack (6 yrs 1 month) 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.

Unlike Carroll’s (2002) findings, some children in this study were aware of the reason they were referred. It should be noted that, due to the semi-structured nature of the interview schedule, not all of the children in this study were directly asked why they came to play therapy. Therefore more children may have been informed or taken part in this part of the decision making. As Wilson and Ryan (2005) note, adults may refer children for particular reasons which are 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. Likewise Herbert’s views of why he was coming to play therapy and what he would focus on appeared to have been taken into consideration. It seems, at least for these three children, that 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 meetings

Four children explicitly talked or played about their involvement in the initial meeting and receiving information from the therapist about what play therapy would be like. Eddie (9yrs 3mths) 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 appeared 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? You haven’t talked of no therapist mum… I said when we drove home from school. Oh that therapist

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 (8yrs 7mths) played out a story in the ‘Miniature Playroom’ 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:

**Lee (holding therapist figure and child figure):** would you like to come and see my bag of toys? Yes yes yes please

**Judy:** so we’ll pretend she’s got a bag of toys

**Lee:** Here’s the bag of toys. Ohh thank you I’ll play with the toys on the table there’s a little teapot set here you are then [enacts child figure giving therapist and parent figures cups of tea]

**Judy:** hmm [smiles nods head raises eyebrows]

**Lee (as child figure):** have some tea have some tea have some tea

**Judy:** hmm [smiles] playing a game

Lee continued the story by demonstrating 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.

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. Gabriella's (8yrs 9months) 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. She recalled being shown photos of the playroom and demonstrated actions of flicking through the pictures. She commented that the play therapist would show you what there is in the room including the sand pit, teddies and colouring. This suggested that this was a significant memory for Gabriella.

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 Ryan, 2005; Axline, 1989). Cathy, Lee and Gabriella’s responses highlighted their appreciation of being well-informed prior to play therapy starting, via a variety of methods.

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, and the therapist having a bag of toys available for the child figure to explore. 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, enabling
children's participation and understanding of the process. 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 impart to them.

Only four children talked and/or played about the initial meeting or home visit with their therapist. One might 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 explicitly included on the ‘Expert Show’ interview schedule. This is a limitation which has led to alterations to the schedule.

**During Play Therapy**

Over half of the children (eleven) described being able to choose in their sessions. Children made general comments about choice and comments specifically about the therapist following the child’s lead and instruction (see Jäger, in preparation, for further details). Four children specifically commented on the child being afforded choice regarding the process of play therapy. One of these, Elizabeth, (8yrs 7mnths) commented on the therapist allowing choice 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. The other two children, Sarah and L-man (10yrs 10mnths), suggested that the therapist would allow the child choice about when the therapy ended.

**Progress Meetings**

Fifteen children made comments about the progress meetings play therapists hold with parents/carers/professionals. The five remaining children were not asked about the progress meetings. 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. 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’, (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 (8yrs 5mths) used the general term “play therapy type stuff” to refer to what would be talked about and then abruptly disengaged the caller. Rob (8yrs) commented on not being there so wouldn’t know what happened, and Susie (5yrs 6mths) said she could not remember talking about the progress meeting even with prompts from her therapist. Bob (13yrs 9mths) asserted: “there’s nothing to be worried about” and Billy stated: “…you won’t even realise because you’ll be too busy at school honestly”.

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:

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
Eddie: He feels bad {eye contact;} because he doesn’t really know what they’re talking about
Rachel: 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 confirmed on her questionnaire that Eddie himself had not attended the progress meeting. Both Lee and Eddie shared that the child figure’s 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 (10yrs 1month) 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.

As argued above, the play therapy literature and training suggests that children’s levels of participation and sense of autonomy during NDPT sessions should be high. This study provides evidence from the child’s perspective to support this assertion. However, outside of the actual play therapy sessions there is a drop in participation as evidenced by children’s views on their review/progress meetings. This study highlighted children’s dependence on their parents to inform them about what was happening. Clearly this is a small sample and therefore cannot be generalised to all children receiving play therapy. However, previous research on children’s views of individual or group play therapy (Axline, 1950; Brownlie, 2006, unpublished; Carroll, 2002; Green & Christensen, 2006) has not actively sought children’s views of parental involvement, nor progress meetings. Furthermore there is little emphasis on this part of the process in the play therapy literature. Children’s views, expressed in this study, point to the benefits of children themselves being included in progress meetings. The one older
child who did attend the progress meeting, Sarah, 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 safeguarding 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 the 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 less 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 from Lee and Eddie’s expressed views that when children themselves do not attend they can be left with anxiety about what is discussed and several children would choose to go to the meeting if they were invited (see above).

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. As stated above, Ray (2011) acknowledges the common practice of play therapists holding meetings with a wide range of significant people in the child’s life. However, it does not appear to be 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 this is an area where play therapists can take a graded approach to considering children’s participation rights in the play therapy process, akin to Hart’s model described above. Play therapists could more actively seek children's views regarding progress meetings, in terms of the child’s own attendance, other attendees, what is discussed, and the methods used to facilitate these discussions. The implications of this finding and potential changes to practice are discussed further below.

Ending Play Therapy

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 did not want to finish their sessions they would probably get more.

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 had had enough sessions, he appeared
uncertain in himself but trusting in his play therapist to have made the right decision:

Bob: It depends really {looks downward}

But if the play therapist has said that's it then, she knows what she's doing

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.

Some children in this study 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 their having enjoyed their time and finding it hard to say goodbye. Wilson and Ryan (2005) and Ray (2011) provide a helpful discussion on making these decisions in therapy. 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. 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.

Implications

The application of Hart's model to existing play therapy practice literature coupled with the analysis of children's views in this study highlights progress/review meetings as a time where children experience a reduced level of participation. The views expressed by the children in this study suggest a need to review play therapy practice in this area. It is suggested that applying a graduated model to consider possible participation opportunities for children in relation to progress meetings would be a positive addition to therapists' routine practice. 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. This finding needs to be taken into account when considering children's participation in therapy review meetings.

As stated above, in play therapy training therapists are encouraged to ask children, particularly older 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, this is usually done through verbal communication. However, as Stith, Rosen, McCollum, Coleman & Herman (1996) 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.

Clearly the need to have the primary focus on the parent and adult issues is likely to continue to be indicated for at least part of the meeting or a combination of joint review meetings with parent and child and parent/adult only meetings throughout the intervention might be most practicable. Therapists need to make judgments which take into consideration the needs of the parent, the child and the system around the child and family, maintaining the best interests of the child at all times. When direct inclusion of the child at the meeting is not indicated, consultation with the child remains possible, and a ‘lower’ level of participation can be achieved. This might include seeking the child’s view on who is invited to review meetings, and how the decisions made in review meetings are subsequently communicated to the child. In this study Lee and Eddie’s experiences imply that therapists may need to take a more active role rather than relying on parents to convey these messages. Review meetings with children present can include discussion on frequency, time and location of play therapy sessions at the very least. In the author’s opinion, children should be given an opportunity to share their views on these issues and be given clear information on the decisions made as soon as possible. Finding appropriate and playful ways to explore themes arising in the therapy may also be possible and helpful.

Inclusion of children in review meetings is contra-indicated when the therapist is teaching the parent skills to enhance the parent-child relationship (as described by Ray, 2011) or more in depth discussion of the meaning of play themes is taking place and when the therapist predicts the parent may be overly negative in front of the child (Ray, 2011). However, it is suggested that therapists explicitly communicate to children the general purpose of the meetings they hold with the child’s parent and also briefly communicate the themes they will share in an age appropriate manner if the child wants to know. Again, the use of non-verbal methods of communication can greatly assist this process.

The findings of this study have led the author to change her own clinical practice and begin piloting the use of incorporating non-verbal means of communication in progress meetings with parents, carers and children. One example highlights the advantages of this practice.

Liam, 10 years old, had been attending weekly individual play therapy sessions for a year. He had relatively recently moved to having joint play therapy sessions, with both his therapist and his carer being active participants in the session. He had been invited to the first half of all the one hour progress meetings with his therapist and carer. He had been eager to attend the meeting; however, whilst he shared some of his thoughts in these meetings, he often appeared inhibited and uncomfortable. He provided minimal verbal responses. He usually chose to leave the meeting after ten minutes. Prior to the next meeting his therapist acknowledged that he sometimes seemed uncomfortable during the meetings and they felt different to their time in the playroom, mainly because it was just talking. The therapist acknowledged that maybe this made it feel a bit boring and also difficult to share how he felt about things. Liam nodded. The therapist said that she had been thinking that it might be helpful for her to bring the picture cards from the playroom, things for drawing and some of the figures to help them talk about things. Liam’s eyes lit up at this suggestion and he agreed that this was a good idea.

At the progress meeting, held at the carer’s home, the therapist laid out a series of picture cards, some art materials and miniature figures. She acknowledged to Liam and his carer that they were there for everyone to use if they wanted to. She said that they would be thinking about how things were at home, school and in the playroom and, as usual, invited Liam to choose which ‘place’ they should think about first. Liam chose to think about home but wanted his carer to start. As his carer talked about Liam’s mixed progress at home and talked about how difficult it was when he had contact with different members of his birth family, the therapist used the chameleon figure and four different miniature trees and said it sounded a bit like Liam was having to be like a chameleon and change each time he visited a different tree. She enacted the
chameleon moving from one tree to another. Liam watched intently and named the different trees as the different places he visited. He said the spiky one was like his grandparents. He pointed to the bare winter tree saying that was like his mum’s. The bright orange tree was like his brother and the full green tree was like ‘being here’ at his carer’s home. His carer had tears in her eyes as he said this. She softened her tone of voice and acknowledged how difficult it must be for the chameleon to move from one tree to another.

Liam chose a picture card to describe how he felt about his therapy sessions at the moment. He chose a card with a picture of a hand. Contained in the open hand was a tornado. Liam said that the tornado was what happened in the playroom and the hand was Sarah (his carer) and Jess (his therapist). It was agreed by everyone that it seemed helpful to keep working altogether in the playroom. The therapist reflected that together she and Sarah could give Liam a safe place to express and explore his big feelings.

This short vignette indicates how useful incorporating non-verbal materials in progress meetings can be. Clearly further exploration of this issue is warranted. However, it is suggested that active and meaningful involvement of children at this stage of the therapy process can be achieved and may help to shape the intervention in the most meaningful way for the child. The author is currently piloting the use of the miniature playroom, a miniature dolls house and miniature school as props in progress meetings to facilitate younger children’s involvement.

**Conclusion**

This study has highlighted that children are enabled to participate in a variety of decisions throughout the play therapy process and afforded a high degree of autonomy and choice. Incorporating play-based evaluations into play therapy practice further enhances the child’s experience of participation, respect and collaboration throughout the process. 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. It appears that extending this practice to carefully involve children in appropriate and meaningful ways in review meetings is now the challenge.

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**REFERENCES**


**BRIEF PLAY THERAPY TRAINING ACROSS KENYA FOR PROFESSIONAL COUNSELLORS**

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**Abstract**

This paper evaluates the perceived benefit of brief Child-centred play therapy training to 32 caring professionals across Kenya in Nairobi, Kisumu and Mombasa. It follows and replicates a previous study evaluating the perceived benefit to a group of caring professionals with counselling qualifications of a brief training in Child-centred play therapy in Nairobi (Hunt, 2006). The counsellor participants, 29 female and 3 male representing 9 tribes and 5 non-tribal groups, were predominantly Christian with few Muslims. The mean average age was 36 years with a mean average of 9 years of experience in the caring professions. Teaching methods included theory presentations; case presentations, practical skills demonstration and tuition with feedback and self-awareness group work. Questionnaires provided quantitative and qualitative data. Key findings were prevalent pre-training feelings of inadequacy to meet the therapeutic needs of vulnerable children using adult style counselling methods and post perceived benefit of training including a perceived increase in therapeutic skills, therapeutic power of play and a positive influence on professional lives, regardless of tribal, religious or geographical differences in the cohorts. There was an unexpected finding of reported prevalent child abuse in all three regions.

**Key words:** Brief Child-centred Play Therapy Programme, Kenya,

**Introduction**

In 2005, after gaining qualifications in counselling some caring professionals in Nairobi, Kenya, found that they were required to counsel vulnerable children and young people and felt inadequate to provide developmentally appropriate interventions. One response was a brief Child-centred play therapy programme of 120 hours duration, requested by and delivered at Kenya Association of Professional Counsellors (Hunt, 2006). The KAPC certified programme was designed and delivered by the author and a colleague (also a BAPT recognised play therapist) in Nairobi at KAPC Headquarters. A Person-centred approach (Rogers, 1951, 1957) to counselling had been perceived as a culturally useful approach for KAPC Masters graduates (McGuiness, Alred, Cohen, Hunt & Robson, 2001) and the outcome inspired the consequent theoretical approach taken in the design and delivery of a KAPC brief Child-centred play therapy programme (Axline, 1947, 1969; West, 1990, 1992; Landreth, 2002; Ray, 2006).

The outcome of the evaluation for the programme first delivered in 2004 was that it successfully increased the group’s perceived knowledge, confidence and skills to offer
appropriate therapeutic interventions to vulnerable children. More specifically, prevalent pre-training feelings of inadequacy to meet the therapeutic needs of vulnerable children using adult style counselling diminished; the participants reported perceived raised awareness of the therapeutic power of play, a positive impact on professional and personal lives; perceived increase in therapeutic play skills and increased ease in establishing therapeutic rapport with children (Hunt, 2006).

In 2006 following a further request from KAPC the programme was delivered again in KAPC Kisumu in the Rift Valley. Course evaluations indicated that the training was once again positively received.

A later request from KAPC for further programme delivery across Kenya in the three regional KAPC centres stimulated the desire in the author to explore whether the generic programme, so far delivered only in Nairobi and Kisumu, would prove to be culturally acceptable to all. Nairobi is the capital city of Kenya, Kisumu is located in the Rift Valley and Mombasa is situated on the coast of Kenya. Each city has its own particular character. Kisumu is a rural quiet city. Nairobi is a modern post-industrial style busy city and Mombasa, a coastal city with a large sea port with a strong Muslim and Swahili population with historical and cultural influences from the Middle East with a bustling international tourist industry. Traditional Kenyan tribal groupings are mixed in all three locations with a predominance of Kikuyu in Nairobi and Lua and Kisii in Kisumu.

The relationship between the author and three Kenyan tutors was collegial in nature. The main teaching responsibilities were shared out in a meeting before the programme was delivered and all sessions were co-taught and reflected upon at the end of each day. The Kenyan tutors took responsibility for noting any cultural or local adaptations to the training materials which resulted in a tutor working group in Kisumu to develop an ethical framework for practice with children within the Kenyan culture. For example, the training programme highlighted the cultural practice of giving or receiving gifts from the families of children offered play therapy. Not to allow families to do so was not acceptable as it was seen as a lack of respect for the play therapist. Societal cohesion relies on a system of gift-giving in parts of Kenyan society, particularly in the more traditional rural areas. These gifts could include milk or other locally produced foods, for example. In addition, the morning round in each group meeting, where each group member including tutors, was expected to share their current internal state, was characterised by a lengthy process of disclosure and sharing of experience and not to be rushed, irrespective of the needs of the teaching timetable for the day ahead. Hurrying this process along was frowned upon and the author respected this once informed by her Kenyan tutor in Kisumu.

The 120 hour programme was delivered in two five-day teaching blocks in each of the three settings with a month in between to begin to practice. There were 80 hours of direct face to face contact between tutors and participants in workshop style meetings. The remaining 40 hours were for private study, observation of play in the community, assignment writing, practice of skills learnt in playing with a child to support social and emotional development using play and keeping a learning journal for personal reflection of the process.

The programme included the introduction of theories of play with exploration of the various definitions and purposes of play (Bruner, 1983; McMahon, 1992; Cattanach, 1995). Play was explored as an unfolding developmental process in childhood and the groups were able to experience different kinds of play including somatic, projectory
and dramatic (Cattanach, 1995, based on Embodiment - Projection - Role, Jennings, 1990) and to gain understanding of the role of each kind of play and how it could be facilitated. The reporting of prevalent child abuse (Cattanach, 1992) during the programme delivery and lack of structures that offer child protection services in Kenya was explored further by the author (Hunt, 2009).

Following the establishment of a good understanding of play within the participant groups, the tutors made presentations of theory. Child-centred play therapy (Axline, 1947, 1969; West, 1992; Landreth, 2002) was introduced and tutors focussed on the links between this approach and an adult Person-centred (PCT) approach to counselling (Rogers, 1951, 1957, 1961), exploring the similarities and differences.

The previous training experience showed that participants valued gaining specific skills to facilitate competency in play therapy skills. Teaching methods included instruction, offering tutor demonstrations, opportunities to practice skills and giving feedback, case studies of children in play therapy with video footage and facilitating discussion. The tutors began by teaching attention to play, followed by how to make a reflective commentary on play, following a child’s lead and pace and employing Axline’s principles to guide the process of play therapy. Many participants gained confidence knowing that by providing a safe therapeutic play space, clearly setting boundaries for behaviour, offering a particular kind of therapeutic relationship, using therapeutic skills and materials, they could readily begin.

Training included an experiential participant-led and minimally-directed group process, for one hour a day during the programme which developed and sharpened personal awareness of childhood histories and what it is to be a child in current East African society. It also offered opportunity to identify and discuss the future needs of the participants. Debates around Axline’s concept of permissiveness (1947, 1969) in play were thoughtful. Many of the participants recalled their own childhood experience of discipline and reflected on their approach to their own children and how this was changing in the light of education and knowledge of developmental psychology.

KAPC provided play mats made from sheets of PVC tablecloth material purchased in the local markets for the participants to use as the play therapy space (Cattanach, 1992). For sand trays they supplied plastic baby baths. Sand and water were in plentiful supply. In addition there was paper and crayons, paint and brushes, small world toys of various kinds, some dolls and soft toys and many different coloured play doughs made by the participants during the workshop on somatic play.

The participants offered play therapy interventions to each other using sensory materials (Lowenfeld, 1979), painting and drawing, small world equipment and also experienced a workshop in playing dramatically (Cattanach, 1995, Jennings, 1995).

After the first five days of intensive workshops including theory and practice the programme participants were asked to demonstrate competency to ensure safe practice during the one month break. They offered play therapy interventions to each other with child friendly contracting and the introduction of boundaries to maintain safety and good time-keeping. Each was observed and assessed in a play therapist’s role for 20 minutes for ethical practice, quality of relationship offered and skills used. During the break participants would be observing play and recording their observations, playing with a child in their own community using a facilitative approach based on the learning on the programme, keeping a journal for self-reflection (Rainer, 1980) and writing an essay linked to theory and literature to demonstrate knowledge and understanding of the play experiences with the child in practice.

The author was conscious that supervision, although firmly established within the counselling culture in Kenya would not be specifically available for the emerging play therapists. Many in the groups made use of normal counselling supervisory relationships. Sometime later, the programme co-designer from the UK returned to Kenya to offer a supervision programme to play therapists wishing to further their knowledge and skills.

In the second teaching block the opportunity
was provided to share and reflect on practice and consolidate knowledge gained and identify gaps. Further tuition was offered in the introduction of theories of attachment, separation and loss and childhood bereavement (Bowlby, 1953, 1969, 1973, 1980, 2004; Bowlby & Parkes, 1970; Robertson & Bowlby, 1952). The participants made group presentations of their client work from the practice experiences and identified further training, professional needs and future directions. By the end of the programme in addition to the skills assessment, participants were expected to demonstrate knowledge of play, its purpose and development and knowledge of the theory of Child-centred play therapy.

Before commencement of the programme delivery across the three regions the author gained ethical approval from KAPC and her University to conduct evaluation research into the perceptions of the research participants. As an academic researcher she was not required to seek research supervision beyond normal university structures. Following on from the initial training provision in 2004 and 2006 which led to positive training outcomes for the counselling professionals (Hunt, 2006; 2009), the primary research question here was:

“Are there differences in the perceived brief play therapy training expectations and post training benefits for caring professionals working therapeutically with vulnerable children in Kenya, East Africa, depending on geographical location and subsequent cultural groupings?”

Research Methods

Participants

Programme participants were invited to become research participants. 32 of the 50 participants agreed to take part in the research. The questionnaires were filled in anonymously and the author is unaware of the tribal affiliation of those who chose not to take part. There was no discernable pattern as to gender or age related participation. There were 11 research participants from Nairobi, 10 from Kisumu and 11 from Mombasa.

Measures and procedures

Data was collected using a mixed methodology of quantitative and qualitative approaches (McLeod, 2001). The research participants filled in a pre-programme questionnaire and post-programme evaluation forms.

Ethical issues

Participants were given information on the project and signed forms giving permission for the findings to be published and used for teaching purposes. Data was scrutinised for possible identification of the source and any clues to the source eliminated. Informed consent was obtained from the participants in writing and information about the study offered with time for questions. Those who decided not to take part in the research project were offered the same intervention in every aspect of the programme experience.

The pre-training questionnaire

The pre-training questionnaire generated data on the demographic characteristics of the participants along with some qualitative data. The pre-training questionnaire asked the following questions:

1. What is your profession and in what capacity do you work with children?
2. Why do you want to do this course?
3. What do you hope you will learn?
4. What are your qualifications?
5. How many years of experience do you have in your profession?
6. What is your tribe?
7. What is your gender?
8. What is your religion?
9. What is your age?
10. What counselling qualifications do you have?

The pre-training questionnaire analysis

The pre-training questionnaire responses were scrutinised and collated on a table from the three
centres of programme delivery and compared for similarities and differences. (See Table 1 in Appendices)

There were 32 research participants from the caring professions 29 females and 3 males. Across the cohort they represented 9 different tribes and were mostly Christian with a few Muslims (based on the coast) none of the participants stated having no religion. The mean average age was 36 years (ranging from 19-69 years) and they had an average of 9 years of experience of working in the caring professions. Although a small sample, they represented a range of tribes and were a mixed group in terms of geographical location, which addressed the cultural diversity aspect of the research question. The counselling profession in Kenya is predominantly a female profession and the sample reflects this.

**Nairobi**

The gender distribution was 100% female. There was one male course participant in Nairobi but he chose not to take part in the research. They included a range of professionals including generic counsellors, counsellors working specifically with children and families, specialist HIV/AIDS counsellors, counselling psychologist, social worker, nurse, hospital play worker and teacher.

46% of these women were graduates in Psychology, Social work and Education and 27% educated in Counselling to Higher Diploma level. This means that 73% were educated in counselling to at least Higher Diploma level making this a highly educated group with high level specific knowledge and skills in Counselling supported by education and training. Of these, 36% were postgraduates (Masters) in Counselling, which denotes a very high level of knowledge and competence.

They were the youngest group (23-50) with a mean average age of 32 years. As they lived in Nairobi and had a good educational background they had been able to make use of the Master of Counselling programme offered in KAPC Nairobi office, validated by the University of Durham and taught by a combination of UK University Lecturers and young Kenyan Tutors.

All of them were Christians. The tribal affiliation was predominantly Kikuyu (55%). The estimated distribution of tribal affiliation in Nairobi is 7.5 million Kikuyu living in the central province. Even within this small sample the dominant tribal pattern is in evidence. The three other tribes Luo, Luyha and Turkana were represented by one participant for each. Of course many people migrate to live in Nairobi from other parts of Kenya as it is the capital city.

The main reason for taking the programme included the acquisition of new knowledge (73%), the development of therapeutic skills (45%) and therapeutic confidence (45%). This group of participants highly educated in the subject of Counselling, had enough knowledge and awareness to know that adult style counselling methods were not adequate to help children. Many would have studied this aspect to a lesser degree on the Master of Counselling Studies Programme (27%) in an ‘Introduction to Working with Children and Young people’ workshop.

They hoped that as a result of the programme experience they would develop the confidence to assist children (100%) and be able to offer developmentally appropriate therapeutic interventions to young children (100%). This indicates they were the least confident in working with children which may be because they were the least experienced group, albeit the more highly educated in the formal sense. They also wanted to gain knowledge of play therapy theory (100%) and knowledge of skills (100%), thus indicating knowledge of the relationship between theory and practice, which is to be expected in those who are well educated in Counselling. In addition there was a high focus on ethical practice with children and awareness of the differences between adult and child work (82%).

**Kisumu**

The gender distribution was 70% female and 30% female. The range of professionals included generic counsellors, counsellors working specifically with children, a trauma counsellor, nurses, teachers and a couple of pastors (only one decided to participate in the research).
30% of the participants were graduates in Sociology and Education. This indicates a much lower level of education than in the Nairobi group. Kisumu is a long way from the capital city of Nairobi and although connected by rail, road and air transport it would not be easy to travel to gain university qualifications for most of the participants since travel and accommodation outside of the home are expensive. 40% of the participants had a Counselling Higher Diploma. This is offered by KAPC Kisumu office and readily accessible. Only 1% of this group was educated to postgraduate (Masters) level in Counselling. Of the three groups this group was the least educated in Counselling, which is not surprising as Nairobi KAPC is the main location to gain postgraduate qualifications and many had travelled from more remote rural areas in the Rift Valley to take the programme.

Kisumu is located in Nyanza province on the shores of Lake Victoria and the tribal composition is estimated to be 6.4 million Luo and Kisii. This is reflected in the group composition which is 90% Luo and Kisii with only one participant from the Kikuyu tribe. Not many leave the central province to move out to the rural Rift valley as most of the migration would be from rural provinces to the capital city, Nairobi.

They represented the eldest group of the three cohorts with an age range between 30-60 years and a mean average of 40 years. Many of the participants were very experienced professionals with a mean average of 12 years of experience. This doubled the Nairobi group's level of professional experience and approximately a third more experience than the Mombasa group. All the group were Christian. This is to be expected as Christianity is the major religion in Kenya.

The main reasons for taking the programme included wanting to help children (40%), to develop therapeutic skills (40%) and to gain new knowledge (40%). This even focus on skills and knowledge may reflect the more experienced professionals who wanted to gain more practical training in working with children and less interest in the acquisition of knowledge for its own ends.

Their hope of the programme experience was above all to gain knowledge of play therapy theory (90%) and play therapy practice (80%) with knowledge of how to offer developmentally appropriate interventions as a major force too (60%). This may reflect the lack of access to training and resources in Kisumu and the high interest in counselling children there, indicated in those making long journeys and only one book in the library about counselling children. Kisumu also lacks good bookshops and getting hold of such resources is very expensive indeed. The author's co-tutor was a teacher and very keen to integrate the knowledge and skills gained from the programme into his KAPC course on Counselling Children which was popular. Lack of confidence in being able to assist children was evenly spread at 50%. This is perhaps indicative of the high level of professional experience in this group.

Mombasa

The female participants constituted the vast majority with one male participant who was a Head Teacher specialising in special education needs, also highly educated as a graduate in Education and an experienced counsellor and counsellor trainer for KAPC. This is consistent with the author's experience of male participants in the programme who tended towards this kind of professional profile. Once again there was a range of professionals in the group including teachers, child counsellors, school counsellors and those working with children and families.

18% of the group were educated to graduate level. 45% had a Certificate in Counselling and 73% a Higher Diploma and none were educated to postgraduate level in Counselling. The Certificate level in KAPC focussed mainly on skills acquisition. The Higher Diploma is available at KAPC Mombasa office. To study at postgraduate level regular trips to Nairobi would need to be undertaken with all the expenses that this would involve. Of the three groups this group was the least educated in generic terms.

The tribal distribution on the East Coast of Kenya is very mixed in terms of ethnic backgrounds and different languages and religions and this is reflected in the group. The dominant tribe is Kikuyu but only 36%, the rest is comprised of
various disparate groups reflecting an international character including European origin (9%) and Goan (9%) participants in addition to Kenyans with African origins.

The age range of the group was a wide spread from 19 to 47 years which included the youngest participant, and the average professional life experience was 8.5 years, making this group middle range between the two other groups.

The Mombasa group was the most culturally diverse with 64% Christians and 36% Muslims. Although Christianity dominates the group, Islam is a major influence on the coastal region where the people have Swahili Arab origins from the Middle East.

The main reason for taking the programme included wanting to help children (82%), to develop the skills to do so (73%) and to increase therapeutic competence (73%). The acquisition of theoretical knowledge was 100%. This was a highly motivated group wanting new knowledge and practical skills.

Their hopes of the programme experience were to develop confidence to assist children (64%), to learn how to offer developmentally appropriate and therapeutic interventions for young children (64%) and to have competency in play therapy skills and knowledge (64%). Confidence is an issue as this group is less experienced than the Kisumu group.

**Motivation for study**

In all three groups there was frustration expressed with adult style verbal counselling approaches as inadequate to help children and a need to develop child appropriate practice with abused, traumatised and vulnerable children (Cattanach, 1992). There was an indication of sound knowledge of child developmental psychology and the particular needs of the individual developing child. Most wanted to incorporate new learning into existing professional roles and only one participant wanted to offer training to others in the future in Nairobi.

In all three regional settings there were some highly educated and experienced, mature, caring professionals with sound counselling qualifications and experience of counselling. They offered similar expressions of motivation for studying the programme and expectations of learning, irrespective of geography which links to main tribal and religious groupings. The differences in expectations focus mainly on the differences in confidence associated with degree of professional experience and background in general education and counselling education between the three groups.

**The post-programme evaluation questionnaire**

Anonymous questionnaires designed by KAPC for programme evaluation generated numerical data on post-programme satisfaction and some qualitative data.

1. Did the course meet your expectations? Using a likert scale 1-5 from not at all (1) to very much (5)
2. What learning was useful to you? (key learning moments)
3. What factors helped your learning?
4. What factors hindered your learning?
5. How useful was the personal development group? Using a likert scale 1-5 from not useful (1) to very useful (5)
6. In what way was the personal development group useful or not?
7. How useful was the skills training? Using a likert scale 1-5 from not useful (1) to very useful (5)
8. In what way was the skills training useful or not?
9. How useful was the theory input? Using a likert scale 1-5 from not useful (1) to very useful (5)
10. In what way was the theory input useful or not?
11. How appropriate did you find the teaching methods?
12. How appropriate did you find the teaching materials?
13. What kind of follow up would you like to see?
14. What recommendations do you have to improve this course?
15. Were the physical conditions of the premises all right?
16. Were the initial arrangements for attending the course satisfactory?

The post-training questionnaire analysis
The post–training questionnaire was analysed to determine numerical levels of satisfaction with the training and usefulness of the various aspects of the training. These were collated on a table from the three centres of programme delivery and compared for similarities and differences. (See Tables 2 and 3 in Appendices)

Discussion of the quantitative aspects of post-programme evaluation
Overall, the analysed data in Table 2 indicates between 91-100% overall satisfaction with the programme. All three groups found the theory, skills and experiential self-development group work useful. The skills aspect was perceived by the participants as being ‘more than satisfying’ for 99% in Nairobi, 100% in Kisumu and 92% in Mombasa. The author hypothesises that the lower satisfaction with skills in Mombasa could be linked to the Kenyan co-tutor’s teaching input on the programme. He was more confident in presenting theory and although he had taken the programme himself previously he had not practiced and was not confident in teaching skills in the group, nor did he have practice experience to draw on to illustrate the skills. In addition he presented daily in a smart tailored suit and was unwilling to take part in messy play activity to demonstrate skills.

The theory aspect was perceived to be more than satisfying for 100% in Nairobi, 90% in Kisumu and 100% in Mombasa. The author suggests that in Kisumu the more experienced group included members who would have a very thorough understanding of Person-centred Therapy (PCT) hence the application of theory to children (Axline, 1947, 1969) would be fairly simple to grasp.

The experiential focussed personal development group was perceived to be at least 91% satisfactory to the Mombasa group and 100% useful to the other groups. The author suggests that one of the major difficulties with the personal development group in Mombasa was the mix of Christian and Muslim members which also meant the mix of Arab Africans and tribal Africans, very different cultural groupings. The two cultural groups rarely interacted outside of the programme in everyday life and self-disclosure may have been a sensitive issue for these two groups whilst in one another’s company. However, considering the challenges inherent in cultural diversity, all three regional settings perceived significant perceived gains from the intervention, irrespective of cultural differences.

Discussion of the qualitative aspects of post-programme evaluation
(Refer to Table 3). Key learning moments were predominantly attributed to the value of play therapy knowledge and skills in Nairobi (36%), Kisumu, (40%) and Mombasa (100%). There had been some disappointment expressed in Nairobi that play therapy was not a crisis intervention therapy and the more recent awareness of child abuse and many instances of disclosure in the Nairobi group (Hunt, 2009) necessitated discussion around the ethical imperative of working with a child who is in a ‘good enough’ and safe situation to benefit from the approach (Cattanach, 1992). This may account for a lower rating for key learning from the programme in this area as there was voiced frustration at not being able to help so many children in Nairobi using play therapy.

Factors that helped learning were overwhelmingly attributed to the experienced facilitators’ student centred educational approach in Nairobi (55%), Kisumu (80%) and Mombasa (100%). Students in Nairobi had been exposed to UK university lecturers using a PCT approach to education whilst studying the postgraduate programme offered by KAPC and would not find this as remarkable as those in the other two groups who were more used to a formal African teaching approach in training.

The factors that hindered learning were scantily reported and attributed to disparate factors with little clustering around one major area. In Kisumu 20% indicated concerns about language and cultural barriers between the facilitators and the
participants. The author found Kisumu to be the least cosmopolitan location, with Nairobi an international city and Mombasa an international major port. This may account for this minor difference.

The personal development group was overwhelmingly characterised as useful to reflect on the participants’ own childhood experiences: Nairobi (81%), Kisumu (60%) and Mombasa (64%). The Nairobi participants could see the value of this group to their development as play therapists (36%) as could those from Kisumu (20%) but not so for those from Mombasa (0%). This is disappointing from the author’s point of view as this is the main aim of incorporating a PD group into the programme. The Nairobi participants who have a high level of counsellor education are aware of the importance of personal development to therapeutic work already and this may reflect the high score. This is a concerning finding of the study, because if this awareness of the use of self and self process is not already present in the developing play therapists at the start of training then the length of the programme is too short to develop it. This is the reason for only offering the brief training to qualified counsellors. The implications are for an increased programme length with a focus on this aspect of the training. However, it may just not have been reported explicitly but still understood.

The skills input was valued with a particular focus on the use of peer play therapy practice on the programme in Nairobi (82%). Increased skill levels in Kisumu (70%) and Mombasa (82%) were other highly valued aspects. The increased skill level may reflect the pre-programme desire for increased confidence levels in Kisumu (50%) and Mombasa (64%). All three groups similarly valued their personal and professional growth and development on the programme: Nairobi (73%); Kisumu, (60%); and Mombasa (73%).

The theory input was valued in terms of being able to link theory to practice in Nairobi (55%) but in Kisumu and Mombasa this was least remarked on. The high level of education in Counselling in Nairobi may account for this professional approach. In Kisumu the focus was more on the usefulness of the curriculum in a minimal way (20%) and increased understanding of play therapy in general (20%). On the whole this very experienced professional group were less concerned with theory and more focused on practical skills. In Mombasa the theory was valued as an increased understanding of play therapy in general (55%).

The groups recommended improvements to the programme. Overwhelmingly the participants in all three settings requested to make the programme longer: Nairobi and Kisumu (55%) and Mombasa (100%). The author believes that this refers to the teaching blocks rather than the practice in between the blocks. Many on the programme requested direct feedback and a chance to practice more skills with tutor feedback, although all achieved a good level of competency after the first block. In addition the group in Mombasa requested more resources (64%). The library was very small with no play therapy books at all provided. No such requests came from Nairobi where there is a very good library. Kisumu participants were more concerned with chances to study at a Higher Diploma level in future (30%) and some had concerns about resources (20%) which reflects the lack of opportunity to get training outside of the Rift Valley and a small library resource.

In Kisumu (20%) and Nairobi (18%) there was a minimal request for the “Kenyanisation” of the programme. this was not significant but the author was aware of the useful discussions on the programme around the rights of children and child protection issues in the Kenyan context in addition to the ethical issues pertinent to the cultural nuances and the strong support for this.

Overall, there were indicators of perceived increased confidence, knowledge and skills with requests for further training and development including more resources. There does not appear to be any association between geographical location and subsequent tribal groupings and the perceived benefit of brief Child-centred play therapy training to the 32 caring professionals across Kenya in Nairobi, Kisumu and Mombasa. The main differences in pre training expectations and learning outcomes appear to be associated with educational background in the subject of Counselling and years of experience in professional life. Those with more
experience were more confident in helping children in general and were more interested in and benefitted by learning the skills aspect of play therapy. The higher educated younger women, predominantly graduates in Nairobi were more interested in theory and how theory and practice were linked. They were more familiar with a student centred approach to learning than their fellow participants in the smaller cities of Kisumu and Mombasa. Those in the capital city have many advantages and easy access to education and resources whilst those in the rural area and the international port are less advantaged in this respect.

The study’s strengths

The mixed methodology used in this study allowed the voice of the participants to be heard in addition to the statistical confirmation of perceived value. The information gleaned is rich and useful in confirming the generic usefulness and the particular future local refinements of the programme. The findings replicate the earlier study based in Nairobi (Hunt, 2006).

The study’s weaknesses

As a single researcher study there was no opportunity to bounce ideas with others during data collection. The role of dual researcher and programme designer/tutor/ facilitator added complexity as it brought the researcher closely in touch with enriched qualitative data and also reduced distance which is valuable for more objective views. Lastly, the nature of a small scale study with a small sample means that findings cannot easily be generalised.

Implications of the findings

The asked for “Kenyanisation” of the programme is best left up to the Kenyan tutors who now manage and teach the programme for KAPC and early indications suggest this is in process. It would be desirable to increase the duration of the programme and to increase the library resources in all three centres focussing on Kisumu and Mombasa as a first priority. Changes to the curriculum could include issues such as children’s rights and protection which are currently centre stage (Kippenberg, 2009; Pichegru, 2010) and the context within which counsellors must offer their services to children. The personal development group could be better introduced and links made to practice as this is not altogether clear for those who have not been exposed to high level education in Counselling. A lengthened training programme would also help with this aspect of the work and maybe using some more clearly defined personal development activities to support the development group objectives.

Overall, the play therapy research participants perceive that a generic training is most helpful in increasing knowledge skills and confidence in offering therapy to children, regardless of cultural differences within Kenya. The curriculum for further higher level training is a developmental process best shaped by Kenyans in the interests of Kenyan children.

Author’s reflections

The author is left with a feeling of privilege to be invited into the lives of the play therapy programme participants. The opportunity to share time with developing play therapists living and working to improve the lives of children in their care in a developing country where water, food, shelter and electricity cannot be taken for granted by most, put into perspective the normal concerns of everyday life back home. One participant arrived a little late one day for the training group, having walked for 12 miles to be there. Such was the commitment and avid interest in gaining new knowledge and skills. In addition, there is a bubbling consciousness of the demanding need now for adequate child protection procedures to be put in place so that play therapists can practice knowing that children will not be returned into abusive situations. Dr Balmer, the founder of KAPC, stated that the KAPC play therapy programme would strongly influence how play therapy develops in Kenya into the future and a finer tribute one could not wish for.
REFERENCES


### APPENDICES

#### Table 1: Quantitative Findings from Pre-training Questionnaire

<table>
<thead>
<tr>
<th>Questions</th>
<th>Nairobi</th>
<th>Kisumu</th>
<th>Mombasa</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is your profession and in what capacity do you work with children?</td>
<td>Counsellor Psychologist (n=1)</td>
<td>Trauma Counsellor (n=1)</td>
<td>Special needs teacher/ counsellor (n=1)</td>
</tr>
<tr>
<td></td>
<td>Counsellor (n=2)</td>
<td>Counsellor for children and families (n=1)</td>
<td>Counsellor trainer (n=1)</td>
</tr>
<tr>
<td></td>
<td>Social Worker/ counsellor (n=1)</td>
<td>Pastor/ counsellor for children and families (n=1)</td>
<td>Adult and child counsellor (n=3)</td>
</tr>
<tr>
<td></td>
<td>Counsellor for children and families (n=2)</td>
<td>HIV/AIDS counsellor for children and adults (n=2)</td>
<td>School counsellor (n=3)</td>
</tr>
<tr>
<td></td>
<td>HIV/AIDS Counsellor (n=1)</td>
<td>Nursing officer/ counsellor children and their families (n=1)</td>
<td>Social worker/ counsellor (n=1)</td>
</tr>
<tr>
<td></td>
<td>Early Childhood Teacher/ Counsellor (n=1)</td>
<td>Teacher/ counsellor (n=1)</td>
<td>Child counsellor (n=1)</td>
</tr>
<tr>
<td></td>
<td>Hospital Play Worker/ counsellor (n=1)</td>
<td>Education guidance counsellor (n=1)</td>
<td>Montessori teacher/ counsellor (n=1)</td>
</tr>
<tr>
<td></td>
<td>Registered Nurse/ Counsellor (n=1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Teacher/ Counsellor for adults and children (n=1)</td>
<td></td>
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</table>
Question 2 on reasons for undertaking the programme elicited useful data which was further analysed and reduced in a process of phenomenological reductionism (McLeod, 2001) to the following categories:

Category 1: to help children

Category 2: to develop therapeutic skills

Category 3: to gain therapeutic experience

Category 4: to increase my therapeutic competence

Category 5: to advocate for a child appropriate therapy

Category 6: to gain new knowledge

Category 7: to offer training to others

<table>
<thead>
<tr>
<th>Category</th>
<th>Nairobi</th>
<th>Kisumu</th>
<th>Mombasa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1: (n=4)</td>
<td>36%</td>
<td>40%</td>
<td>82%</td>
</tr>
<tr>
<td>Category 2: (n=5)</td>
<td>45%</td>
<td>40%</td>
<td>73%</td>
</tr>
<tr>
<td>Category 3: (n=3)</td>
<td>27%</td>
<td>10%</td>
<td>45%</td>
</tr>
<tr>
<td>Category 4: (n=5)</td>
<td>45%</td>
<td>30%</td>
<td>73%</td>
</tr>
<tr>
<td>Category 5: (n=3)</td>
<td>27%</td>
<td>10%</td>
<td>9%</td>
</tr>
<tr>
<td>Category 6: (n=8)</td>
<td>73%</td>
<td>40%</td>
<td>100%</td>
</tr>
<tr>
<td>Category 7: (n=1)</td>
<td>9%</td>
<td>0%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Question 3 on expectations of learning elicited useful data which was further analysed and reduced in a process of phenomenological reductionism (McLeod, 2001) to the following categories:

Category 1: develop confidence to assist children

Category 2: how to offer developmentally appropriate & therapeutic interventions for a young child

Category 3: how to help vulnerable children

Category 4: have competency in play therapy skills

Category 5: gain knowledge of play therapy theory

Category 6: gain knowledge of child development

Category 7: know what equipment is needed for play therapy services

Category 8: know how to communicate with young children

Category 9: know how to conduct ethical practice with children

Category 10: be able to explore my own therapeutic process and development
### 3. What do you hope you will learn?

<table>
<thead>
<tr>
<th>Category</th>
<th>Nairobi</th>
<th>Kisumu</th>
<th>Mombasa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1: (n=11)</td>
<td>100%</td>
<td>Category 1: (n=5)</td>
<td>50%</td>
</tr>
<tr>
<td>Category 2: (n=11)</td>
<td>100%</td>
<td>Category 2: (n=6)</td>
<td>60%</td>
</tr>
<tr>
<td>Category 3: (n=4)</td>
<td>36%</td>
<td>Category 3: (n=2)</td>
<td>20%</td>
</tr>
<tr>
<td>Category 4: (n=11)</td>
<td>100%</td>
<td>Category 4: (n=8)</td>
<td>80%</td>
</tr>
<tr>
<td>Category 5: (n=11)</td>
<td>100%</td>
<td>Category 5: (n=9)</td>
<td>90%</td>
</tr>
<tr>
<td>Category 6: (n=4)</td>
<td>36%</td>
<td>Category 6: (n=4)</td>
<td>40%</td>
</tr>
<tr>
<td>Category 7: (n=4)</td>
<td>36%</td>
<td>Category 7: (n=2)</td>
<td>20%</td>
</tr>
<tr>
<td>Category 8: (n=5)</td>
<td>45%</td>
<td>Category 8: (n=4)</td>
<td>40%</td>
</tr>
<tr>
<td>Category 9: (n=9)</td>
<td>82%</td>
<td>Category 9: (n=3)</td>
<td>30%</td>
</tr>
<tr>
<td>Category 10: (n=3)</td>
<td>27%</td>
<td>Category 10: (n=1)</td>
<td>10%</td>
</tr>
</tbody>
</table>

### 4. What are your qualifications?

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Nairobi</th>
<th>Kisumu</th>
<th>Mombasa</th>
</tr>
</thead>
<tbody>
<tr>
<td>BA Psychology (n=1)</td>
<td>9%</td>
<td>BA Sociology (n=1)</td>
<td>10%</td>
</tr>
<tr>
<td>BA Social Work (n=)</td>
<td>19%</td>
<td>BA Education (n=2)</td>
<td>20%</td>
</tr>
<tr>
<td>BA (Ed) Education (n=2)</td>
<td>18%</td>
<td>Diploma Business Administration (n=1)</td>
<td>10%</td>
</tr>
<tr>
<td>Registered Nurse (n=1)</td>
<td>9%</td>
<td>Diploma in Medical Lab Technology (n=1)</td>
<td>10%</td>
</tr>
<tr>
<td>Early Years Teacher Certificate (n=1)</td>
<td>9%</td>
<td>Registered Nurse (n=2)</td>
<td>20%</td>
</tr>
<tr>
<td>Early Years Teacher Certificate (n=1)</td>
<td>9%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 5. How many years of experience do you have in your profession?

<table>
<thead>
<tr>
<th>Location</th>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nairobi</td>
<td>Mean average = 6 years</td>
</tr>
<tr>
<td>Kisumu</td>
<td>Mean average = 12 years</td>
</tr>
<tr>
<td>Mombasa</td>
<td>Mean average = 8.5 years</td>
</tr>
</tbody>
</table>
### 6. What is your tribe?

<table>
<thead>
<tr>
<th>Tribe</th>
<th>Nairobi</th>
<th>Kisumu</th>
<th>Mombasa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kikuyu (n=6)</td>
<td>55%</td>
<td>Luo (n=8) 80%</td>
<td>Kikuyu (n=4) 36%</td>
</tr>
<tr>
<td>Non-tribal (n=2)</td>
<td>18%</td>
<td>Kikuyu (n=1) 0%</td>
<td>Arab (n=2) 18%</td>
</tr>
<tr>
<td>Luo (n=1)</td>
<td>9%</td>
<td>Kisii (n=1) 10%</td>
<td>Goan (n=1) 9%</td>
</tr>
<tr>
<td>Luyha (n=1)</td>
<td>9%</td>
<td>Khoja (n=1) 9%</td>
<td></td>
</tr>
<tr>
<td>Turkana (n=1)</td>
<td>9%</td>
<td>Giriama (n=1) 9%</td>
<td></td>
</tr>
<tr>
<td>Non-tribal (n=2)</td>
<td></td>
<td>Karuba (n=1) 9%</td>
<td></td>
</tr>
<tr>
<td>Arab (n=2)</td>
<td></td>
<td>Persian/ African/ European (n=1) 9%</td>
<td></td>
</tr>
</tbody>
</table>

### 7. What is your gender?

<table>
<thead>
<tr>
<th>Gender</th>
<th>Nairobi</th>
<th>Kisumu</th>
<th>Mombasa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female (n=11)</td>
<td>100%</td>
<td>Female (n=7) 70%</td>
<td>Female (n=10) 91%</td>
</tr>
<tr>
<td>Male (n=0)</td>
<td>0%</td>
<td>Male (n=3) 30%</td>
<td>Male (n=1) 9%</td>
</tr>
</tbody>
</table>

### 8. What is your religion?

<table>
<thead>
<tr>
<th>Religion</th>
<th>Nairobi</th>
<th>Kisumu</th>
<th>Mombasa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian (n=11)</td>
<td>(Including 1 identified Catholic)</td>
<td>100%</td>
<td>Christian (n=7) (Including 3 identified Catholic) 64%</td>
</tr>
<tr>
<td>Christian (n=10)</td>
<td>(Including 1 identified Jehovah's Witness) 100%</td>
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<td></td>
</tr>
<tr>
<td>Muslim: (n=4)</td>
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<td></td>
<td>36%</td>
</tr>
</tbody>
</table>

### 9. What is your age?

<table>
<thead>
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<th>Kisumu</th>
<th>Mombasa</th>
</tr>
</thead>
<tbody>
<tr>
<td>23: (n=1)</td>
<td>30: (n=2)</td>
<td>19: (n=1)</td>
<td></td>
</tr>
<tr>
<td>24: (n=1)</td>
<td>32: (n=1)</td>
<td>35: (n=1)</td>
<td></td>
</tr>
<tr>
<td>26: (n=1)</td>
<td>37: (n=1)</td>
<td>37: (n=1)</td>
<td></td>
</tr>
<tr>
<td>28: (n=2)</td>
<td>40: (n=2)</td>
<td>42: (n=1)</td>
<td></td>
</tr>
<tr>
<td>38: (n=1)</td>
<td>41: (n=1)</td>
<td>45: (n=1)</td>
<td></td>
</tr>
<tr>
<td>39: (n=1)</td>
<td>44: (n=1)</td>
<td>38: (n=2)</td>
<td></td>
</tr>
<tr>
<td>46: (n=1)</td>
<td>49: (n=1)</td>
<td>57: (n=1)</td>
<td></td>
</tr>
<tr>
<td>50: (n=2)</td>
<td>60: (n=1)</td>
<td>41: (n=1)</td>
<td></td>
</tr>
<tr>
<td>Mature Adult (n=1)</td>
<td></td>
<td>47: (n=1)</td>
<td>Not stated (n=1)</td>
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</table>

Mean average = 32 years  Mean average = 40 years  Mean average = 36 years
10. What counselling qualifications do you have?

<table>
<thead>
<tr>
<th></th>
<th>Nairobi</th>
<th>Kisumu</th>
<th>Mombasa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certificate in Counselling (n=1)</td>
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<td>Certificate in Counselling (n=5)</td>
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</tr>
<tr>
<td>Diploma in Counselling (n=1)</td>
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<td>Diploma in Counselling (n=0)</td>
<td>0%</td>
</tr>
<tr>
<td>Higher Diploma Counselling (n=3)</td>
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<td>Higher Diploma in Counselling (n=4)</td>
<td>40%</td>
</tr>
<tr>
<td>MA Counselling Studies (n=3)</td>
<td>27%</td>
<td>MA in Counselling Studies (n=1)</td>
<td>1%</td>
</tr>
<tr>
<td>MA Counselling Psychology (n=1)</td>
<td>9%</td>
<td>Short course counselling certificates:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Couple counsellor (n=1)</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Crisis pregnancy counsellor (n=1)</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HIV/AIDS Counsellor (n=2)</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Voluntary Counselling and Testing Counsellor (n=2)</td>
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</table>

Table 2: Quantitative findings of post-programme evaluation

<table>
<thead>
<tr>
<th></th>
<th>Number Responses</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>not at all</td>
<td>below satisfaction</td>
<td>satisfied</td>
<td>More than satisfied</td>
<td>Very much</td>
<td>Overall Satisfaction</td>
<td></td>
</tr>
<tr>
<td>Did the programme meet your expectations?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nairobi</td>
<td>11</td>
<td>10%</td>
<td>54%</td>
<td>36%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kisumu</td>
<td>10</td>
<td>10%</td>
<td>45%</td>
<td>45%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mombasa</td>
<td>11</td>
<td>55%</td>
<td>45%</td>
<td></td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How useful was the PD group?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nairobi</td>
<td>11</td>
<td>18%</td>
<td>45%</td>
<td>37%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kisumu</td>
<td>10</td>
<td>10%</td>
<td>45%</td>
<td>45%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mombasa</td>
<td>11</td>
<td>9%</td>
<td>27%</td>
<td>36%</td>
<td>28%</td>
<td>91%</td>
<td></td>
</tr>
<tr>
<td>How useful was the skills training?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nairobi</td>
<td>11</td>
<td></td>
<td>19%</td>
<td>81%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kisumu</td>
<td>10</td>
<td></td>
<td>55%</td>
<td>45%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mombasa</td>
<td>11</td>
<td>9%</td>
<td>18%</td>
<td>73%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How useful was the theory input?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nairobi</td>
<td>11</td>
<td></td>
<td>34%</td>
<td>66%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kisumu</td>
<td>10</td>
<td></td>
<td>35%</td>
<td>55%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mombasa</td>
<td>11</td>
<td>10%</td>
<td>36%</td>
<td>64%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 3: Qualitative findings of Post-Programme Evaluation

#### Learning aspects

**What were the key learning moments?**

This question elicited useful data which was further analysed and reduced in a process of phenomenological reductionism (McLeod, 2001) to the following categories:

- **Category 1:** the child leads in Child-centred play therapy
- **Category 2:** personal development
- **Category 3:** the value of play therapy knowledge & skills
- **Category 4:** increased confidence
- **Category 5:** tutor demonstrations & immediate tutor feedback
- **Category 6:** increased knowledge theories of attachment, separation & loss

<table>
<thead>
<tr>
<th>Teaching Aspects</th>
<th>Nairobi</th>
<th>Kisumu</th>
<th>Mombasa</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category 1 (n=2)</strong></td>
<td>18%</td>
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</tr>
<tr>
<td><strong>Category 2 (n=2)</strong></td>
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<td>30%</td>
<td>18%</td>
</tr>
<tr>
<td><strong>Category 3 (n=4)</strong></td>
<td>36%</td>
<td>40%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Category 4 (n=0)</strong></td>
<td>0%</td>
<td>10%</td>
<td>36%</td>
</tr>
<tr>
<td><strong>Category 5 (n=1)</strong></td>
<td>9%</td>
<td>10%</td>
<td>18%</td>
</tr>
<tr>
<td><strong>Category 6 (n=1)</strong></td>
<td>9%</td>
<td>20%</td>
<td>0%</td>
</tr>
</tbody>
</table>

#### What factors helped your learning?

The question on the factors that helped learning elicited useful data which was further analysed and reduced in a process of phenomenological reductionism (McLeod, 2001) to the following categories:

- **Category 1:** written student notes to support learning with reading lists for further study
- **Category 2:** experienced facilitator’s student-centred educational approach
- **Category 3:** value of group members as a learning resource
- **Category 4:** good organisation of the programme
- **Category 5:** possibility for personal & professional development
- **Category 6:** value of exposure to real case material provided by facilitator’s own practice
- **Category 7:** value of new knowledge and skills

<table>
<thead>
<tr>
<th>Teaching Aspects</th>
<th>Nairobi</th>
<th>Kisumu</th>
<th>Mombasa</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category 1 (n=2)</strong></td>
<td>18%</td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Category 2 (n=6)</strong></td>
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<td>80%</td>
<td>81%</td>
</tr>
<tr>
<td><strong>Category 3 (n=3)</strong></td>
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<td>27%</td>
</tr>
<tr>
<td><strong>Category 4 (n=4)</strong></td>
<td>36%</td>
<td>30%</td>
<td>36%</td>
</tr>
<tr>
<td><strong>Category 5 (n=2)</strong></td>
<td>45%</td>
<td>10%</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Category 6 (n=1)</strong></td>
<td>9%</td>
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<td>18%</td>
</tr>
<tr>
<td><strong>Category 7 (n=3)</strong></td>
<td>27%</td>
<td>0%</td>
<td>9%</td>
</tr>
</tbody>
</table>
What factors hindered your learning?

This question elicited useful data which was further analysed and reduced in a process of phenomenological reductionism (McLeod, 2001) to the following categories:

Category 1: course too short

Category 2: assignments too demanding

Category 3: lack of elaborated handout material

Category 4: poor teaching resources/environment

Category 5: personally challenged by PD group

Category 6: language/ culture barrier

Category 7: KAPC organisation of timing of the programme

Category 8: demanding time commitment to the programme

<table>
<thead>
<tr>
<th>Category</th>
<th>Nairobi</th>
<th>Kisumu</th>
<th>Mombasa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>9%</td>
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</tr>
<tr>
<td>Category 2</td>
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<td>Category 3</td>
<td>0%</td>
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<td>18%</td>
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</tr>
<tr>
<td>Category 8</td>
<td>9%</td>
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<td>0%</td>
</tr>
</tbody>
</table>

In what way was the PD group useful or not?

This question elicited useful data which was further analysed and reduced in a process of phenomenological reductionism (McLeod, 2001) to the following categories:

Category 1: sharing of experience

Category 2: useful reflection on own childhood experiences

Category 3: to some extent useful reflection on own childhood experiences

Category 4: could see the value to my development as a play therapist

Category 5: not long enough

Category 6: valued the facilitators in the group

Category 7: challenging

<table>
<thead>
<tr>
<th>Category</th>
<th>Nairobi</th>
<th>Kisumu</th>
<th>Mombasa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
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<td>0%</td>
</tr>
<tr>
<td>Category 6</td>
<td>0%</td>
<td>0%</td>
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</tr>
<tr>
<td>Category 7</td>
<td>9%</td>
<td>10%</td>
<td>9%</td>
</tr>
</tbody>
</table>
In what way was theory input useful or not?

This question elicited useful data which was further analysed and reduced in a process of phenomenological reductionism (McLeod, 2001) to the following categories:

<table>
<thead>
<tr>
<th>Category</th>
<th>Nairobi (n=8)</th>
<th>Kisumu (n=6)</th>
<th>Mombasa (n=8)</th>
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</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>73%</td>
<td>60%</td>
<td>73%</td>
</tr>
<tr>
<td>Category 2</td>
<td>73%</td>
<td>70%</td>
<td>82%</td>
</tr>
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In what way was skills input useful or not?

This question elicited useful data which was further analysed and reduced in a process of phenomenological reductionism (McLeod, 2001) to the following categories:
### Recommendations for improvement of the programme?

This question elicited useful data which was further analysed and reduced in a process of phenomenological reductionism (McLeod, 2001) to the following categories:

- **Category 1**: make the programme longer
- **Category 2**: offer a curriculum based on the Kenyan/African context
- **Category 3**: Continuing professional development from the facilitators
- **Category 4**: offer a programme at Diploma/Higher Diploma level/ Masters level (preferably funded though humanitarian org.)
- **Category 5**: explore expectations in PD group
- **Category 6**: increase resources
- **Category 7**: work with real children in the community during the programme supported by facilitators
- **Category 8**: research to indicate future needs in Kenya
- **Category 9**: increase theoretical input
- **Category 10**: offer a curriculum that includes more child development and children’s rights

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DOMESTIC ABUSE:
COLLATERAL DAMAGE - COLLATERAL TREATMENT

Linda St Louis
London, England

Abstract

At the centre of play therapy is the evolving relationship between the child and the therapist. It is this relationship which enables the child to grow, address traumatic events, learn new skills and re-evaluate self-concept. Children who experience domestic abuse are exposed to significant traumatic events which impact on their mental and physical day to day functioning. Parents, predominantly mothers, experience the same traumatic events which give rise to disrupted and disorganised patterns of attachment. The involvement of parents in play therapy is often in a peripheral role. This case study explores the impact on the mother-child relationship after completion of play therapy with a parent which incorporated non-directive and directive approaches and the delivery of a separate non-directive play therapy intervention with her son.

Key words: Play therapy, culture, domestic abuse, trauma, attachment, parental involvement

Introduction

This case study was completed to fulfil the requirement of the Masters in Play Therapy. My starting point had been for me a very simple question, “Why is it that as play therapists we only work with the child within the structured approach of play therapy, when the creative arts seem to do so much more with adults?” In writing about the play needs of adults, McMahon (2009, p25) argued that many adults who had been denied opportunities to play in their own childhood, enter into adulthood as hurt individuals, burying traumatic experiences while developing defences as a means of self-protection. The medium of play enables the adult to reconnect to child-like states which can in turn benefit parent and child.

As I embarked on this journey of play therapy with an adult alongside a child, I discovered a significant gap in play therapy research documenting non-directive play therapy with adults. But first however, a brief description of non-directive and directive play therapy is required. In non-directive play therapy the child is placed at the centre of the intervention. The response of the therapist permits the child to lead and direct his or her own play by tracking, paraphrasing and reflection. The non-directive approach enables the therapist to focus on the child and not the problem as experienced by the child. Carroll (1995 p77) states that non-directive work allows the emotions, thoughts and feelings to emerge while being contained by a trusting adult. I found that my intervention with this parent also warranted the need to combine non-directive play with directive play therapy approaches, which involve the therapist initiating and directing aspects of the play activities. Jennings (1999) makes reference to the application of directive play when working with...
children who are unable to develop their play. She argued that when play becomes rigid in nature the ability of the child to develop problem-solving resources remains hampered.

My search of databases did not identify case studies documenting play therapy with a parent in parallel with their child. The mainstay of research concentrates on studies engaging parents through either Theraplay, Filial Therapy or within Family Therapy. At the opposite end of this spectrum is research which explores the benefits of play with the elderly to aid memory recall (Ledyard, 1992). Trizinski and Higgings (2001) measured the impact of play and its ability to increase self-awareness, enable the exploration of feelings and increase socialisation amongst residents of a nursing home. The studies undertaken by Demanchick, Cochran and Cochran (2003) concentrated on an adapted form of child-centred play therapy with adults with learning disabilities to help this client group better manage behavioural and emotional difficulties.

There is a scarcity of research therefore which documents directive and non-directive play therapy with adults and non-directive play therapy with children delivered in parallel. It was this notion which I chose to examine within the context of this study. The most comprehensive publication to date is that edited by Charles Schaefer (2003): ‘Play Therapy with Adults’. However, even within this comprehensive volume there is the absence of texts documenting non-directive play therapy, with the exception of those drawing on the field of the creative arts. Research in the field of creative arts with adults predominantly exists in relation to art, drama, and music. Malchiodi (2008, p12) makes a clear distinction between the creative arts and play therapy in that creative arts therapies require knowledge of the art form, be it music, drama or art with principles of psychotherapy and counselling. Play therapy draws on the medium of play and child development through play.

**Working Collaterally**

At the centre of any therapeutic intervention is the complex nature of the relationship between child and therapist as it continues to evolve throughout the intervention. Parents can sometimes feel as though they exist ‘outside’ of this relationship despite all efforts made to include, consult and involve parents in the play therapy process (Cates, Paone, Packman & Margolis, 2006; VanFleet, 2000). O’Connor (2000, p332) purports that working collaboratively with parents serves to ensure that the child’s needs are effectively met by either engaging in filial therapy, joint family sessions or individual or couples intervention, all of which should sit parallel to the work being undertaken with the child. My ambition and hopes for this study therefore, were to give meaning to terms such as ‘partnership’, ‘involvement’, ‘consultation’ and ‘engagement’ within the context of play therapy by undertaking parallel yet separate interventions with a child and his mother, who for the purpose of this paper and to maintain confidentiality shall be called ‘Ijaz’ and ‘Nishat’.

**Case Presentation and Assessment**

**Profile of Nishat**

Nishat is 28 years of age, of South Asian descent and had an arranged marriage in 2000. She separated from her husband in 2008 after repeated domestic abuse. Nishat arrived in the UK at the age of 8 years and is the younger of two siblings. Her eldest sister, who is single, was born with a learning disability and requires ongoing care and support. Nishat is instrumental in providing support to her family, especially in the administration of the home and health needs of all family members. Her mother does not speak English and her father died in 2005. Nishat therefore undertakes interpreting tasks and liaison with agencies on behalf of both her sister and her mother.

**Profile of Ijaz**

At the start of play therapy in March 2010 Ijaz was 9 years of age. He has a younger brother of 6 years who is diagnosed as autistic. Both siblings are of South Asian descent and practicing Muslims. At the time of his father’s arrival in the UK Ijaz was 19 months old. The violence between his parents started in 2004 when Ijaz was 4 years of age. Ijaz now lives with his mother, maternal grandmother
and aunt. Ijaz believed the family home, where he witnessed the abuse towards his mother, to be haunted. Nishat became concerned about Ijaz after he stopped communicating with his peers, teachers and extended family. The referral for play therapy was made by the psychologist supporting families with autistic children.

The Assessment

I received minimal information about Ijaz at the referral stage. The psychologist who made the referral wrote the following about him:

- Presents with difficult behaviour at home and does not like his mother raising her voice.
- Ijaz does not like mixing with other people and does not like attending school.
- Ijaz used to talk constantly about trees, cutting trees and imagined body parts, that is feet and hands in the trees.
- Ijaz does not like rules but tries to rule the family.
- Ijaz does not engage in any conversations about his father.

O’Connor (2001) and Webb (2007) advocate the importance of assessing children and their presenting difficulties within the context of family and community systems. My starting point with Nishat was to undertake an eco-map to document the family unit’s relationship to outside systems and as a result I learned for the first time that Ijaz was mid-way through his assessment with his psychiatrist. Nishat was of the belief that Ijaz was also autistic and had asked for an assessment to ascertain this. The eco-map enabled me to obtain a more comprehensive picture of Ijaz as Nishat amplified concerns highlighted in the initial referral and provided a clear picture of how Ijaz had been affected by the abuse he experienced. She described Ijaz as being “paralysed with fear”. Ijaz made reference to the family home as being haunted and would ask his mother to sleep with the bedroom door open in case they had to escape in the night. He assumed the role of ‘caretaker’ for his mother, cleaning her cuts which often meant wiping blood from Nishat’s face and searching her body for bruises or the slightest mark. Ijaz would save his pocket money and buy toy guns. He had told his mother that one day he would kill his father.

A meeting with the psychiatrist assessing Ijaz, permitted me access to the results of his speech and language assessment and the outcome of a shortened version of the Three-Dimensional Diagnostic Interview used to assess the potential diagnosis of Autistic Spectrum Disorder (ASD). The diagnosis and management plan for Ijaz was as follows:

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<th>DIAGNOSIS</th>
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<tr>
<td>a) Generalised Anxiety Disorder</td>
<td>a) Referral for individual psychotherapy</td>
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<tr>
<td>b) Expressive and Receptive Language Disorder</td>
<td>b) Ongoing speech and language therapy</td>
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<td>c) Social communication difficulties</td>
<td>c) Nishat to be encouraged to address her past experience of domestic abuse</td>
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<td>d) Long standing exposure to domestic abuse</td>
<td>d) Liaison with school regarding Ijaz’s academic achievement as well as social development</td>
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Table 1: Outcome of Psychiatrist Assessment

The psychiatrist report highlighted the following about Ijaz:

- Is making significant academic progress in school.
- Anxiety levels had decreased once the immediate stressor, the violence, had been removed.
- The oppositional defiant behaviour towards his mother had reduced.
- Ijaz remained limited in his ability to verbally express and articulate himself to others.

As I moved closer to formulating a hypothesis, I questioned the effectiveness of psychotherapy as a course of treatment with a child who barely spoke, and who was receiving speech therapy and experiencing social communication difficulties. My attention was also drawn to Ijaz developing
secondary nocturnal enuresis. Phares (2003) states that enuresis is only diagnosed when there is no physiological evidence as to why bedwetting occurs. Barker (1995) and Goodman & Scott (2001) identified a link between enuresis and conduct and emotional disorders. As I began to formulate a picture of Ijaz’s early years and his early experiences of abuse in the home, non-directive play therapy became my choice of intervention, not only for Ijaz but his mother too. I had observed Nishat’s interaction with Ijaz as they undertook a series of activities which involved them playing together. Nishat would invite and encourage Ijaz to join in the activities without being overbearing or directing. She entered into role-play with a certain ease and in turn Ijaz responded to his mother as I observed him become more vocal and expressive in his play.

A ten week intervention was agreed after a sub-clinical diagnosis of Post Traumatic Stress Disorder (PTSD) had been made by his psychiatrist. Nishat’s intervention, which combined directive and non-directive approaches, ran for this duration of ten weeks. As it transpired however, Ijaz received twenty sessions of non-directive play therapy.

Aims of Play Therapy

The aim of play therapy according to McMahon (1992), Cattanach (2003), and Blom (2004) is to bring about self healing through the process of play. The behaviour identified as part of the assessment deserves to be understood within the context of Ijaz’s experience of growing up with domestic abuse. Landreth and Sweeney (1997, p21) state that maladjustments occur when there is an incongruence between the experiences of the child and the child’s concept of self. Taking this into account, at the centre of my intervention with Ijaz was the aim to acquire an understanding of the inner person and his internal working model. Consequently my aim for Ijaz was to oversee a period of growth and development by tracking the nature of his play, the themes which emerged during the course of play therapy and his ability to move towards verbal expression.

My next step was to obtain a view of Ijaz’s emotional and cognitive difficulties as seen by his mother, the school and Ijaz himself. The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997) was used as a pre- and post-assessment tool to measure changes in behaviour before and after the delivery of play therapy. After having successfully used this self-report questionnaire (designed to be used by children over the age of 11 years) with a 9 year old child I was keen to look at ways of including Ijaz in his assessment. However on reflection, my hope that he would be able to complete a self-report had been unrealistic: it proved too difficult for Ijaz as he would respond with silence or statements such as “I don’t know”. I decided that it was best to refrain from what might have appeared as an interrogation as it was evident that Ijaz became anxious with each question presented. He had suffered significant trauma which affected his speech and ability to communicate. Assessments should be therapeutic and ideally should not unsettle or create additional anxieties for the child. By presenting Ijaz with the self-report I increased his anxiety. I therefore decided to use the SDQ only with Ijaz’s mother and teacher.

Nishat’s Wishes

In a separate meeting with Nishat I was able to ascertain her hopes, wishes and the changes she would like to see come about as a result of my intervention, which were:

- To be strong enough to finalise her divorce
- For Ijaz to socialise with his peers
- For Ijaz to become less “bossy” and for there to be general improvement in his behaviour
- For Ijaz to come out of himself and not be so locked up in his mind

Nishat experienced incongruent feelings about the decisions she and others were making about her life. Later, during the course of her play sessions, the Muslim community’s perceptions and expectations of how she should conduct herself were expressed and evident through her play. When presented with the offer to undertake play therapy, Nishat demonstrated an immediate interest: “Will it help me to help Ijaz? I haven’t played for so long - what will I do?” Nishat’s first thoughts were of Ijaz and
then herself. I was aware of the extent to which Nishat apportioned self-blame for Ijaz’s difficulties and expected this to surface in therapy. I was unprepared however for what emerged from Nishat’s play sessions and the responsibility placed on me as the therapist to provide answers to her dilemmas.

Attachment Style and Working Hypothesis

The referral information obtained at the initial stage of the referral together with SDQs, psychiatrist reports and the introduction and review meetings with Ijaz and Nishat, were fundamental in identifying the mother-child attachment style. Exposure to violence and trauma has a direct impact on the mother-child and parent-child relationship. At the centre of attachment theory is the ability for the child to feel protected, safe and secure (Ayoub, Fischer & O’Connor, 2003; Howe, 2006; Odegaard, 2005; Ryan & Needham, 2001). Howe argues that children exposed to maltreatment from a caregiver develop insecure attachments and remain alert, aroused and hyper vigilant. In therapy sessions with Ijaz he remained alert to sounds within and outside the room. In one session as I moved forward to brush the clay off his jumper, he jumped backwards and covered his head with his hands. After informing him of my action I reassured him that I would never hit him and reminded him of the rule: “no hitting or hurting each other”. Bosco, DeBoard and Grych (2007, p11) and Vetere and Cooper (2005, p77) highlight increased emotional responses in children exposed to domestic abuse. Vetere and Cooper state that the presence of violence directly affects parenting styles. Caregivers are less attentive to the needs of the child and parenting becomes more inconsistent and volatile. For children seeking the safety and protection of their caregiver in response to the violence, the ability to regulate their emotions is further encumbered. Additional information on how Ijaz would clean his mother’s cuts, plead with her to leave his father and sleep with his bedroom door open, were indicators of a child displaying ambivalent and insecure attachment.

Working with Cultural Difference

The topic of cultural difference is raised with particular reference to Nishat and Ijaz. Bosco et al, (2007), Malchiodi (2008) and O’Connor (2000) emphasise the need for the play therapist to become culturally competent that is, developing an awareness of skills, knowledge and best procedures to ensure the effectiveness of the intervention. As an African Caribbean I approached this work sensitively having worked in a variety of multicultural settings. I was aware of the cultural assumptions that we might both hold towards each other. My starting point focused on getting to know the family, their customs and practices, for example during my first visit to the family home I removed my footwear as this is the custom in Nishat’s household. She insisted I kept them on. I enquired of the practice within her household and she informed me that they all removed their shoes, a pile of which was visible in the hallway, so I told her that I was happy to do the same. Throughout his play therapy, Ijaz would start by removing his shoes and saying on occasions, “I’m ready now”. Carroll (1998, p40) highlights the point that Islamic children may feel misunderstood and have to account for their differences within a political and social context. Carroll argues that the strong work ethic within many Asian households may present as a difficulty when undertaking play therapy since cultural attitudes may place little relevance on play and its therapeutic value. This was not the case for Ijaz and Nishat who attended each session with excitement and questions for me about each other. Indeed, managing and upholding confidentiality for Ijaz and Nishat was of great importance. Ijaz would walk around the room asking “What did my mum play with today?” I would have to remind Ijaz of our play therapy agreement by saying “What happens in the room stays in the room”. Nishat too would enquire about her son’s activities during her session. On each occasion I would let them know that by discussing them with each other I would be breaking our agreement. It was not long before these conversations moved from the play room to the family home with Ijaz and Nishat exchanging stories about their individual time in the play room.
Analysis of Play Themes - Nishat

“My Family”

Nishat was overwhelmed the first time she entered the play room: “Oh my god this reminds me of my childhood!” she exclaimed. She informed me that she liked playing as a child. I observed her as she moved hesitantly round the room: she was almost child like in her posture. Nishat settled on the floor, a place where she did most of her playing except for when painting. The theme of ‘family’ seemed to be ever present in her play. As she played with the dolls and the dolls house furniture she created the scene in figure 1 and referred to it as “My family”.

I enquired as to what her sons might be thinking as they sat next to her. She mentioned that it was difficult to know because Ijaz never spoke to her and she is never sure what her youngest son is thinking. She was clear to say that she wished every day could be like that depicted in her scene because the stillness enabled her to enjoy her children. The truth was that it was near impossible for Nishat to experience her children in this way. Her idealised notion of family, together with the demands of parenting and caring for her disabled sister and mother, were the true realities of her situation. As Nishat went on to produce farmyard scenes, country villages and pictures of warm picturesque homes, the realisation that Nishat resented her situation became apparent. During session four Nishat mentioned how much she resented aspects of her life and how she wished it had been different. She painted a picture of how she would have liked her life to have been, see figure 2.

In this picture she is alone walking through a park. Her children are in safe hands elsewhere.

“That Thing That Happened”

During her time in the play room Nishat struggled to give a name to her experiences of domestic abuse. In her first session while playing with the dolls, she said “We don’t like raised voices in our house because of, you know”. I invited her to say more but was left with “You know what we went through”. As her play progressed she would refer to the abuse as: “That thing that happened”, “The event” and “His behaviour”. Given that we both knew the violence had taken place, why was it so difficult to name? Enosh and Buchbinder (2005, p10) explored the strategies used by women to distance themselves from their experiences of domestic abuse and advocate the importance of understanding the construction of memory when working with trauma and abuse.

In my work with Nishat I combined a non-directive and directive approach as I found that otherwise conversations would take over and the play would stop. I asked if she could produce a representation of her life when she had been living with domestic abuse and of life after violence and abuse, see figure 3 and 4.
After Nishat produced the images I asked, “Can you tell me what is going on?” In her description of events taking place, Nishat described a family immobilised with fear; hence the absence of smiles. Nishat’s husband had just finished fighting with her. He has removed her dupatta (head scarf) and her hair is in a mess after he used it to pull her round the room. Her husband’s mouth is wide open as he shouts and calls her names. She is frightened on seeing his raised hands and prepares for another beating. She begins to cry and looks for her children who are huddled in a corner, too scared to go to their aid.

Nishat produced a graphic representation of how domestic abuse attacks the mother-child relationship and mentioned that the only time she was able to get close to her children was when their father was absent from the home. I enquired about her second painting and a smile appeared on her face, “We are happy here Linda”. She explained how the colour reflected the happiness of her family, her sons freely reaching out to her without fear. In their study of the use of drawings with people suffering from PTSD, Lev-Wiesal and Liraz (2007, p66) reported on the significance of the use of colour within a therapeutic setting to assist clients in reorganising their emotional reactions to traumatic life events. Nishat’s use of the colour black to describe the dark cloud hanging over her family was symbolic of the fear she experienced, whilst the brighter colours clearly denote happier times.

By working psychodynamically, Nishat recreated her experiences of violence through the production of art work; this enabled her to reflect on what had happened while she expressed her thoughts and feelings about her situation. As my work with Nishat progressed, she was able to explore aspects of her behaviour such as, minimising, denial and shame which were central to her experience. The therapeutic relationship which was now well established helped to facilitate the process of self-actualisation; Nishat was able to recognise her own worth. Coholic, Lougheed & Cadell, 2009; Lev-Wiesel & Liraz, 2007; McNiff, 2007; Waller, 2006).

“Voices in the Wind”

Nishat’s culture was inextricably linked to her experiences of abuse and interwoven throughout her play. Nishat informed me that before she met her husband she always wore western clothing. On separation from her husband she donned the abaya in order to convey to her community the strength of her faith and that her behaviour as a wife could not
have been the reason why her marriage failed. As her internal representation (how she would like to be) conflicted with her external representation (community expectations of what was expected from her), Nishat created symbolic images of how she experienced this conflict, see figures 5 and 6.

In figure 5 she spoke about the “voices in the wind” which she likened to the whispering she thought she could hear as she passed people on the street. The image in figure 6 was created as she sought direction from me as to whether or not she should divorce her husband. The tennis bats represent the elders in her life giving advice and direction. The ball is representative of Nishat and how she experienced the involvement of others in her life. “What do you think I should do Linda?” asked Nishat as she reflected on her paintings. “What would you like to be able to do?” I asked in return. She went on to describe how she could not return to her husband. I soon came to learn that Nishat had yet to encounter an emotional separation from her husband as she remained adamant about not being the first of them to bring forth divorce proceedings.

In her work with South Asian women, Kallivayalil (2010) found that for many, the need to ruminate their histories served as the starting point in working towards a solution. Kallivayalil reported that women in her study would vacillate between vowing never to remarry and seeking to be rescued from their single parent status by re-marrying. This was not that different from Nishat who would tell herself that maybe her marriage could work if her husband were to seek help and she fantasised about finding the right man who could be a husband and father to her children.

“This is All I Ever Wanted: A Conversation”

Over the course of this intervention I was able to gain a greater understanding of Nishat’s attachment to her husband. As she recounted the events which led to her taking an overdose while her husband watched, I enquired how she would have liked her husband to have responded. Nishat produced the image in figure 7 saying: “This is all I ever wanted, a conversation. Why could we not have a conversation Linda, why?”

I remained with the image and asked Nishat what she would like to say to her husband as they both sat facing each other. She proceeded to make a card which she left blank inside and said, “This card is for my husband. I left it blank because there are no more words left for me to speak”.

“I’m Stepping Out”

Nishat arrived at our final session crying uncontrollably. I learned that her husband had communicated through relatives his wish to remarry and in accordance with Islamic custom was seeking Nishat’s permission to take a second wife. I listened as Nishat expressed her concern at the shock of her marriage coming to an end and her hope that her husband would seek help. She expressed the need for her sons to have a man in their lives who they could call father, “What am I going to do? I’m never going to get a man to take me on with two sons!” she cried. Then anger set in, “After all that I have done for him!” I experienced a roller coaster of emotions and the one thought uppermost in my mind was, “This is not how I want our sessions to end”.

I suggested we looked through her art work and rediscover the journey she had been on in the play room. Each picture told a story which I asked her to recount, in other words, relive her journey and chart her growth. Her tears dried up and smiles returned. I asked if she could recreate her journey using any of the equipment in the room. Nishat recreated the images in figure 8 and 9.
In figure 8 she is moving forward with her life leaving behind the “blackness” associated with the violence and abuse. When she arrived for play therapy Nishat was in the centre of the circle (see figure 9) and described how she had been trapped. “Where are you now?” I asked. “Right on the edge with one foot inside and the other outside the circle. I’m stepping out Linda”. With this our session came to an end. Three weeks later when Nishat brought Ijaz for play therapy she announced that she had some good news for me and told me that she had a meeting with a solicitor to start divorce proceedings. “I am going to be the one who decides what happens in my life” she said. I could not help but give her a warm embrace.

Analysis of Play Themes – Ijaz

Castles and Monsters

Castles and monsters were a dominant theme throughout Ijaz’s play sessions. It was this aspect of his play which I presented to the child psychiatrist and my supervisor for further analysis. This resulted in the extension of my intervention from ten to twenty sessions, and in the sub-clinical diagnosis of PTSD. Over the course of the first five play sessions, monsters entered castles which became haunted. I learnt that the King and Queen vacated the castle because when it became haunted an invisible man began to reside within the empty space. The symbolic images presented over five weeks were powerful and incredibly moving. Not only did they provide Ijaz with the opportunity to speak about the way he experienced the abuse in his home, it also reflected the importance of the therapeutic relationship. The symbolic images of monsters spoke of the violence which drove the family to their second home. I later discovered that when people enquired as to the whereabouts of Ijaz’s father he would tell them that he became a ghost. There was a clear need for Ijaz to unburden himself of these events. My role as therapist was to remain a witness and contain the feelings and experiences being played out before me. McCarthy (2007, p34) states that the role of a witness is a key element of the transformative process. The more I made myself available to Ijaz the more he revealed aspects of the trauma he experienced. By the thirteenth session, Ijaz’s monsters and castles became more sophisticated, see figure 10.

On completion of what he called his “masterpiece” I said to Ijaz, “I wonder what it would be like to enter the castle”. He was quick to tell me...
that I would die if I entered the castle and painted a haunted maze (see figure 11). Monsters with blood dripping from their mouths had been trapped inside. I studied his maze and told him that I would close my eyes to see if I could see what it might be like to be inside. He told me I was not allowed and hurried to paint the letter ‘T’ in black paint, “There, it’s a timer; the maze is invisible so you can’t get in”.

I reflected on his response and my use of magical thinking to enter his world. He clearly conveyed that, a) my role was to witness and listen, b) that he was in control, directed events and decided who could and could not enter or leave this world and, c) that he sought to protect me from the danger held within: if I were to die, who would be available to hear his story? I speculate that Nishat had been emotionally unavailable to share in her son’s memories of the past.

The creation of the image in figure 11 depicts an internal struggle, one that Ijaz returned to repeatedly. For the first time he seemed able to exert control over his situation through the re-enactment of the trauma and directing the outcome. Symbolic play created a safe distance for him to explore and act out traumatic events (Crenshaw & Hardy 2007; Ryan & Needham, 2001; Schaefer, 1985). Chazan (2002, p107) made reference to the conflicted player as one who plays out issues and feelings he is not able to resolve. Wilson and Ryan (1992) present the significance of symbolic play as a means to enable children to reintegrate their past experiences into current levels of functioning.

Body Awareness and Splitting

I was first introduced to Poo in session six. I had observed Ijaz passing wind while playing with the slime but said nothing as I did not wish to embarrass him.

“That’s the poo falling” said Ijaz as he poured the slime and passed wind simultaneously. I enquired where it had come from and he laughed saying, “someone’s bum.” Ijaz introduced Poo as a rude young boy without manners, he said, “He doesn’t have table manners you know? He farts in front of people and burps. Oh, he puts food in his bum and shoots it at people, it lands on their faces”. Ijaz laughed hysterically and then ran round the room knocking toys over saying, “Poo done that! Poo done that!” Interestingly I was never allowed to meet Poo or converse with him. As Poo became part of our sessions, Ijaz made it clear to me that I would not be allowed to meet him because he was too disgusting. Ijaz and Poo presented as two separate people.

I was fascinated with the character of Poo. I first noted the connection between Poo, the slime and the messy play being undertaken by Ijaz. Jennings (1999) stated that sensory play has the potential to bring about a physical experience within the child. Differing textures, in this case slime mixed with paint can provide a sensory experience for children whose senses have been delayed as a result of their early experiences. Blom (2004, p90) makes reference to defence mechanisms used by children who have experienced trauma whereby children shut themselves off sensorily as a means of protection from internal or external painful stimuli. In the case of Ijaz, a child with poor body awareness, the play room enabled him to return to an early stage of development that he had yet to encounter and experience, in other words an opportunity to regress. My acceptance of Poo was therefore imperative in the development of my relationship with Ijaz and the development of his ego.

In my final session with Ijaz he informed me that Poo was present in the room and asked, “Does other play therapy people know about Poo?” I told him that I did not speak about him or Poo to anyone else. He enquired of the reason why, asking if it was because Poo was disgusting? I told him that it was because Poo was his friend and my work with them is confidential. My response was met with a long drawn out and questioning “Ohhh?”

Rejecting Poo would have been a rejection of Ijaz. Carroll (1998) reiterates the importance of working at the pace of the child so that he acquires the ability to integrate the ‘good’ and ‘bad’ aspects of the self.
Learned Helplessness

From my observations of Ijaz at play he had developed behaviours that one could describe as ‘learned helplessness’. In their study of depression in children, Nolen-Hoeksema, Girgus and Seligman (1986, p435) revisit the theory of learned helplessness. They state that where children have been exposed to repeated and uncontrollable events, they quickly learn that no response will bring about a change to their situation. In the case of Ijaz and his exposure to domestic abuse, he was powerless to control the outcome of his situation. This response in Ijaz permeated aspects of his life and was visible in his play activities. He made very little effort to remove lids from paint bottles and the play dough despite his excitement at discovering these items. My immediate thought at the time was that Nishat did everything for Ijaz and this was confirmed after I observed Nishat dress Ijaz in the waiting room with his hat, scarf, gloves and coat. I used the review meetings to present my observations to Nishat where it transpired that she did everything for Ijaz and his brother including bathing him. I used this opportunity to explore with Nishat how she could enable Ijaz to develop self-help skills by setting small tasks for Ijaz such as clearing the dinner table after a meal, dressing himself, buttoning his coat and washing dishes. It became clear that Ijaz had not quite separated from his mother as Nishat’s parenting had not yet enabled separation to take place. Over time Ijaz became more assertive in executing tasks and more persistent, in the sense that he would not give up. He would denote his success with, “Look what I did! I did it!”

Cole, Warren, Dallaire, Lagrange and Ciesla (2007, p306) present the notion that learned helplessness develops from problematic parenting. They go on to say that when children have been exposed to aversive and inescapable stimuli, such as domestic abuse, children become powerless to bring about a change to their situations. As Ijaz began to experience increased mastery in practical tasks, I observed how this transferred into the re-enactment of traumatic experiences in which he repeatedly returned to his monsters, ghosts and haunted castles. This process allowed Ijaz to direct and formulate his own outcomes (Blom, 2004; Benedict, 2006).

Aggressive Play

With knowledge of Ijaz’s personal history, I was careful to equip the play room with toys which could serve to permit release of suppressed emotions. He would often dress up like a policeman in search of the “baddies”. At times I was invited to assist. Other times I was the one being attacked. One play scene in particular stayed in my mind: Ijaz walking round the room dressed in armour. As I reflected his thoughts saying, “It seems that you are looking what to do next”, he replied, “Let’s have a fight”. The fight begins as we lunge towards each other with play swords made out of foam and Ijaz’s face was contorted with rage, something I had not seen before. His fighting became more ferocious and I knew I was not the object of his anger. As he began to kick me I sat down and said I was tired as a way of diffusing his play. I remembered being transfixed in that moment by the rage portrayed on his face, I think he was oblivious to it. Momentarily I was transported back to my youth; I could have been watching a scene of violence from my own childhood.

McCarthy (2007) refers to the power of symbols and their ability to enable the release of energy from within the child. West (1996, p202) states that symbols have the power to mediate experience of great intensity. In accordance with object relational theory, my relationship with Ijaz had been established and we were entering the second phase of therapy. Benedict (2006, p7) emphasised the importance of this phase in that the goal of therapy is to modify Ijaz’s internal working model or his object relations. The re-enactment of traumatic events shifted from portrayal in art form to that of role play. Symbolic play serves a myriad of functions as in this case Ijaz projected an aspect of his trauma that was so powerful I was taken off guard. In doing so I failed to reinforce the limit of no hurting each other. This scene was replayed on two more occasions, for which I was better prepared.


Discussion

“Izzat and Sharam”

The creation of an eco-map served as a visible tool in mapping the context of the lives of Nishat and her family. Fosco et al (2007) state that the culture, religious values and community conceptions of violence have a strong impact on the ability of families to make decisions about their future. The taboo nature of domestic abuse in South Asian households coupled with patriarchal family systems prevents a number of women from leaving abusive relationships. Women who decide to separate from their husbands are deemed to have brought dishonour (‘izzat’) on the family, as it is the woman who is responsible for upholding family honour. When women protest and fight back against the abuse, even through legal channels, they are held accountable for bringing shame (‘sharam’) on the family (Toor, 2009). Within the context of her therapy Nishat was able to produce graphic images depicting the impact of ‘izzat’ and ‘sharam’ in her life (see figures 5 and 6). As she recreated images of her youth, hopes and dreams for her family combined with the reality of her lived experiences, Nishat became able to verbalise the conflict she felt within and she named her experiences. Wilson and Ryan (2005, p60) refer to this as the reintegration of past experiences as a means of updating mental schemas with current experiences. It is imperative to review the application of attachment theory in the lives of South Asian women living with violence. Such is the patriarchal structure of many Asian cultures, the concept of honour and shame are embedded within belief systems and serve as a means of social control (Toor, 2010, p242). It is not men who bring dishonour and bad repute on the family but women. Women’s attachment to their husbands should be explored in light of this fact.

A number of factors precipitated the success of this intervention. The first being Nishat’s genuine concern and willingness to participate in her son’s intervention by making herself available for play therapy. “What did my mum play with today? I can’t believe she is doing play therapy” was one of the comments made by Ijaz as he tried to understand his mother playing. It was not long before these conversations moved from the play room to the family home with Ijaz and Nishat exchanging stories about their individual time in the play room. The attachment between Nishat and Ijaz notably changed as a result of undertaking separate interventions. In my final session with Ijaz, Nishat was invited to take part; I experienced Ijaz as a child who felt comfortable to be separate from his mother. As Nishat invited Ijaz to play with her, he replied, “Mum you can do anything in this room - just play with yourself”. Chethik (2002, p19) explained the importance of children being able to “let go” and makes reference to children’s experience of freedom within their play as they become less bound by the demands of reality.

My understanding of the relationship between Nishat and Ijaz had been further enhanced by Andre Green’s (2005) concept of the depressed mother as the ‘Dead Mother’. The unstable triangulation of relationships as experienced by Ijaz, a concept referred to by Green (2005, p150) resulted in the loss of sleep, and the desire to “delete my dad from the planet.” Ijaz, who had made many attempts to rescue his mother from his father, felt he had failed. His preoccupation in destroying his father lessened as Nishat became attuned to his needs and less preoccupied on how to save her marriage. Nishat had been depressed and we agreed prior to the commencement of play therapy that she would return to her psychotherapist at the end of her play therapy which she proceeded to do.

Figure 12
“I Sleep Now, I Never Used to Sleep Before”

Two months after his play therapy intervention, Ijaz joined a group programme delivered by the project in which I worked, for young people to share their experiences of domestic abuse. Each young person was asked to create a picture of how they experienced the violence in their homes and produce a picture of what life had been like after their fathers had left their homes. Ijaz produced the images in figure 12 and 13.

He explained how the fighting had kept him awake. Even when there was no fighting he would lie in bed listening and waiting for the fighting to begin. Figure 13 depicts Ijaz enjoying sleep and struggling to get out of bed in the morning. “I sleep now, I never used to sleep before” said Ijaz.

Nishat’s Future

Nishat too had begun to experience change in her life: “Linda I understand what you meant when you said that therapy will continue long after the intervention - I have a job interview!” Nishat was successful with her application to undertake play-based training to promote communication between carers and their autistic children. Nishat explained that as she relayed her and Ijaz’s experience of play therapy to the interview panel, the lead member of the interview panel stood up and saluted her. “I’ve never had a man salute me before” said Nishat through tear filled eyes. She was overcome with emotion at the gesture. I hold many dreams for Nishat, but I recognise them as my dreams and not those which belong to her.

Implications for Future Practice

In the process of devising this case study, it was important from the outset to take into consideration the needs of this client group. Such is the transient nature of families living with domestic abuse: victims are fleeing danger, seeking refuge or thinking about how to leave the violent relationship. It is therefore necessary to establish and consider the following factors prior to embarking on any similar collateral intervention with a parent and child:

a) A period of 2-3 months separation from the perpetrator to have taken place because women and children in crisis are not able to focus on their needs as long as they are unsafe and without financial support, i.e. social welfare benefits, a place to call home and access to support services.

b) The completion of risk assessments and the production of a safety plan to be in place prior to the commencement of therapy. The risk assessment should also consider the safety of the play therapist where home visits might be required.

c) Due to the transient nature of this population group it is not uncommon to begin an intervention only to learn half way through that the family are being re-housed in another location which makes it impossible for them to continue with their therapy. For this reason I recommend that only families who are seeking permanent housing with the intention of remaining in the borough, should be considered.

Conclusion

The notion that clients can be empowered to take greater control over their lives by making life changing decisions has been integral to the way in which I deliver my practice. Given the topic of this study, it is important to bring to the attention of the reader my childhood experiences of domestic abuse and my desire to guard against the exploitation of the participants presented in this case study. It is impossible therefore to be completely objective. The
nature of quantitative research is such that the researcher is often in the position of balancing the dual role of researcher and practitioner. Researchers therefore should be concerned with the notion of bias and instead of trying to control or eliminate it, to be transparent by reflecting their own history and values (Brechin & Sidell, 2000, p19; Johnson, 2000, p70). Consequently, my position as a feminist and a believer in the rights of women is reflected in this case study, as is my perspective and belief in children’s rights. It was crucial to recognise when my values, beliefs and experiences were at risk of having an impact while conducting this case study and when the experiences of Ijaz and Nishat were being transferred onto me. The delivery of regular clinical supervision which ran parallel with this study proved to be advantageous in enabling me to reflect on my practice.

By working collaterally, I hope to have conveyed and documented the progress and growth of the relationship between a mother and son while undertaking parallel yet separate interventions. Through his play, Ijaz explored aspects of the self, learned new skills and how to negotiate his relationship with Nishat. Developmentally, Nishat faced a differing set of tasks within her life which involved caring for others, finding purpose and meaning in her life and problem solving. Through the application of directive and non-directive play therapy, positive outcomes were achieved as the main obstacles impeding the growth and development of Nisat and Ijaz’s relationship were explored in the play room. It is not possible to apply the findings of this study to other populations. However, the absence of research and studies documenting play therapy as a systematic use of a theoretical model with an adult who is not elderly or mentally disabled, holds opportunities for a number of play therapists.

**Update – Eight Months On**

Nishat continues to work part-time helping parents of autistic children to use play as a means of enhancing the communication with their children. In addition to this she has secured a second part time post as a support worker with children who have special needs. In six months time she will complete her training in therapeutic play and begin the training of parents in the use and application of this model with their children.

Ijaz continues to thrive and his use of language has continued to develop. He is able to articulate his needs, feelings and wishes. Nishat described an incident where Ijaz had been called names at school. He told her he was feeling sad and that his chest felt heavy all day. He asked her why he had felt that way. Nishat was overjoyed and said, “Can you believe it? He described a feeling and connected it to a sensation! This has never happened before”.

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DOMESTIC ABUSE: COLLATERAL DAMAGE – COLLATERAL TREATMENT


DOMESTIC ABUSE:
COLLATERAL DAMAGE – COLLATERAL TREATMENT


**THE USE OF AGGRESSIVE-RELEASE TOYS IN NON-DIRECTIVE PLAY THERAPY: IS THERE ANY IMPACT ON CHILDREN’S AGGRESSIVE BEHAVIOUR?**

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**Abstract**

In recent years there has been a strong controversy among play therapists regarding the necessity or not of aggressive toys in play therapy. Using a survey-based research method questionnaire it was possible to investigate play therapists’ perceptions on the use, role and effect of aggressive-release toys, and whether such toys have any negative impact on children’s aggressive behaviour when provided in a play therapy setting. As a result, it was demonstrated that play therapists believe aggressive toys could have a positive impact on the cathartic release of aggressive emotions, in support of the catharsis hypothesis, while other factors may contribute to the cathartic effect as well.

**Keywords:** aggressive-release toys, play therapy, aggressive behaviour, catharsis.

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**Introduction**

In play therapy, the way that children use toys is viewed as their words or communication, providing them with a means of expressing their inner world. Toys and play materials become an extension of the child’s self (Axline, 1969; Landreth, 1993), and as such they constitute an important therapeutic variable, which should not be underestimated. According to Landreth (1991) there are three general categories of toys and materials for play therapy, which include: a) Real life toys, b) Toys for creative expression and emotional release, c) Acting out – aggressive toys (Landreth, 1991). The last category includes toys such as handcuffs, toy soldiers, rubber knives, swords, guns, rope, pounding bench, bop bag (Bobo), aggressive animals, puppets (e.g. dragon, alligator) etc, and refers to items which facilitate the expression and acting out of children’s anger, hostility, and frustration, among other feelings and needs (Landreth, 2002).

Children’s emotional expression and release is acknowledged as one of the most important elements in the play therapeutic process (Ginsberg, 1993). However, there is no unanimity among play therapists regarding whether to facilitate or inhibit children’s aggressive expression and release in the playroom (Drewes, 2001; Landreth, 2002; Stone, 2000; Trotter et al., 2003). This disagreement becomes more intense concerning children with aggressive behaviour referred for play therapy, but is not restricted only to this client group. It is further extended to strong controversy over the inclusion of aggressive toys in the playroom. Play therapists’ opinions diverge regarding the therapeutic value and resulting effects of offering children the chance to play with aggressive toys. Specifically, some play therapists argue that the use of aggressive toys facilitates positive therapeutic change and regard them as crucial tools in the therapeutic process (e.g. Moustakas, 1973; Trotter et al., 2003), while some others espouse the belief that aggressive toys can prove harmful and as such they should be excluded from the playroom (e.g. Drewes, 2001; Rapier,
Research on aggressive toy play

In the past years, several studies have been conducted in order to examine the relationship between aggressive toy play and children’s aggressive behaviour, and to assess the value of cathartic expression of aggression in play. The relevant research has been based on two contending theories posited to explain and predict the relationship between aggressive play and aggressive behaviour. The first refers to the ‘cathartic effect theory’ which is founded on the catharsis hypothesis, and the second pertains to the ‘cuing effect theory’ that is mainly based on social learning theory (Bushman, 2002; Jukes, 1991; Schaefer & Mattei, 2005; Scheff, 2007; Watson & Peng, 1992).

The cathartic effect theory suggests that humans are predisposed with an aggressive drive or instinct. Thus, anger and aggressive urges exist inside the human psyche and have the tendency to build up (Bushman, 1999) until they get released in a secure environment such as a playroom (Schaefer & Mattei, 2005). In the absence of such a release, the pressure will become too intense and the aggressive impulses will erupt in real life, causing harm to self and others (Ginsberg, in Schaefer, 1993). This theory proposes that increased war play can increase children’s pretend aggression, acting as a substitute for children’s real aggressive tendencies, resulting in a reduction of children’s aggressive drive and subsequent aggression (Dollard et al., 1939; Feshbach, 1956).

On the other hand, the cuing effect theory contends that there is no aggressive drive or instinct in humans and regards aggressive behaviour as a learned behaviour, mainly through imitation of others and/or social reinforcement (Bandura, 1973). From this standpoint, aggression is not likely to decrease as a consequence of catharsis. Indeed, aggressive toy play is expected to lead to an increase in both real and pretend aggression, as one cannot serve as a displacement for the other (Watson & Peng, 1992).

Overall, the empirical studies tend to argue against the catharsis hypothesis yet provide only limited support for the social learning theory. A synopsis of most of the studies is provided by Schaefer & Mattei (2005), while Goldstein (1988; 1992), Jenvey (1988), Jukes (1991), and Sutton-Smith (1988) have extensively reviewed the relevant studies indicating that there were all flawed in various respects, leading to conflicting views and elusive conclusions (Goldstein, 1994). Moreover, most of them were conducted over 30 years ago and their implications for play therapy are strongly questioned (Schaefer & Mattei, 2005) and significantly none of them were conducted within a play therapy setting.

Until 2004 there were no research studies in the literature to document the role and effects of aggressive toys within the play therapy field. A few case reports, solely focusing on the use of Bobo, mainly indicate that aggressive play with the Bobo does not increase aggressive behaviour outside the playroom (e.g. Baggerly, 2003 in Trotter et al., 2003; McGuiness, 2001 in Kaduson & Schaefer, 2001). An informal survey conducted by Trotter, Landreth, and Eshelman (2004), was the starting point for research studies in play therapy which investigated the ways that children use the Bobo within the therapeutic intervention. The main finding was that the Bobo was played with very little for aggressive types of play, thus it was concluded that the way children use the Bobo depends on their personal needs (Trotter et al., 2004).

In conclusion, the relevant literature suggests that aggressive or war toy play is an issue of controversy, not only within the therapy community, but also in the general population. The theoretical approaches, the empirical findings, the implications for play therapy and the play therapists’ opinions, are all contradictory and do not lead to any certain conclusions. Thus, it was inferred that further updated research in this area was necessary to shed some light and determine the prevalent notions regarding the use of the aggressive toys in current play therapy practice.

The present study

The current research examines the role of
aggressive toys as a therapeutic tool, investigating the perceived impact, if any, of the use of such items on children’s aggressive behaviour in a play therapeutic setting. The research was devised to look at play therapists’ perceptions of the use of aggressive-release toys in the playroom. Overall, this study aimed to offer a greater insight into the role and effect of aggressive toys in play therapy, which subsequently could assist the play therapy community not only to gain a better understanding of the function of such toys, but also to adopt a more critical perspective regarding the inclusion or not of such toys in the playroom.

The initial main hypotheses of this research were:

1) The use of the aggressive-release toys in play therapy can lead to positive therapeutic change.
2) Children’s initial levels of aggression are not heightened at the end of a therapeutic intervention by the use of aggressive-release toys.
3) The use of aggressive-release toys in the playroom can result in a cathartic release of children’s aggression.
4) There is no difference, after therapy, in the aggression levels of children who played with aggressive-release toys and those who did not.

For the purposes of this study the terms ‘aggressive toys’ and ‘aggressive-release toys’ are interchangeable and refer to the following: Bobo/punching bag, toy swords, toy guns, toy soldiers, handcuffs, and rubber knives.

**Methods**

In order to investigate play therapists’ beliefs, attitudes, and experiences regarding the role and effect of the aggressive toys in play therapy, a questionnaire based survey was conducted. It was a medium scale survey which involved 70 qualified play therapists, practising in different regions of the United Kingdom and selected from the register of the British Association of Play Therapists (BAPT). From the research sample a smaller group of play therapists adherent to Non–Directive Play Therapy was used for the data collection and analysis. For the data collection a questionnaire was developed and its validity and reliability determined. Further interviews which had been planned to involve a small number of play therapists were not carried out due to the large data selection from the questionnaire.

The questionnaire (see appendix) consisted of four parts, including both questions and scales which were coded and scored. The first two parts of the questionnaire requested information on aggressive toys drawn from the play therapists’ overall clinical practice, while the last two parts requested information only from the play therapists’ last completed therapeutic interventions. Specifically, items were included that focused on children’s levels of aggression (LOA), frequency of aggressive play (FOAP), and intensity of aggression (IOA) while playing with aggressive or non-aggressive toys, during three stages of the intervention (Beginning, Middle, End).

Data was analysed using the Statistical Package of Social Science (SPSS) software package. Investigation of the data included frequency tables, correlation and regression analysis (Pearson’s), and non–parametric tests, like Mann-Whitney U test. Additionally, for within–subject analysis the Friedman non–parametric equivalent of the analysis of variance (ANOVA) was used. The significant level was set at p≤0.025 (after the Bonferroni correction).

**Ethical considerations**

Significant ethical issues were taken into consideration throughout the process of this research. The research project conformed to all the appropriate ethics guidelines, rules, and regulations of BAPT and those published by Roehampton University. Confidentiality and anonymity were ensured and confirmation provided to the respondents that all the data would be treated anonymously and with great respect. Moreover, the items included in the questionnaire were carefully considered in terms of their ethical appropriateness. Thus, questions or statements that would request very personal or intrusive information were strictly
Results

Part 1

From all the email questionnaires sent to 70 play therapists, a total number of 60 questionnaires were returned, giving a response rate of 85%. For the research purposes, only the non-directive play therapists’ questionnaires were selected and analysed. From the 51 non-directive play therapists, 45 had aggressive toys available in the playroom (88%) and 6 did not (12%). Figure 1 shows which aggressive toys were available in the playroom by the play therapists (n=51).

Figure 1. Bar chart showing aggressive toys provided in the playroom (n=51).

Aggressive toys provided by play therapists in the playroom (n=51)

<table>
<thead>
<tr>
<th>Toy Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Punching bag/Bobo</td>
<td>22%</td>
</tr>
<tr>
<td>Toy Guns</td>
<td>69%</td>
</tr>
<tr>
<td>Rubber Knives</td>
<td>41%</td>
</tr>
<tr>
<td>Toy Swords</td>
<td>61%</td>
</tr>
<tr>
<td>Handcuffs</td>
<td>39%</td>
</tr>
<tr>
<td>Toy Soldiers</td>
<td>32%</td>
</tr>
<tr>
<td>Other</td>
<td>86%</td>
</tr>
</tbody>
</table>

‘Other’ group included action figures and aggressive animals.

Part 2

From the overall results of the 25 items of the ROLE and 7 items of the EFFECT dimensions, it was found that play therapists perceive aggressive toys to have a highly positive therapeutic role and aggressive toy play to be cathartic since it decreases children’s aggression. A Pearson’s correlation analysis for the dimensions ROLE and EFFECT showed that there was a strong significant positive correlation between the role of aggressive toys and their perceived effect ($r=0.71$, $df=49$, $p<0.001$). Another finding was that play therapists share many uncertainties in respect to the use of aggressive toys which are briefly presented in the discussion section.

Part 3a

From the total of 45 play therapists who provided aggressive toys, drawn from their overall clinical practice, the main findings were:

• 86% responded that 6 out of 10 children use aggressive toys for aggressive types of play.
• 57% responded that children express aggressive behaviour through playing with aggressive toys at any stage of a therapeutic intervention, while 36% reported that children express aggressive behaviour through playing with aggressive toys at the middle stage of a therapeutic intervention.
• 66% responded that aggressive toys are mainly used by children for aggressive types of play, while 86% responded that children use aggressive toys for non aggressive types of play.
• 57% responded that children who are referred with aggressive behaviour do not play with aggressive toys more often than those referred for other reasons.
• 66% responded that children do not use aggressive toys with higher frequency as the sessions progress, while 51% responded that children do use aggressive toys with greater intensity as the sessions progress.
• 89% responded that children appear more calm and relaxed following the expression of their feelings through playing with aggressive toys, and 85% responded that children lose their interest in aggressive toys when their feelings are validated.

Moreover, it was also found that 15 of the 45 play therapists who provide aggressive toys in their clinical practice, have occasionally removed these items from the playroom, in circumstances such as:
disapproval of the carer
• possible children's feelings of conflict when these items are not allowed in other settings
• children’s difficulty to control and contain their emotions during or after aggressive toy play, especially for children with mental health issues
• concerns for the safety of both the child and the therapist

Parts 3b & 4a – last completed interventions

From the 45 play therapists who included aggressive toys in their practice, it was found that 36 children (80%) did play with aggressive toys during the intervention, while 9 children (20%) did not. For the 36 children who played with aggressive toys, with one exception all the play therapists reported that the child's play with aggressive toys resulted in positive therapeutic change.

For the total of 45 children who had aggressive toys available, the highest percentages of play activity were found to be for toy soldiers (47%), toy swords (47%) and toy guns (38%). Results of the play and non-play behaviour with aggressive toys showed that the highest percentages were observed for pretend aggression with toy soldiers (42%), toy swords (36%), toy guns (33%), and handcuffs (20%). The second highest behaviour was physical aggression with toy swords (20%), toy guns (13%), and toy soldiers (9%). Verbal aggression was highest mainly for toy swords (13%), with all the rest no higher than 7%. Lastly, non-play behaviour was reported higher ranking with toy soldiers (51%), toy guns (38%), rubber knives (36%), toy swords (27%), handcuffs (25%), and 'Other' (24%).

Moreover, from the total of 51 children, 78% expressed aggressive feelings while playing with non aggressive toys (n=40), which included: Cars, miniature figures, fierce puppets, art materials (clay, paper, scissors), medical kit/ needles, wild animals and dinosaurs, fantasy aggressive heroes (i.e. pirates), football and competitive games, balloons, dolls house, dolls, family figures, domestic animal toys, cushions, lego, action figures and plastic food.

LOA, FOAP and IOA for children who had and did not have aggressive toys available

For the children who had and did not have aggressive toys available in the playroom, the non–parametric Mann-Whitney U test showed that the mean scoring for LOA, FOAP, and IOA had no significant difference. However, the way of looking at LOA, FOAP, and IOA using the mean scoring is general and does not indicate possible changes or differences between individual stages of the

Figure 2. Graphical representation of mean scores (±SEM) for LOA, FOAP, and IOA for all three stages of the intervention for the group of children who were provided with aggressive toys (n=45). †: LOA_B vs. LOA_M; §: FOAP_B vs. FOAP_M; §§: FOAP_M vs. FOAP_E; #: IOA_B vs. IOA_M. * p ≤ 0.025; ** p ≤ 0.01; *** p ≤ 0.001.
intervention. Thus, Pearson's correlation was used to compare the data between the three stages of the interventions (B, M, and E) for each of the dimensions. For the children who had aggressive toys available, it was found that there was a strong significant positive correlation for the LOA ($r=0.34, N=45, p<0.007$), between the middle ($M=3.27, SD=1.29$) and beginning ($M=2.04, SD=1.71$) stages of the intervention. For the FOAP there was a strong significant positive correlation ($r=0.39, N=45, p<0.008$), between the middle ($M=4.00, SD=1.39$) and beginning ($M=2.47, SD=2.08$); a strong positive significant correlation ($r=0.41, N=45, p<0.006$) between the middle ($M=4.00, SD=1.39$) and end ($M=2.13, SD=1.45$) stages of the intervention, and for the IOA there was a strong significant positive correlation ($r=0.50, N=45, p<0.0001$) between the middle ($M=3.42, SD=1.19$) and beginning ($M=1.97, SD=1.07$) stages of the intervention (Figure 2). No correlations were found for children who were not provided with aggressive toys (Figure 3).

**LOA, FOAP and IOA for children who played and did not play with aggressive toys**

For the children who played ($n=36$) and did not play with aggressive toys ($n=15$), the non-parametric Mann-Whitney U test showed that the mean scoring for LOA, FOAP, and IOA had no significant difference. Moreover, Pearson’s correlation was used to compare the data between the three stages of the interventions (B, M, and E) for each of the dimensions. For the children who played with aggressive toys, it was found that there was a near significant positive correlation for the LOA ($r=0.36, N=36, p<0.034$), between the middle ($M=3.44, SD=1.23$) and beginning ($M=2.19, SD=1.69$) stages of the intervention. For the FOAP there was a strong significant positive correlation ($r=0.45, N=36, p<0.007$), between the middle ($M=4.05, SD=1.37$) and beginning ($M=2.41, SD=2.03$); a strong positive significant correlation ($r=0.41, N=36, p<0.015$) between the middle ($M=4.01, SD=1.37$) and end ($M=2.33, SD=1.43$) stages of the intervention, and for the IOA there was a strong significant positive correlation ($r=0.61, N=36, p<0.0001$) between the middle ($M=3.47, SD=1.18$) and beginning ($M=2.11, SD=1.83$) stages of the intervention. For children who did not play with aggressive toys, there were no significant correlations for LOA, FOAP and IOA at any stage.

In addition, the non-parametric
Friedman Test was used to compare the data between the three stages of the intervention (B, M, and E) for each of the main variables (LOA, FOAP, and IOA, respectively). For the group of children who played with aggressive toys (n=36), the Friedman test showed that there was a strong significant difference for the LOA, FOAP, and for the IOA. Post-hoc analysis using the Bonferroni test showed that for LOA, there was a strong significant increase between the beginning and the middles stages of intervention (p=0.001), and a strong reduction between the middle and end (p=0.0001). For FOAP, there was a strong significant increase in the middle vs. the beginning (p=0.0001), and a significant reduction between the middle and end (p=0.0001). For IOA, there was a strong significant increase in the middle vs. the beginning (p=0.0001), and a strong reduction in the middle vs. the end (p=0.0001) (Figure 4). The same analysis for the group of children who did not play with aggressive toys showed that for LOA, and FOAP there was no significant difference between the three stages of intervention. For IOA, there was a strong significant increase between the beginning and middle stages of the intervention (p=0.005), and a significant decrease between the middle and end (p=0.008) (see Figure 5).

For the group of children who played with both aggressive and non-aggressive toys (n=25) for aggressive types of play, the non-parametric Mann-Whitney U test showed that there was no significant difference for the mean scoring of the FOAP and IOA when children played with aggressive toys vs. non aggressive toys.

**LOA, FOAP, and IOA in relation to the gender of the child**

For the group of children who used aggressive toys, the Mann-Whitney U test showed that there was no significant difference for the mean scoring of LOA, FOAP and IOA, when comparing the boys to the girls. When the data was analysed in relation to the stage of the intervention, the Mann-Whitney U test analysis of the scores for each dimension (i.e. LOA, FOAP and IOA), showed that there was a significant difference for the LOA (U=33.0, N1=30, N2=6, p=0.014) at the beginning of the intervention with boys (mean scores: 2.5) scoring higher than girls (mean scores: 0.67). There was also a close significant difference for FOAP (U=38.0, N1=30, N2=6, p=0.025) at the beginning of the intervention with boys scoring higher than girls. No significant differences were found for IOA and all other data. Additionally, for the group of children who did not play with aggressive toys, the Mann-Whitney U test found no significant differences for the LOA, FOAP and IOA, between the boys (n=7) when compared to the girls (n=8).

**Figure 4.** Results of mean scores (±SEM) for LOA, FOAP, and IOA for all three stages of the intervention for the group of children who played with aggressive toys (n=36). †:LOA_B vs. LOA_M; ††:LOA_M vs. LOA_E; §: FOAP_B vs. FOAP_M; §§: FOAP_M vs. FOAP_E; #: IOA_B vs. IOA_M; ##: IOA_M vs. IOA_E. * p ≤ 0.025; **p ≤ 0.01; ***p ≤ 0.001.
From the total 51 children, 17 were referred for play therapy with aggressive behaviour (33%), and 34 were referred for other reasons (67%). From the 17 children, 10 played with aggressive toys, 5 had chosen not to play and 2 were not provided with aggressive toys. A Mann-Whitney U test analysis showed that there was no significant difference between the LOA, FOAP, and IOA between the 10 children who played with aggressive toys in comparison to the 7 children who did not play with aggressive toys. Furthermore, analysis of LOA, FOAP and IOA for each individual stage of the intervention, in relation to the same groups did not reveal any significant difference.

Furthermore, within groups analysis using the Friedman test showed that for the group of children who were referred with aggressive behaviour and played with aggressive toys (n=10), there was a significant difference for the LOA, FOAP, and for the IOA (Figure 6). Post-hoc analysis using the Bonferroni test showed that for LOA, there was a significant decrease between the middle and end stages of the intervention (p=0.022). For FOAP, there was also a significant reduction in the middle vs. the end (p=0.016). Additionally, for IOA, there was a significant decrease in the middle vs. the end (p=0.021). The same analysis for the group of children who were referred for other reasons and played with aggressive toys (n=26), found similar results (Figure 7). Particularly, for LOA there was a
THE USE OF AGGRESSIVE-RELEASE TOYS IN NONDIRECTIVE PLAY THERAPY

Figure 7. Post hoc test of mean scores (±SEM) for LOA, FOAP, and IOA for the three stages of the intervention (n=26). †: LOA_B vs. LOA_M; ††: LOA_M vs. LOA_E; §: FOAP_B vs. FOAP_M; §§: FOAP_M vs. FOAP_E; #: IOA_B vs. IOA_M; ##: IOA_M vs. IOA_E. *p ≤ 0.025; **p ≤ 0.01; ***p ≤ 0.001.

Discussion

The main findings of the present research indicated that:

1) The majority of play therapists in the United Kingdom include aggressive-release toys in their clinical practice since they perceive these items to have a positive therapeutic role and effect.

 Particularly, they perceive aggressive toy play to be cathartic, in the sense that it decreases the children's levels of aggression in the course of a therapeutic intervention. Play therapists' clinical experience is that aggressive toy play does not provoke children's aggressive behaviour and indeed it facilitates positive therapeutic change. Thus, play therapists' perceptions are in accordance with the first hypothesis (that the use of aggressive toys can lead to positive therapeutic change). However it may be argued that it is the therapeutic relationship and the therapists' reflective responses to the child's play with aggressive toys that result in therapeutic change and not the play with aggressive toys itself. In that regard the initial hypothesis remains unproved.

However, despite the play therapists' consensus over the positive therapeutic role and effect of aggressive-release toys, not all the therapists provided aggressive toys. Moreover, for those who did, not all of the toys listed as aggressive were equally provided (see Figure 1), since play therapists show some preference for toy soldiers, toy guns, and toy swords. Furthermore, 11% provided solely toy soldiers and no other aggressive toys. It was also of interest that the availability of punching bag/Bobo was comparatively limited (22%) in relation to other aggressive toys (e.g. toy soldiers, 86%), since authorities in play therapy argue over the inclusion of this item in the playroom (Trotter et al., 2003).

Therefore, the above findings suggest that there is a contradiction between play therapists' opinions and attitudes. Considering that there is no research evidence, apart from Drewes' case study (2001), to support that aggressive toys have any negative effects upon children's aggressive behaviour, it is worth questioning the reason for their unequal inclusion or even exclusion. It could be inferred that this tendency is influenced by and reflects the conflicting views and uncertainty within the play therapy community around the use of Bobo and the
other aggressive toys. Perhaps the lack of relevant empirical research, in conjunction with some negative outcomes drawn from studies carried out in other settings, further contributes to the maintenance of feelings of uncertainty, confusion, and hesitation around the inclusion of aggressive toys. Another hypothesis could be that play therapists find the use of some of the aggressive toys superior to others, in terms of their therapeutic necessity and effect. Moreover, variables such as the therapists’ uneasiness or even prejudice towards all or some of the aggressive toys may influence their decision as to whether or not to provide them.

2) There are some uncertainties on issues related to the provision of aggressive-release toys.

Specifically:

2a) Despite the play therapists’ strong agreement on the therapeutic benefits of aggressive toys, there remains important prevailing uncertainty as to whether or not they constitute a therapeutic necessity.

2b) Play therapists still share many uncertainties regarding the impact of aggressive toys on the therapeutic relationship. Even though it became apparent that aggressive toys are tools which necessitate the need for limit setting, it is not clear whether they facilitate or indeed hinder the building of the therapeutic relationship.

2c) Whether these items make it easier for the therapist to understand the underlying feelings and themes of children’s play still remains under question. However, Landreth supports the view that the use of aggressive toys makes it easier for the therapist to understand the child’s feelings, which according to Ginott is a determinant for selecting appropriate toys for therapy (Landreth & Bratton, 2002; Ginott, 1960).

2d) There is no clear agreement upon their adequacy in helping children learn how to handle their aggressive feelings or if alternative expressive materials are rather more appropriate.

2e) Uncertainty is also observed on the major issue regarding children’s potential feelings of conflict while playing with aggressive toys in the play therapy space, when these are not permitted in other settings, albeit some authorities in play therapy argue that the very exclusiveness of the playroom diminishes any feelings of such a conflict (Trotter et al., 2003).

2f) Whilst the play therapists support the view that aggressive toys do not direct children’s play behaviour, at the same time perspectives diverge on whether they may have behaviour propelling qualities, inviting children to act–out play and aggressive expressions.

2g) Despite their unanimous strong disagreement on the exclusion of aggressive-release toys from the playroom, a query is expressed regarding the exclusion of these toys from the playroom for specific client groups.

3) Not all the children who were provided with aggressive-release toys played with them.

This finding runs counter to the argument that aggressive toys have behaviour-propelling qualities and strongly direct the children’s play behaviour. If that was the case all of the children would have played with them. Instead it may be concluded, as Landreth (2004) states, that children use or do not use the aggressive toys according to their personal preferences and needs. However, it was found that a significant proportion of children did play with aggressive toys when provided with them.

4) All children expressed aggressive feelings in the course of the play therapy sessions, while playing with aggressive and/or non aggressive toys.

This finding is quite important since it suggests that the majority of children referred for play therapy, regardless of the reason for the referral, are expected to express aggressive feelings. Specifically, from the 45 children who had aggressive toys available 36 (80%) included them in their play, 25 of them (55%) used both aggressive and non aggressive toys in an aggressive manner, 9 (20%) preferred to use exclusively non-aggressive item to express their aggressive feelings, and finally 11 (25%) used solely aggressive toys for the expression and acting-out of aggressive feelings. This finding implies that irrespective of the presence or not of the aggressive toys in the playroom, children will express their aggressive feelings if needed. However, this does not diminish the importance of including aggressive toys in the playroom. Since it appears that most children tend to express aggressive feelings in the playroom, the inclusion of aggressive toys
becomes of great importance, given that their main purpose is the facilitation of such an expression. It was also evident that some children used solely aggressive (25%) or non-aggressive items (20%) to express their aggressive feelings. Thus, it could be concluded that aggressive and non-aggressive toys are equally essential in providing children with adequate means of self-expression and self-exploration.

5) The children’s play with aggressive-release toys was proportional to their availability.

Specifically, it was found that children played more with toy soldiers, toy swords, and toy guns, which were also the toys mostly provided by the play therapists. Thus, it is not feasible to draw any conclusions regarding the children’s preferences for the aggressive toys.

6) Pretend aggression was children’s main play behaviour with aggressive-release toys.

Particularly, it was found that children mainly used aggressive toys to express pretend aggression, while the expression of real aggression was quite limited. This finding lends itself to the assumption that aggression is not transferred outside the playroom since it takes place in the symbolic/fantasy sphere. It could be further argued that aggressive toys are appropriate tools to facilitate the expression of physical and verbal aggression, complementary to the pretend aggression. Furthermore, the above finding contradicts the view that aggressive toy play impoverishes the children’s imagination (Carlsson–Paige & Levin, 1987; Sutton–Smith, 1988).

7) Both groups of children who played and did not play with aggressive-release toys ended up with similar LOA, FOAP, and IOA.

The overall course of LOA, FOAP, and IOA for both groups of children was similar, reflecting a decreasing trend, which means that at the end stage of the interventions the children’s scores of LOA, FOAP, and IOA fell similarly below that of the initial levels. This observation refutes the proposition that aggressive toys should not be used in the playroom because they increase the aggression of the child, usually leading to excessive acting-out behaviours (Drewes, 2001). Moreover, the above finding lends support to the second hypothesis (that children’s initial levels of aggression are not heightened at the end of a therapeutic intervention by the use of aggressive toys). However the fact that other elements are involved in the therapeutic process (as in point 1) means the hypothesis remains uncertain.

Additionally, based on the findings it becomes apparent that the fourth hypothesis (that there is no difference, after therapy in the aggression levels of children who played and did not play with aggressive toys) was successfully proved. However, significant differences between these groups of children were found for the middle stage of the interventions, suggesting that even though all the children will end up with similarly lower than the initials levels of aggression in the therapeutic interventions, those children who do use aggressive toys follow a different process of aggression expression throughout the sessions.

8) Children who played with aggressive-release toys followed a different process of aggression expression.

For the children who played with aggressive toys there was a significant increase in the middle of the intervention for the LOA, FOAP and IOA (Figure 4). On the other hand, analysis of the group of children who played with non-aggressive toys, showed that only the end stage was significantly lower in IOA, when compared to the middle of the intervention (Figure 5).

Generally, the data obtained from both groups of children who played and did not play with aggressive toys, are in accord with Fukaka’s views on the aggression in play therapy as a process between different periods (Fukaka, 1971). According to Fukaka (1971), the initial anxiety is followed by a period of aggressive behaviour, an expansion of aggressive behaviours and a last period of creative reorganisation that is followed by adaptation outside the playroom. Likewise, the period of expansion of the child’s aggressive behaviour in the playroom could be further linked to the view by Ginott (1994) that it is the strong therapeutic alliance which develops between the therapist and the child that allows the freedom of expression of aggressive behaviours (Ginott, 1994). Since these behaviours are openly expressed and accepted by the therapist, and since the child’s feelings are validated,
then the need for expression and intensity of aggressive play decreases (Moustakas, 1953; McGuiness, in Kaduson & Schaefer, 2001; Trotter et al., 2003).

Similarly, Guerney (1983) reported that aggression and emotional expression increased as the sessions increased but then fell to a level below the initial rate of aggression and emotional expression, which is supported from the current results. As such, after an initial period of increased aggression, there is a lessening of aggression to a level below that of the initial sessions for both groups of children. However, the increase or expansion of aggression was found to be significantly greater for the aggressive toy play group. As such, our findings could indicate that children's release of aggressive emotions through the use of the aggressive toys had a greater cathartic effect in comparison to the children who did not use these items, which is also in agreement with the play therapists' perceptions. In other words, this finding stands against the social learning theory and actually provides support for the catharsis hypothesis. Thus, based on the play therapists' perceptions, the third hypothesis (that the use of aggressive toys in the playroom can result in a cathartic release of children's aggression), is supported. Relating all of the above with the finding that pretend aggression was children's main observed play behaviour with aggressive toys, it could be further concluded that aggressive toys facilitate what Feshbach (1955) names as “symbolic catharsis”. Thus, the symbolic aggression expressed in fantasy can result through catharsis in a reduction of aggression (Ginsberg, 1993). In addition, the finding that it was mainly the pretend aggression which increased at the middle stage of the interventions, clearly contradicts the cuing effect theory which would predict both pretend and real aggression to increase following aggressive toy play (Watson & Peng, 1992).

However, even though the aggressive toy play group appeared to have a greater cathartic effect it seems unclear whether this effect resulted solely from the use of the aggressive toys, since other key elements may be involved, such as the therapeutic relationship. Thus, a hypothesis could be that play therapists who allow aggressive toys are more able to tolerate aggression and therefore are stronger in the therapeutic relationship, which consequently facilitates the great cathartic effect instead of, or in combination with, the aggressive toys themselves.

9) Children who were referred with aggressive behaviour had similar LOA, FOAP, and IOA with children who were referred for other reasons.

From the data analysis of the 36 children who played with aggressive toys, of which 10 were referred with aggressive behaviour and 26 were referred for other reasons, it was observed that for both groups there was an increased aggression expression in the middle stage of the intervention, which was followed by great lessening of aggression to a level below that of the initial sessions (see Figures 6 & 7). The only difference between children who were referred with aggressive behaviour and those who were referred for other reasons seems to be between the beginning and middle stage of the intervention. Particularly, children who were referred for other reasons presented a great increase of LOA, FOAP, and IOA between the beginning and middle stage, which was not the case for the children referred with aggressive behaviour, since they already had increased levels of LOA, FOAP, and IOA from the onset of the interventions. Overall, the total number of children who played with aggressive toys, irrespective of the reason for referral, ended up with similar LOA, FOAP, and IOA.

Moreover, from a total of 17 children who were referred with aggressive behaviour, of which 10 played with, 5 did not choose to play with, and 2 did not have aggressive toys available in the playroom, it was found that there were no significant differences between the mean scores of LOA, FOAP and IOA. The above results are of great interest given the heightened concern of a large proportion of play therapists around the inclusion of aggressive toys in the playroom for children who have been referred with aggressive behaviour. The present findings contradict the views that aggressive toys should be excluded from the playroom for these children, as they can prove emotionally harmful. Also, these findings are evidence against the position that children with aggressive impulses
are easily over-stimulated by aggressive toys, which leads to weakened inner controls and increase aggressive behaviours (Drewes, 2001; Crenshaw & Mordock, 2005; Schaefer & Mattei, 2005). Additionally, the fact that 34% of the children referred with aggressive behaviour did not choose to play with aggressive toys shows that it is not a rule that aggressive children will play with aggressive toys. The above statement runs counter to the general perception that aggressive toys will attract the preference of aggressive children.

10) Boys had higher LOA, FOAP, and IOA for the beginning stage of the interventions.

Therefore, boys are more likely to have greater expression of aggressive feelings when playing with aggressive toys in the beginning of the intervention. However, it is of importance that at the end stage of the interventions boys and girls had similar LOA, FOAP, and IOA. In addition, it was found that boys present a preference for the aggressive toys in comparison to the girls which is also supported by other studies (Jukes, 1991; Sutton-Smith, 1988).

Limitations

The present study has certain limitations that need to be taken into consideration. An important limitation inherent in the procedure of this study concerns the fact that the whole research was devised to look at play therapists’ perceptions on the use of aggressive toys in play therapy. Thus, the children’s behaviour was researched through the play therapists’ perspectives and did not involve the children’s direct participation, which could significantly impact on the reliability and validity of the findings. The data collection and analysis were strictly based on the play therapists’ perceptions which are naturally imbued with their personal beliefs, opinions, and attitudes. That suggests that some degree of subjectivity is inevitable. Moreover, the present findings might have been influenced by a self-fulfilling prophecy. In other words, play therapists may be persuaded that catharsis effects resulting by the use of aggressive toys are real and effective and thus they act on these beliefs, i.e. allowing and facilitating aggressive toy play. Likewise, these beliefs and expectations might have influenced them perceive beneficial effects that have eluded laboratory researchers (Bushman et al., 1999).

Additionally, the fact that interviews were not carried out represents another limitation, since interviews would have elicited more specific and in depth information regarding issues such as the circumstances of aggressive toys’ exclusion from the playroom, their possible impact on the therapeutic relationship, the play therapists’ feelings and skills on the topic of facilitating aggressive expression or aggressive toy play etc. In general, further interviews would assist in illuminating many of the play therapists’ uncertainties.

A further limitation surrounds the fact that in this research it was not feasible to segregate the variable ‘aggressive toys’ in order to investigate their accurate impact on children’s aggressive behaviour, as happened in laboratory research studies. This was not achievable since other factors are involved in play therapy process, which also influence and impact on children’s aggressive behaviour. Thus, before the current findings can be considered conclusive, it is important that further research be conducted to clarify the relationship between aggressive toys and the therapeutic relationship, as well as the relationship between aggressive toys and the therapeutic limit-setting process.

Conclusion

In this study no negative impact was found to support or to justify the exclusion of aggressive-release toys from the playroom. Indeed, the findings contradict the social learning theory and provide support for the catharsis hypothesis. As such, the major conclusion of this research could be summarised as that aggressive toys do not have any negative impact on children’s aggressive behaviour in the play therapy process. Indeed aggressive toys were found to be of equal therapeutic value and necessity with non-aggressive items in providing adequate means of self-expression, self-exploration and particularly aggression expression, which was found to be a very common feature of play therapy. Taken together, the findings suggest that aggressive toy play has cathartic value in play therapy process,
whilst other elements contribute to the cathartic effect as well.

Considering this research as a first step, more research is needed to examine and clarify other issues, possibly in more depth. A key point for future research would be to assess any developmental factors relating to the use of aggressive toys, and to investigate whether aggressive toys should be excluded for specific client groups, such as children with mental health issues. Moreover, future qualitative case studies in respect of aggressive toys could be a new research direction in order to enrich understanding (i.e. to clarify the relationship between aggressive toys and other therapeutic elements, such as the therapeutic relationship, the limit setting process etc.). In conclusion, it would be interesting for this study to be replicated in other countries and cultural settings to find out if the tentative findings of this research are backed up by future research.

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**Web sites:**

PIVOTAL MOMENTS OF CHANGE IN EXPRESSIVE THERAPY WITH CHILDREN

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Abstract

This paper focuses on pivotal moments of change in expressive therapy with young children. While there has been interest in studying the changes that result from play therapy, many of these studies have been conducted using group quantitative data. There is a gap in understanding change during specific moments. Literature concerning moments of change both in and out of therapy and with children was reviewed. A small number of experienced expressive therapists from diverse contexts were asked to provide retrospective descriptions of case examples from their work in which a child they were seeing changed dramatically for the better. A general sequence of how these moments developed was identified and used to examine the common elements among them. The common elements of these examples included a therapist creative response to a child’s novel action, a sharing of positive feelings among the players, and the mutual development of an expressive metaphor that represented a new interpersonal state. These observations are used to suggest further research.

Keywords: play therapy, dance therapy, expressive therapy, moments of change, family therapy and young children

Pivotal Moments of Change in Expressive Therapy with Children

There has been interest in how children change when provided with play therapy interventions over the last several years (Leblanc & Richie, 1999; Ray, Bratton, Rhine & Jones 2001). Bratton and her colleagues (Bratton, Ray, Rhine & Jones, 2005) reported in a meta analysis of many studies that Play Therapy contributed to significant change for a wide variety of children who experienced a range of difficulties. These findings suggested that children who engage in a Play Therapy intervention can improve in many areas of their life. In these studies, changes are related to groups of children who are studied before and after several sessions of an intervention. While group data can be important in understanding the impacts of intervention in a general way, such research does not address the importance of how change might be expressed, develop, or be observed in a specific session or in a specific moment. In this paper I discuss unique single moments in sessions of young children that appear to be pivotal in their change.

I reviewed five moments from within expressive therapy sessions that experienced therapists identified as being central to the change for the children they were working with. These moments were selected retrospectively by the therapists from their long term practices. Each therapist was asked to provide a brief description of a single moment from their past interventions in which a child they were working with appeared to make a significant change. These case examples were selected by the therapists using their own personal judgements. The commonalities of these specific case examples were
then reviewed. The goal for this review was to describe some of the qualitative aspects of the change process that appeared to be present in moment to moment interactions. The review was limited to children under ten.

Change is often thought of as occurring in incremental steps or stages over time. However there has been interest recently in changes that can happen in a more instantaneous manner. Miller and C’de Baca (2001) identified the phenomenon of quantum change with adults who had undergone sudden and dramatic transformations that affected a range of emotion, cognition, and behaviour. Such moments included a sense of distinctiveness in that those who had this experience reported they knew that something out of the ordinary was happening. These experiences were also surprising and included strong positive feelings that led to permanent life changes. Many of such change experiences occurred outside of a therapy context. However Bien (2004) suggested that quantum change can and does occur in psychotherapy albeit in more micro-stages or small yet recognisable moments.

Terr (2008) recently suggested that there are single episodes during child psychotherapy in which children and young people dramatically change for the better. Such moments can occur in a matter of minutes or even in an instant during which the young person begins to experience life in a new and more positive way. According to Terr, these moments seem to be related to several factors including the role of the therapist, the atmosphere of therapy, empathy, timing and style of therapist response. The success of these moments appears to be related to both the creativity and relationships between the children and therapist and occurs within the immediacy of the shared moments.

Carroll (2002) reported on children’s subjective experiences of play therapy in a qualitative study. The children in this study did not comment on the process of their changes or about specific moments directly. However they did report that the relationship with their therapists was important. They also reported that the times they experienced the pleasure of having fun in sessions was central for them. Carroll concluded that an implication of these children’s views was that the experience of pleasure and shared fun with a therapist was a therapeutic process.

**Review of Literature**

**Now moments**

Specific moments have been identified as being important and directly related to major change in psychotherapy (Person, 2000). Stern (2004) and his colleagues reviewed their clinical material to describe how these moments might function. These authors identified such events as “now moments” and later elaborated as “moments of meeting.” Such episodes included an instantaneous attunement or shared emotional subjective experience that leads to a co-occurring implicit understanding among the participants. This meeting is similar to that which occurs between a parent and infant during intimate episodes of high intensity positive emotional interaction. Such episodes involved nonverbal communication during the present moment and were distinctly different from usual transference or fantatised projected images that accompany most therapeutic interactions. Stern stated that the therapist needed to respond to a client-initiated interaction with genuineness in a spontaneous manner and that this response required a moment of personal risk and creativity for the moment to develop. For “now moments” to occur, it was not enough for the therapist to repeat interactive routines, rehearsed or learned therapy plans, or for the family or child to engage in interactions that did not make use of spontaneity in some way.

Some child and parent/child interventions have incorporated this concept of the “now moment” within their approach. Makela (2003) noted that both a matching of physical interaction and attunement to the child-initiated emotional expression occur during special single moments of Theraplay. Theraplay is a therapist-structured intervention based on adult-child interaction that is physical and playful. Booth (2008) stressed that current best practice of Theraplay has evolved to include an emphasis on the adults (parents with therapist help) attuning to their child clients in the actual present of the game structures introduced in this intervention.
Harvey (2006) described how important specific moments of change can occur in a family-oriented creative arts therapy approach called Dynamic Family Play. In Dynamic Family Play, an expressive momentum can develop when the players become both very involved with and attuned to each other's play improvisation. Expressive momentum refers to a state that emerges among players when they become intrinsically engaged, curious, and committed to the experience of the play moment. Often this is recognised as the fun of the play, particularly by those who are involved in the action. The intensity and focus of play expression usually increases in this state. It is during these times that players can develop creative leaps and find shared pleasure in their mutual play. Such moments are beyond mere verbalisation and require the actual shared experience. Intimacy can develop as parents enter their children's metaphors that have emotional relevance when expressive momentum emerges.

**Study of Single moments**

Various expressive therapists have looked at specific single moments in the study of the subjective experience of the participants involved in expressive therapies. Loman (2009) reported on the experience of student dance therapists who encountered infants, young children, and in one case, parents in brief nonverbal interchanges in which they specifically noticed and responded to the physical expressions of the children. In these moments, two of the students were able to engage the young children through an attunement and matching of physical expressions. These experiences appeared to deepen the student's subjective experience and understanding of working with parents and children.

Hill (2006) reported on single moments in an ongoing Dance Therapy intervention with an elderly woman with dementia. In this phenomenological based study, Hill identified moments which, in the therapist's judgment, stood out in some way. In these videoed sessions the client danced in a free form manner to improvised music with the therapist's support and therapeutic alliance. The tapes of these sessions were then reviewed and discussed by the therapist and client. During the moments identified by the therapist as significant, the client's movement was more integrated, focused, and not similar to much of her other more confused expression. As the client reviewed the video of these significant moments, she described her dancing as showing her to be more like what she remembered her old self to be like.

Trondalen (2005) presented a study of a series of significant moments of young adults with eating disorders while they engaged in musical improvisation with a music therapist. The moments were selected because they stood out to the therapist as well as the clients due to their intensity. After they listened to replays of their co-improvisations, the clients verbally reported that they felt themselves to be free to be independent yet in relationship with the therapist during these moments. The researcher also identified these moments as being different from the rest of the improvisations due to the type of intensity matching of the musical improvisations. Interestingly, during these moments, the intensity of the therapist was slightly less intense than the client's. However the dyadic intensity patterns of these moments were very similar to each other yet different from the other ongoing improvisations.

Terr (2008) as cited above, reviewed forty-seven moments taken together from her past cases as well as from thirty-three of her child and adolescent psychiatrist colleagues. Terr concluded that these moments emerged when the psychotherapy with the child/adolescent was playful, creative, and elastic; that therapists were playful both with their language as well as in the action of play; that the therapist-client relationship was very important in the achievement of these turnabouts especially in the real here and now of the intervention; and finally, that the significant moments were surprising, instantaneous, and unplanned for, particularly on the therapist's part.

**The Review**

The main purpose of this project was to explore what was common among a variety of single episodes identified by experienced expressive therapists in which dramatic change occurred with
their young child clients. I decided to review a small number of case examples (five) in depth and report on some initial observations about these single moments. Terr (2008) reported that she believed single moments of dramatic change were relatively rare. At the beginning of this project, I also had the assumption that these moments might be uncommon and somewhat hard to recognise. The strategy for the selection of these case examples was to ask therapists who have specialities and experience in working with children under ten using expressive therapy, so that they would be likely to have observed such moments and also had the experience of reflecting on their past cases to be able to highlight such unique episodes. I also wanted to select therapists who worked with different populations in diverse contexts using a variety of methods. The goal of drawing examples from diverse examples was initially to explore the possible commonalities of the pivotal moments outside of the more specific contexts such as mode of expression used, age and types of child problem, and inclusion of family or group members.

The therapists were selected because each had several years of experience working therapeutically with children using expressive therapies, had published case studies that reviewed this work, and had shown expertise in a specific area. The therapists also worked in very different contexts: one provided services to special needs children in a large urban public school, another provided parenting enrichment groups for normally developing children in a small city, and one provided home based early interventions for preschool aged children with developmental disorders in rural settings. One of my own case examples I have selected came from my consulting with a governmental child protection agency in a mid-sized city while the other was drawn from work consulting in a hospital paediatric department around health related issues. Both of these cases included family members. The case examples came from three different countries. The therapists also were trained and used either Dance or Play Therapy. I used a family Dance Therapy approach with one case and a family Play Therapy approach for the other.

I selected the modalities of Dance and Play Therapy as I have experience in each discipline and have developed an interest in how play and dance expression are similar yet also are unique ways for children to express themselves (Harvey, 2006, 2008). Both practices encourage spontaneous expression from participants, involve the adult participants within the expression in an active way, and are based in a large part on the experience of an empathetic relationship. In both Play and Dance Therapy, therapists use their observations to attune to their clients' nonverbal and symbolic expressions closely. However Play Therapy makes use of toys and direct metaphorical expression while Dance Therapy relies primarily on movement interaction.

A more complete presentation of the theoretical backgrounds or techniques used by each of the therapists is not given here as the main focus of this paper is to compare the actual moments across these practices rather than the theory or technique employed.

The goal of selecting case examples from these diverse situations was to provide a wide range of types of pivotal moments to review. The challenge and question of this review was to identify commonalities among these different ways of engaging children (Dance Therapy vs. Play Therapy), the differences in types of problems the children presented (children with autistic spectrum, trauma, and adjustment problems), different therapeutic contexts (urban, rural, child protective agency, and medical/hospital service), different countries, and the difference in who is involved within the moments (family, group, or individual therapy).

The selection of the moments

The therapists who contributed to this paper were asked to review their practices and identify what happened in a single event in which the child they were working with changed dramatically for the better. No other criteria were provided. Each therapist was encouraged to use their own judgement as to how to select this episode. The therapist then provided descriptions of their case examples from their past notes and/or personal recall. One dance therapist presented a moment in
her one to one work with an eight year old boy with autism. Another play therapist presented a case in her one to one play session with a preschool aged autistic boy. Another dance therapist presented a case example of a group situation with early school aged children and their parents who were developing normally. I presented one situation in which I used a dance/movement approach with an adoptive mother and her six year old son who had experienced severe abuse in his birth family. I also included another case of a nine year old girl who had experienced ongoing major surgeries, and her parents. This family was involved in a family Play Therapy approach exclusively. I included two cases from my past experience as they were drawn from very different contexts, countries, and used different approaches. This case material was retrospective. All identifying information of the children and their families was changed.

The Significant Moments

Ending a session

A dance therapist was working with an eight year old autistic boy in a school setting. They had experienced several sessions together in a one to one intervention. When it became time to end the session, the therapist began to put the materials they had been using away and helped the boy prepare to leave as she had several times before. The boy then collapsed in passive weight to the floor and became limp. He appeared to stop his preparation to leave the room.

The therapist began to sing an improvised song about picking the boy up and going through the door. After a few words of singing, the therapist started to use the rhythms to pick the boy up and develop an improvised dance of jumping and skipping around the room with him. The boy actively joined with the therapist in dance and song as they moved in the space. When they reached the edge of the room, he was standing on his own feet and ready to walk out the door. His feeling changed dramatically from very distressed to happy and his happiness was expressed fully in his singing and dancing. After only a few minutes, the boy and therapist danced out of the room together and he returned to his next activity for the day in an attentive manner. The song/dance activity became a part of each transition (both in greeting and leaving the therapist) and the boy had no further conflicts with stopping the session. After this session, the boy would greet the therapist each time he saw her by singing the song she had developed with him through the improvised ending. The therapist reported that she felt then that the boy had formed a special relationship with her.

Imaginary play

A play therapist was attempting to help a preschool aged child with autism develop imaginary play using a directive approach. In this particular session, she was using a teddy bear and tea set pretending to have a tea party with the child. The therapist and boy were sitting on the floor in a circle with the teddy. All had a cup and spoon in front of them. There was also a pepper shaker from the plastic tea set to the side as part of the toys selected for the tea party. The pepper shaker had been laid out mistakenly by the therapist. The therapist began to pretend to have a cup of tea, offered a cup to the teddy, and then asked the boy if he would also like a cup. After a few minutes the child picked up the pepper shaker and started shaking it on the tea set. The therapist began to pretend to sneeze. The boy laughed and continued to pour pretend pepper over the toys while the therapist continued her sneezing.

After several minutes, the therapist had the teddy continue with the pretend sneezing. The boy then looked directly at the teddy and laughed while continuing to pretend to pour pepper over the entire tea set. The therapist responded by showing the teddy sneezing with such increasing intensity that he began to do somersaults. The child kept encouraging this action by pouring even more pretend pepper.

The child then picked the teddy up and put the pepper shaker up the teddy's nose and moved the teddy in sneezing movements with accompanying pretend sneezing noises (ah-choo, ah-choo). The boy then stopped and hugged the teddy and said “all right.” He repeated this scenario several more times. This was the first incident in which this four year old boy was able to use pretend play to indicate objects as being alive and expressing emotion in a metaphoric manner.
Aggressive play

A dance therapist was working with a group of children who were just beginning school, together with their caregivers, with the goal of helping the adults develop better relationships with their children using physically oriented play. The children had no identified mental health concerns and were all within a normal range of development. One boy was often isolating himself. He would scream if the therapist approached him and wanted to engage in his own play. If the group was doing something he was not interested in, he would either scream or go off to a corner. The therapist was able to engage him and the other children in constructing houses with mats in a group activity. When another child approached his house, he knocked this boy's house down. The therapist said “We can't crash into the other boy's house, but we can crash into a crashing down house.” The therapist and boys then set up a house just for crashing.

A new activity developed where they all knocked down the crashing house and created a pile of mats to jump into. Some time later in the group, the therapist set up a large stretch band held by two adults for all the children to ram into. This elastic prop allowed the boys to crash full force and not get hurt as the band was large enough and the adults were strong enough to contain their movement.

Repetitive play

I was seeing a six year old boy in family oriented Dance Therapy with his adoptive mother. The boy had been removed from his parents’ care due to extensive physical and sexual abuse a year before the sessions began. The aim of the intervention was to improve the relationship between the boy and his new adoptive mother using interactive movement play. After some sessions the boy was able to generate physically oriented dramatic interactions with his adoptive mother that had a narrative about him leaving and returning from a home. The home was made using the pillows and scarves in the room.

As the session developed, the boy left and pretended to fall down “dead”- his body becoming very still. He repeated this action of leaving the home and falling over dead several times. His body became more rigid each time until he pulled a large stuffed animal on top of him as he fell. He was clearly distressed. The therapist guided the adoptive mother over to the boy’s side where he continued to be very still for several minutes. The therapist continued a narrative reflecting the boy’s emotional expressions. At last the boy began to move his fingers slightly. The therapist barely noticed this movement initially but then encouraged the adoptive mother to place her fingers over the boy’s and match his movement no matter how subtle his movements were. This developed into a “finger dance” between them. The dance became more elaborate until he happily began to use his whole body. Finally the boy stood and began to dance around the room holding his adoptive mother’s hands. His mood clearly had changed and he and his parent shared a laugh together. During the following sessions, the boy didn’t initiate being dead and it became easier for him to develop improvised dances together with his adoptive mother that did not have continuing imagery of death or violence.

Family story

I was seeing a nine year girl in a family Play Therapy intervention. The girl had a major medical condition that required her to have significant surgery approximately once a year from her infancy onwards. By the time of the referral but prior to the beginning of the intervention, she had become quite anxious, had nightmares, and became oppositional to the point of refusing to go to the hospital each time the date for her yearly surgery approached. The girl and her mother had been seen in several sessions in which they played together in a nondirective manner addressing anxious themes as they emerged. As the date for the surgery became very near, the girl invited her father to attend. This was the initial session with the father present. It was less than a week prior to the next stay in hospital and the girl’s nightmares had increased. I started the session by asking the parents and girl to create a story about a family in the sand tray using a selection of toy figures. My plan for this activity was to use the story to address again anxious themes with the father’s participation. The girl promptly told her parents that she would create the story and
they were to write it down for her. In her initial scenario, she created a narrative of a storm destroying a house and killing the grandparents. The girl then brought everyone back to life. The story then expanded to the rest of the play room, as the girl placed many puppets and stuffed animals in pairs and then married them. She finally placed the two largest bears together as a married couple and surprisingly put a smaller animal between them as their child in a very nurturing manner. The parents and the girl together smiled with each other enthusiastically when they realised in that moment that the ending image was about their family. As each family member looked at each other they began to verbally share positive feelings by talking to each other using the characters in the image of the new family of soft toys. After this session, the girl’s nightmares became less and she was able to stay in the hospital without excess nervousness while using the support offered from the nurses and her parents.

Common Elements

Each of these pivotal moments was compared to one another to identify what was common among them. These similarities included experiences such as: a shared positive feeling that developed among the participants such as common laughter, a new shared understanding that came from the use of a common prop or action that developed a common meaning, and a mutual co-creative effort on the part of the players such as the development of a common dance. Another important commonality among these moments was a creative therapist response to the unique aspects of the interactions. This response included a simultaneous sensitivity to both the child’s expression as well as the interactional dynamics of the moment. These responses were difficult to categorise however as each therapist used this sensitivity in a unique way that included their own observation skills as well as the scenario that had developed from within the interactions.

The main overall theme that connected these moments was that they all developed in a similar way. Each moment began with an unusual and unexpected action by the child followed by a spontaneous interaction of the participants that led to a new and surprising episode, described by the therapists as genuinely engaging for all involved. I used this concept of a common sequential unfolding process of the moments as a way to compare them more fully (see table 1). These process categories included: how the events started, how the participants interacted to generate the pivotal moment, the emotional response, and the new play/metaphor that developed from this interaction.

Developmental Sequence of the Moments

The beginning of the moment

Each moment developed during an ongoing interaction in which the therapist and child (or child with caregiver) was engaged in play or movement together. In each case the pivotal moment began when the child did something unexpected given what had been done previously or what had been asked for. For example, when the eight year old autistic boy was asked to prepare to end the session, leave the room, and return to his class, he fell limply to the floor. He and the dance therapist working with him had accomplished the ending of the session several times before, and the therapist expected the ending to occur as it had on every previous time. However when the boy went limp, the interaction became something quite different.

This unexpected aspect occurred in each of the moments: the autistic preschooler picked the unused pepper shaker and significantly changed what had been a tea party with preset play props; the primary school aged boy knocked another boy’s house down clearly disrupting a group activity; the six year old adopted boy played dead and became very still unexpectedly after being quite active with his caregiver, and the nine year old girl developed a story by herself when she and her parents had been asked to make a family story together.

Novel initiation and therapist actions

Following the unexpected event, one of the participants initiated a new series of actions that
Table 1
Elements involved in the development of Pivotal Moments

<table>
<thead>
<tr>
<th>Moments</th>
<th>Disruption</th>
<th>Initiation</th>
<th>Positive feeling</th>
<th>New metaphor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Song/dance</td>
<td>Child falling limp on the floor when asked to leave</td>
<td>Therapist picks up boy while improvising a song and dance about leaving</td>
<td>Therapist and boy share an ongoing enjoyment of singing together</td>
<td>The song - the boy continues to sing song whenever he sees the therapist</td>
</tr>
<tr>
<td>Sneezing teddy</td>
<td>The boy picks up an unused pepper shaker and pretends to shake it over tea party</td>
<td>Therapist uses pepper shaker to begin a play episode of sneezing from pretend pepper</td>
<td>Therapist and boy laugh together about the antics of a sneezing teddy</td>
<td>Therapist and boy create a new play episode about a sneezing teddy</td>
</tr>
<tr>
<td>Crash House</td>
<td>One boy became aggressive towards another boy</td>
<td>Therapist developed an alternative use of the props to include aggressive physical expression in an alternative manner</td>
<td>The boys enjoyed each other in their new activity</td>
<td>The props were used to make a new joint enjoyable mutual activity - crash house.</td>
</tr>
<tr>
<td>Finger Dance</td>
<td>The boy introduced a re-enactment of a previous trauma event</td>
<td>Therapist was able to develop alternative physical action using the boy’s unexpected incidental movements</td>
<td>The therapist, adoptive mother, and boy shared happiness in a common dance together</td>
<td>The coming alive dance</td>
</tr>
<tr>
<td>Nurturing family</td>
<td>The girl developed an individual story</td>
<td>The new story introduced a new theme of family inclusion</td>
<td>The family shared feelings related to new theme</td>
<td>Family togetherness shown and narrated using the image of a family of soft toys</td>
</tr>
</tbody>
</table>
somehow incorporated the unexpected event noted above. This creative response was usually initiated by the therapist: developing a song, using the pepper shaker to develop an episode of imaginary sneezing, the pushing down of the mat houses being used to build a separate house that the children could all jump into, and waiting until the boy began to move his fingers so that the boy and his caregiver could develop matched movement together. However the nine year girl initiated a scene of a nurturing family with her mother and father after she had asked them not to join her in developing a family story. This girl initiated this scene on her own despite the therapeutic instruction for the family to develop a family story together.

Each therapist noticed the unexpected action and used it to encourage the development of a new type of interaction. This new development was improvised spontaneously. Two of the dance therapists were sensitive to the movement qualities that had emerged and used these qualities in new actions. In the episode involving the mats, the therapist initially noted the boy’s more aggressive action and developed a more vigorous game using the various materials in the room — a change from the original plan. During the mother-son episode the therapist noticed the boy’s small incidental finger movements to develop shared rhythms. The play therapist responded to the boy’s use of the pepper shaker which had not been set up as part of the play action. The dance therapist attempting to end the session with the autistic boy used his body movement to directly engage him in creating a farewell song/dance. This was a somewhat different use of the unexpected as the therapist went against the boy’s initial expression of physical limpsness with her offer of a song and dance. The success of this ending was likely due to the adult’s ability to improvise the actions to interest the boy.

The therapist response to the nine year old girl’s unexpected individual enactment of the family story was also sensitive to the girl’s play initiatives and family interactions. After I had set the task of having the family create a story with the expectation of them completing this together, I then observed and did not interfere as the girl took on the central role as sole story teller. I encouraged the parents to observe as well. This deviation from the expected play performance led to the girl’s developing a moving communication to her parents using the play material. With my encouragement the parents were able to become emotionally and verbally engaged in the new and unexpected image.

Had any of the therapists not been attentive to the child (or child with parents) in the context of the immediate interaction as a way to facilitate the alternative expressive episode by continuing on with their plans, the participants may well have developed opposition or merely stopped their expression rather than develop the more positive outcome. It seemed likely that the therapists’ awareness of their clients’ expressions (either physical or play) and the meaning of such expression in the interactive context was important to the success of these moments.

**Shared emotion**

In of each of the moments, the participants were reported to experience spontaneously and to express shared positive and pleasurable feelings together as the interactions developed. The dance therapist and autistic boy clearly enjoyed each other during their singing dance out the door. The play therapist and the young autistic boy enjoyed each other during their pretend sneezing. The boys experienced exuberance together during their jumping actions. The mother, her adoptive son, and the therapist shared positive emotion in their coming to life dance. The girl and her parents shared a positive feeling of closeness as the girl placed the image of a daughter puppet together with the parent soft toys after she married them together and they were able to speak through the new family image to verbalise their nurturing feelings.

The positive feelings became a part of these pivotal moments and this shared experience helped the co-participants continue their actions through the completion of the episode with a new enjoyment and increase of interpersonal intensity. This increase in spontaneous emotional expressiveness also changed the relationship of the participants by adding to the shared focus and shared feelings in the present moment.
**New Metaphor**

In these descriptions, after the original interaction was unexpectedly interrupted and new action was initiated that led to a sharing of positive emotion, the participants all used their expression to co-create a new metaphor in an emergent manner. This metaphor was not pre-planned but rather developed from the enjoyable process of interactive expressiveness. This metaphor related directly to the immediate experience of participants. For example, the boy, adoptive mother, and therapist all spontaneously developed the coming alive dance from their finger improvisations. The enthusiastic full bodied movement that symbolically indicated that the boy had come alive after he had played being dead was truly a joint creative effort that was co-developed in the moment spontaneously. This dance was also quite meaningful to his adoptive parent especially given the boy’s past.

Each of the other interactions also led to a metaphorical interaction that was unique and related to each participant’s emotional involvement: the song of leaving the dance therapy session, the teddy who was brought to life and comforted, the boys who brought the crash house alive with their jumping, and the nurturing family of bears whose parents were newly married by the daughter. These new actions reflected a change in the participants’ increased shared positive feeling with metaphors that suggested inclusion. The co-creative efforts also appeared to intensify their shared pleasure.

**Discussion**

The pivotal moments described by these therapists include many of the elements presented by Miller and C’dé Baca (2001), Stern (2004) and Terr (2007) in that they were out of the ordinary events, that they included a shared positive feeling, were surprising, and developed an interpersonal meeting that appeared to increase intimacy. The moments began when therapy sessions seemed to be at risk of becoming disrupted in some way. However as the adult therapist responded with a genuineness and improvisation, a different state of play emerged. This flexible playfulness is much like the quality the psychiatrists showed in Terr’s report (2008). The resulting actions developed an increased sense of shared fun or pleasure that fuelled an emotionally related co-creativity that had not been previously expressed. In this state, the participants developed metaphors that related to their immediate present such as a ‘coming to life dance’ or a good-bye song. These metaphors had not been pre-planned by any of participants but rather emerged from the interpersonal actions. It appeared that the playful improvised expressions came together with shared emotional experience and intimacy was heightened. It may be that this emotional state is related to what the children in Carroll’s study (1992) meant by the pleasure of fun they found central to their therapeutic experiences. Additionally these moments are reported to have generated an increased mutual intensity and focus similar to that within the moments of improvisations in music therapy described by Trondalen (2005).

Taken together the elements described in these moments indicated that the participants all became engaged in an interpersonal creative process. This action was intimate, meaningful, and enjoyable in a manner similar to the highly engaging play between a parent and very young child as presented by Stern (1985). In this way these pivotal moments were similar to the “now moment” presented by the study group on the process on change (1998). However these moments not only contain the intimate meeting as described by Stern and his colleagues but also included a spontaneous metaphorical and playful expression of this meeting simultaneously.

The significance of this observation was that dance and play expressive interactions lent themselves to a spontaneous creativity that involved intimate metaphor-making in single moments. As the moments unfolded, the shared experience of co-creating an interpersonal metaphor appeared to be the ingredient of change. No ongoing verbal interpretation about the event was needed to bring the change about. Both Play and Dance Therapists in these moments were able to use movement or play observations to become sensitively attuned to the children they were working with. It appears that such sensitivity was also an essential pre-condition.
for the process of a pivotal moment to begin. However, the descriptions of these moments do not suggest why the moments developed when they did. It is likely that some disruptions in expressive therapy do lead to a disorganisation of the session or no clear change at all despite a therapist’s attunement to and incorporation of child’s idiosyncratic actions. Though the therapists reviewed here report moments of significant child changes, the reports do not indicate a practice or technique that increased the possibility of these events. As in the literature reviewed above, the pivotal moments appeared to be somewhat uncommon and are not yet fully explained even in sessions with experienced and sensitive child therapists.

Implications

The observations developed in this review can only provide an initial discussion of single moments of change that emerge during expressive therapy with younger children. As only a few therapists retrospectively described pivotal change from their past cases very little can be generalised to other situations. The observations of these common elements do offer areas of further research however. It is important initially to investigate the concept of single moments of change in more detail. Such studies would need to include the other expressive therapies such music, art and drama and sample a much larger range of therapists and children. Some understanding of the contrasting types of moments where things go wrong or the expressive interactions in which no change appears to occur, would also help define pivotal moments more clearly.

Also the current review was based on therapist description. It would be valuable to observe the actual moments as they are occurring to see if the expression during these events can be reliably identified in more objective ways. There may be movement and play qualities that indicate when these episodes occur such as in play themes and attuned interactive movement. Such findings could be useful to investigate questions about how these single moments fit into the general overall process of therapy with children. These questions include:

How often do such improvised creative moments actually occur over the course of an intervention? and What kind of long term change is possible with and without such moments emerging? Should a reliable coding system be developed, these questions could be addressed using quantitative methods.

Further comparisons could be made between pivotal moments in therapies whose expressive styles make use of self generated expression, as those presented here, and those moments that might occur within more verbal or pre-planned styles of therapy, such as cognitive behavioural approaches. Cognitive behavioural approaches are often presented in a preset manner and follow a protocol. This kind of delivery of an intervention restricts the amount of improvised expression and the attunement to such improvisation that seems to be necessary for pivotal moments to occur. The quality and impact of single moments could be quite different in such conditions if they occur at all.

Finally, the experience and style of the therapist might have contributed to the development of the moments presented in this paper. The therapist’s creative reaction and instant adjustments to the breaks the children introduced and the ability to share positive feeling with the child (and important adults involved) appeared to be central skills that allowed the metaphorical communication to emerge. Not all therapists have this kind of inclination and training. Therapist factors could prove to be an important aspect to understand further the emergence of pivotal moments. Future studies need to address such factors along with the subjective experiences of both the therapist and the child/family participants.

REFERENCES


TAYLOR DE FAOITE, A. (ED.) (2011)

Narrative Play Therapy: Theory and Practice

Jessica Kingsley Publishers
ISBN: 9781849051422

This paperback text book edited by Aideen Taylor de Faoite explores the background theory to Narrative Play Therapy, a derivative of the highly effective therapeutic modality for engaging children, Play Therapy, and examines its use in a variety of different contexts.

Taylor de Faoite lives and works in Ireland, where she has a private practice as an Educational Psychologist and a Play Therapist and has lectured on Play Therapy and developed training courses in Ireland. Taylor de Faoite has enlisted the input of various specialists in children's therapy to provide a thorough and exciting look at Narrative Play Therapy and its application.

Taylor de Faoite provides a detailed and fascinating exploration of those theories that can be interwoven to contribute to what we know as Narrative Play Therapy. In exploring the development of Narrative Play Therapy, Taylor de Faoite draws upon the work of Michael White (1990) and Ann Cattanach (1997). White (1990) used social construction theories in family therapy, to explore understanding of problems and more specifically he examined how families relate to their problems in therapy. He developed a technique in which the clients are enabled to 'externalise' their problem and during the course of therapy families create more helpful narratives.

Cattanach (1997), one of the great pioneers in play therapy, developed a model of play therapy which drew upon narrative ideas. Taylor de Faoite describes the process of Narrative Play Therapy most eloquently:

‘In Narrative Play Therapy, the self and identity emerges in the stories that the child chooses to tell and in the open space between the therapist and the child, where the child is storyteller and the therapist is the empathic listening audience’

(p35, ibid)

Within Part 1 assessment is explored: when engaging with the family and the child's network, the practitioner is encouraged to adopt a narrative approach. Whilst taking into account the existing problem-based narratives that surround the child, there is also space and opportunity for identifying and encouraging some focus on the strengths and resilience of the child and the family.

I feel the section on the importance of record keeping and evaluation could have been further developed as this is particularly pertinent given the current economic and political climate which places high value on evidence-based therapies and value for money.

The final part of this section stood out for me as a practitioner: it looks at clinical supervision with a narrative approach. The chapter written by David Le Vay and Ann Marie John explores how supervision can be used creatively using a narrative perspective. The central thread of the chapter explores that we, as supervisors and supervisees, bring stories to our supervision and through the process of supervision stories are co-constructed. We also have a tendency as therapists to try to intellectualise our emotions and consequently some of these stories are only accessible through non-verbal means.

In Part 2, Taylor de Faoite draws upon the input of various specialists who utilise Narrative Play Therapy practice in the primary school system, with children experiencing parental separation or
divorce, with young people who sexually harm and with children in adoptive placements.

Within these chapters there is a good balance of contextual information about the client group and their specific needs and there is also relevant theory and research that enables the reader to develop a greater understanding of work in this area. The examples of practice and children's work illustrates the application of Narrative Play Therapy within particular contexts and offers the reader the opportunity to think about how this approach could be utilised in different contexts.

This is a comprehensive guide to Narrative Play Therapy which includes a detailed articulate theoretical overview and furthermore helpful examples that enable the theory and practice to come alive.

I am always pleased to hear about the arrival of a new play therapy book on the market and it feels that this particular text comes at the right time; when the government is investing in particular psychological therapies and exploring new systems such as Pay by Results. If I had to make a suggestion as to how the book could have been further developed it would be to include further emphasis on evaluation of outcomes for the child. The drive to invest only in evidence based and short term focused therapies puts us as therapists and our professional organisation (BAPT) under pressure to demonstrate the effectiveness and versatility of Play Therapy.

This book provides clear examples of how play therapy can be used in a variety of contexts and of ways to work therapeutically with children and their families but also to support professionals and agencies in understanding the specific often ‘hidden’ (Golding, 2008) needs of individual children and families.

I have found this book both thought-provoking and stimulating. It could be read from cover to cover or be used as a reference point as and when required. It would be a very valuable resource for both experienced practitioners and those embarking upon building their skills in therapeutic work with children, for example students of Play Therapy, Play Therapists and CounSELLors and more broadly speaking child care professionals working therapeutically with children.

REFERENCES:


For further information about developments in the provision of Mental Health Services for Children:


Nina Ridsdale
Play Therapist/Senior Social Work Practitioner: Manchester
Scope of the Journal
The British Journal of Play Therapy is a national journal with a focus on the theoretical and research aspects of play therapy practice. Its aim is to bring together the different theoretical and professional disciplines involved in play therapy and this is reflected in the composition of the Editorial Board. Nevertheless submissions are welcomed from all relevant professional backgrounds.

The purpose of the journal is to promote theoretical and research developments in the fields of play therapy practice and to provide information and ideas about the complete spectrum of clinical interventions used in play therapy.

Submission Requirements & Procedures
Submission of theoretical, philosophical, research and literature reviews will be considered, as will articles which focus on beneficial play therapy practices or on current issues or concerns related to play therapy, underpinned by theoretical knowledge. Submissions may therefore assume any of the following forms:
(a) Papers reporting original research findings.
(b) Theoretical papers.
(c) Review papers, which need not be exhaustive, but which should give an interpretation of the state of research or practice in a given field and, where appropriate, identify its clinical implications.
(d) Systematic reviews.
(e) Case studies and comments.
(f) Book reviews of core relevance to play therapy.

Papers should be submitted electronically in Word format to journal@bapt.uk.com together with one author's address, telephone number and email address for correspondence with the Editor. Fuller submission details may be found at: http://www.bapt.info/journalsubmission.htm

Submissions will be sent anonymously to two members of the Editorial Board who will review the paper in terms of the following criteria:
* Importance of the Subject
* Originality of the Approach
* Soundness of the Scholarship
* Degree of Interest to our Readership
* Clarity of the Organisation
* Strength of the Argument
* Writing Style

Style of submissions
A guideline for length of articles is 4,000-7,000 words (excluding references), but shorter articles are also welcomed. Each submitted paper should be accompanied by an abstract, not exceeding 200 words. The abstract should be followed by up to 6 key words. Authors should also include a reference list that includes all the works cited in the text, listed in alphabetical order. A title page with the name of author(s), position and place of work should be submitted separately as this will not be sent to the reviewers.

All figures and tables should be referred to in the text and their appropriate positions indicated in the text. Any artwork should be submitted in electronic form.

References should follow the format described in the Publication Manual of the American Psychological Association (APA). They should list authors’ surnames and initials, date of publication, title of article, name of book or journal, volume number or edition, editors, place of publication and publisher. In the case of an article or book chapter, page numbers should be included.

EXAMPLES OF REFERENCES:
Journal article:

Book:

Book chapter:

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