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Cross-racial therapeutic dyads : how does race play out in play therapy : a project based upon an independent investigation

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Cross-Racial Therapeutic
Dyads: How Does Race Play
Out in Play Therapy?

ABSTRACT

This study explored the experiences of play therapists working cross-racially with children under the age of 7 to determine if and how play therapy is impacted by a cross-racial therapeutic dyad. Specifically, this study explored whether or not clinicians altered their play therapy approach, made adjustments to the available toys, if race was viewed as connected to the presenting problem, and if play or interactional style differed based on a child's race.

12 clinicians currently conducting cross-racial play therapy with children under age 7 were interviewed using a fixed demographic questionnaire and semi-structured interview guide. Participants consisted of 2 groups; 5 clinicians who identify as clinician's of color and 7 clinicians who identify as White.

The findings of the research showed that client's under age 7 most commonly communicated something about race non-verbally. Less than half of participants directly discussed the racial difference between themselves and their client. Slightly over half of participants did not view race as playing a role in the child's reason for referral. The majority of participants did not make any changes regarding their play therapy approach when conducting cross-racial play therapy. All participants consciously aimed to have a range of figures representing diverse racial/ethnic backgrounds with all their clients but in general did not add or remove toys when working cross-racially.

CROSS- RACIAL THERAPEUTIC DYADS:

HOW DOES RACE PLAY OUT IN PLAY THERAPY?

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
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CHAPTER I

INTRODUCTION

Play therapy is a commonly used therapeutic intervention when working with young children. With the increasingly more racially, ethnically, and culturally diverse composition of the United States population, play therapists will likely encounter children and families in their practice whose racial, ethnic and cultural background varies from their own. This study explores the experiences of play therapists who are practicing cross-racial play therapy with children under age 7, aiming specifically to answer the questions *(1) Are clinicians adjusting their play therapy interventions, toys and physical space when conducting cross-racial play therapy with children under age 7? (2) Are clinicians acknowledging and discussing racial differences in the context of cross-racial play therapy? (3)Do clinician's use specific techniques to bring in and address the client's and their own racial/ethnic identity in play therapy? (4) Is a child's race looked at in relation to the presenting problem*?

For the purposes of this study, a *cross-racial therapeutic dyad* is understood as clinicians engaging with clients who have racial or ethnic identities that differ from their own (Miller & Garran, 2008). A list of all relevant definitions for the current study are located in Appendix E. After conducting a reasonable search of the available literature there was a paucity of results pertaining to clinicians' experiences conducting cross-racial play therapy. In the 1980s and 1990s researchers, theorists, and clinicians began to call

attention to the importance of maintaining '*cultural sensitivity*' in therapeutic relationships. In some of the literature reviewed for this paper the term 'culture' is used to describe race, ethnicity and cultural background. Given the unique experiences individuals face based on their racial identity, cultural sensitivity may not always account for racial sensitivity. The limited research that has focused specifically on race and the therapeutic process have found that "discussions of race significantly affect the therapeutic process (Knox et al, 2003). *Racial sensitivity* requires empathy and the capacity to relate, especially cross-racially, in ways that make others feel racially understood and comfortable" (Laszloffy & Hardy, 2000, pp. 37). An individual's experience is going to vary based on each of the unique aspects of their identity, including his/her racial, cultural and ethnic identity. Due to the range of terms used in relevant literature, the terms culture, ethnicity and race may each be used at various times throughout this paper, with reference to client/therapist dyads where the focus is on an element of identity difference.

Altman (2010) acknowledges the historical and on-going deficit regarding the discussion of race and racism in society as well as the therapeutic dyad; "given the centrality of race and racism in U.S. life, the psychoanalytic neglect of race and racism in society at large and in the analytic dyad is notable up to the present day" (Altman, pp. 122). The current study seeks to add to available literature on the discussion of race within the therapeutic dyad.

Children as young as age 3 begin to notice race and racial difference. Between the ages of 3-5 years old, children tend to observe and discuss physical characteristics about themselves and others (Derman-Sparks, Higa & Sparks, 1980; Tatum, 2007). All

aspects of an individual's identity are shaped by social context and develop over time, therefore, identities are part of the developmental process (Tatum, 2007). Play therapy can be used as a space for children to explore aspects of their identity in addition to addressing the presenting problem. Children who feel targeted based on aspects of their identity, such as their racial or ethnic identity, may be able to use the safety of play therapy to express their anxieties or understandings about race (Gil & Drewes, 2005). Do clinician's use specific techniques to bring in and address the client's and their own racial/ethnic identity in play therapy? Is a child's race looked at in relation to the presenting problem?

CHAPTER II

LITERATURE REVIEW

The current study explores the experiences of clinicians who practice cross-racial play therapy with children under the age of 7. The study seeks answers to whether or not clinicians are making adjustments to their play therapy approach, toys and interactions when working with children from a different racial background than their own. Currently there is a scarcity in available literature pertaining directly to the use of play therapy in a cross-racial therapeutic dyad with children under age 7. However, some authors (Chang, Ritter & Hays, 2005; Hinman, 2003; Vargas & Koss-Chioino, 1992) have addressed cultural considerations and specific adjustments for work with specific ethnic groups. This chapter provides a review of the literature on topics relevant to cross-racial play therapy. The current review will begin with an overview of why children under the age of 7 receive therapy. Next, play therapy, the history and current uses are explored. Literature pertaining to clinician's experiences conducting cross-racial therapy with adults will then be presented, including the experiences of clinician's of color and White clinicians. The final section explores current literature regarding the use of toys, physical space and play therapy adaptations when working with specific cultural or ethnic groups.

Therapeutic Services for Children Under the Age of 7

Children under the age of 7 receive therapeutic services for a number of reasons; a history of abuse or neglect, Pervasive Developmental Disorders (PDD), other biologically based issues including Attention Deficit Hyperactivity Disorder (ADHD) and Learning Disabilities (LD). Additionally children may be brought to therapy to address feelings associated with divorce, or reactions to other transitions including birth of new siblings, hospitalizations, beginning school (separation anxiety), or grief (Landreth, 1991; O'Connor, 1991). Children who survive childhood maltreatment face emotional, behavioral, social and cognitive impacts. Manifestations of symptoms or behaviors associated with childhood maltreatment include cognitive deficits, mood and anxiety disorders, including posttraumatic stress disorder (PTSD), dissociation, attachment difficulties, psychosomatic complaints, poor self-esteem, aggressive behaviors, withdrawal and school-related difficulties (Davies, 2004; Gil, 1991; Landreth, 2001). Symptoms associated with biologically based disorders or social issues may include difficulties with impulse control, over control, and aggressive outbursts (O' Connor, 1991). Parent's may access therapy services for their children under the age of 7 in a private practice setting, at a hospital based setting, at a community mental health agency or receive school based-services.

About 5% - 15% of the child population in the United States has been referred for mental health services in recent years. From 2005-2006, 15% of children ages 4-17 had parents who "talked to a health care provider or school staff about their child's emotional or behavioral difficulties" (Simpson et. al, 2008, pp.1). Children ages 4-11 were just as likely to be referred for services as children ages 12-17. Based on statistics from

American Psychiatric Association (DSM IV-TR), the prevalence of disorders typically diagnosed in childhood varies. Approximately 5% of children are estimated to meet criteria to be diagnosed with a Learning Disorders or Separation Anxiety (DSM IV-TR, 2000).   More children meet criteria for an ADHD diagnosis, with 8% of children ages 3-18 receiving this diagnosis (Simpson et al, 2008). The true number of children who are abused or neglected each year is unknown; however the World Health Organization estimates 40 million children are abused each year around the world. In the US about 30% of reports indicating maltreatment were substantiated in 2005, involving about 900,000 children (Wells, 2008).

The United States, unfortunately has a legacy of racism and sadly, while overt racism is less visible today, it remains, alongside the less visible, aversive, institutional and internalized racism that persist, privileging White members of society over individuals of color (Altman, 2010; Miller & Garran, 2008, Tatum, 1999). The potential impact of racism on the therapeutic relationship will be explored at greater lengths below. One example of institutional racism is evident in the child protective system in the United States. There are rather large racial disparities within the child protective system. African-American children are not more likely to be maltreated when compared to White children however a disproportionate number of incidents involving African-American children are substantiated when compared to White children (Sedlak & Broadhurst, 1996 as cited in Wells, 2008). Furthermore African-American children are more likely to be the subject of protective investigations, to be placed in out of home care, spend longer time in foster care and are less likely to have reunification plans or permanency

placements arranged (Lu, Kandsverk, Ellis-Macleaod, Newton, Ganger & Johnson, 2004; Solomon, 2002).

In 1995, African-American children made up only 15% if the US child population but accounted for 28% of founded allegations of abuse or neglect. Furthermore, African-American children represented 41% of the child welfare population, including 49% of the children in foster care and group care in 1995. In contrast, in 1995, Caucasian children constituted 66% of the US child population but 57% of the substantiated allegations of abuse and neglect. 36% of Caucasian children are in out of home care (Morton, 1999). Maltreatment of children nationwide has drastically increased in recent years; between 1998 and 2002 the number of children in foster care increased from 100,000 to 581,000 nationwide (Children's Defense Fund, 2005). Along with facing the impact of these traumas, these children may also have to face a new culture, foster parents and foster siblings from different races, these transitions may raise additional identity questions that could be addressed in the context of therapeutic services

Play Therapy: The History to Present Day

Contemporary clinician's working with children, have adopted a number of techniques and intervention strategies in order to address the issues for which today's children present. Throughout the history of psychotherapy, there have been a number of views regarding the most effective way for clinicians to engage with their child patients. When psychotherapists began practicing psychotherapy with children in the early 1900s, a commonality among their practices was incorporating play. Play therapy has evolved over the past century and today there are several widely accepted theoretical frameworks of play therapy. In play therapy, a safe, contained space is provided which allows

children to work through their feelings and master their experiences through play (Axline, 1989; Hays, 2002; Rasmussen & Cunningham, 1995).

Early theorists of play therapy recognized that children require unique therapeutic interventions in order to account for their developmental level (Landreth, 2001). Play therapy was developed on the knowledge that play is an essential task during childhood (Schaefer, 1993). In play therapy; play is defined as the "vehicle for communication between the child and the therapist. It allows the child to enact those things for which she does not have words" (O'Connor, 1991, pp. 100). Through the use of symbolic play, the child translates images of people, things and places that he or she hold in their mind into a behavioral sequence of pretend play (Hinman, 2003). The Association for Play Therapy (APT) defines play therapy as, "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (Association for Play Therapy, 2010).

History of Psychotherapy with Children

In the early 1900's, Anna Freud, Melanie Klein and Hermine Hug-Hellmuth each began to incorporate play into their therapeutic work in order to adapt traditional psychoanalysis techniques to meet the needs of children (O'Connor, 1991). Each of these clinicians incorporated play differently into their therapeutic technique with children. Hug-Hellmuth introduced the use of toys and play into psychotherapy with children. Anna Freud primarily used play to develop a therapeutic alliance with child patients. For the purposes of this study, a *therapeutic alliance* is defined as a strong, positive relationship between the therapist and the client (O'Connor, 1991, pp. 10). Klein

took a different approach to using play in therapy with children and focused on making direct interpretation of the child's play (O'Connor, 1991).

The next development in play therapy, known as relationship therapy, took place in the 1930s by Jesse Taft and Frederick Allen (Landreth, 1991; O'Connor, 1991). This conceptualization of play therapy focused on the relationship between the therapist and the client and no effort was made to interpret or explain past experiences within the play. In the late 1940s and 1950s these concepts were expanded by Virginia Axline with the development of "nondirective play therapy principles" (Landreth, 1991, pp. 32). In nondirective play therapy the therapist allows the child to lead the play and the therapist makes no effort to impact the child's behavior; the underlying theory is that "the child's behavior at all times caused by the drive for complete self-realization" and therefore the goals are self-awareness and self-direction of the child (Landreth, 1991, pp. 32).

The history and origin of play therapy theories are significant in order to understand the potential limitations when working with children from varied racial, cultural and socioeconomic backgrounds. Consistent with the practice of psychotherapy with adults, when child focused psychotherapy was introduced, the practitioners as well as the patients were predominately White, European, and upper-middle class. While many traditional theorists of psychotherapy have written about the universality of play and psychotherapy, the foundation of traditional clinical theories reflect the "worldview and values of the Euro-American culture. These values include a bounded, autonomous self with an affect-filled interiority, assertiveness of personal needs, personal achievement, personal identity, democracy, introspection, and interpersonal equality" (Cushman, 1990 as cited in Yi 1998, pp. 257). Many therapeutic theories that were

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developed for work with adults and children around this time reflect value systems consistent with the value systems of the practitioners and patients who were utilizing therapeutic services (Miller & Garran, 2008). For example, Ego Psychology reflects a Northern European value system, emphasizing "tolerance for frustration and abstention from gratification" (Altman, 2010, pp.122) and therefore attracted cliental whose own value system resonated with Northern European value system present in Ego psychology.

Clinical theories and methods were originally designed to meet the needs of Europeans and Westerners, however when working with individuals whose cultural and ethnic background is different, it may be important to question the generalizability of traditional theories (Perez Foster, 1998). In the present study, clinician's theoretical orientation when conducting therapy will be explored as well as any possible considerations and adjustments made to their theoretical approach when conducting cross-racial play therapy.

Racially Sensitive Considerations in Other Disciplines

While considerations of race and racism have been absent from the majority of writings on therapeutic dyads, other disciplines such as education have recognized the importance of teaching to meet the needs of individual students. Early childhood educators are encouraged to adopt "developmentally and culturally appropriate practices" by the National Association for the Education of Young Children (NAEYC) (Lee, Ramsey & Sweeney, 2008, pp. 68). In addition to this recommendation a specific "anti-bias" curriculum has been developed by Louise Derman-Sparks to outline the "best-practice" recommendations when working with preschool aged children.

Derman-Sparks (1989) developed the Anti-Bias Curriculum for preschool age children based on the research that has found that children begin to notice and categorize difference very early, that there are development tasks and steps "in the construction of identity and attitudes" and the fact that "societal stereotyping and bias influence children's self-concept and attitudes toward others" (Derman-Sparks, 1989, pp. 1) Derman-Sparks outlines a curriculum to address and confront the biases preschool age children are impacted by in an effort to teach and foster positive group identity and combat rejection or exclusion based on "difference" whether it is racial, gender or ability (Derman-Sparks, 1989, pp. 2). Early childhood teachers who work from an anti-bias curriculum perspective keep in mind children of color's experiences living within the "dominant" White culture and that children of color are "disproportionally faced from an early age with the risks of poor housing, inadequate health care, poverty and family unemployment" (Derman-Sparks, 1989, pp. 4). Derman-Sparks additionally indicates that a "nonbiased" stance is not effective and that in order to instill positive attitudes in children regarding difference, rather an "active intervention" is necessary (pp. 5). Congruent with Derman-Sparks recommendation of adopting an "active intervention" model, recent research in this field has demonstrated that "when encouraged with meaningful activities and questions, children often do express, compare, and challenge their views and discuss social justice issues among themselves and with teachers" (Lee et al, 2008, pp. 69). The current study seeks to explore if and if so, how, clinicians working therapeutically with children from this same age range think about the impact of a child's racial/ethnic identity within the context of the therapeutic relationship.

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There are limited recommendations available as to how to explore race and racial difference for clinicians working with children under the age 7. One study conducted by early childhood educators, Lee et al (2008), outlines specific materials and activities to have available in order to facilitate discussions about race and class within the classroom. Lee et al (2008) recommend having specific art materials, such as skin tone crayons and markers, displaying "contemporary and realistic" images of people from a range of racial backgrounds, books and music that have themes of "similarities and differences among people and families", puzzles and games that have faces and pictures of individuals and families from a range of racial groups and occupations, and multiracial and multiage dolls and play houses that represent different levels of affluence (pp. 70). Lee et al (2008) go on to say, "art activities can familiarize children with skin tones and help them begin to differentiate subtle distinctions in tone and hue. Moreover, this exposure can potentially counteract the aversion to darker colors that is prevalent in our society (for example, the common use of black and dark to describe negative objects, people, and events) and that children frequently express" (pp. 71). The current study will explore if clinicians working with children under age 7 are incorporating similar concepts and interventions into their practice.

Jacqueline Jordon Irvine who wrote specifically about Black students noted that "when teachers and students are out of sync they clash and confront each other, both consciously and unconsciously" (Cole, 2008, pp. 4). The misattunement becomes evident when teachers wrongly interpret non-verbal cues, dismiss student's language, learning styles and worldview. As students racial and cultural needs must be accounted

for in order to understand behaviors at school, I am interested in finding out how these needs are being addressed in therapy.

Play Therapy Methods

Play therapy is an effective and appropriate treatment modality for children until they reach late latency.   The balance of talk and play methods will vary based on the child's cognitive development; play will be the predominate means of communication during the preschool years as opposed to verbalization which will tend to be used more as the child nears puberty (O'Connor, 1991). A child who has experienced a great deal of trauma may tend to engage in play longer than non-traumatized children (Webb, 1991). With preschool age children, keeping the work in *displacement* defined as not interpreting connections from the play to the child's life – can be an effective way to bring about symptom relief (Webb, 1991).

Children under age 7 will tend to be concrete and literal in their thinking, given their developmental level (Tatum, 1999). Also due to children's developmental level they lack the cognitive ability to verbally express what they are emotionally feeling (Landreth, 1991, pp.13). A children's developmental level under age 7 indicates the importance of using play in order to connect and communicate with young children in an effort to address their emotional and behavioral needs through the use of therapy.

Theories

There are a number of different theoretical approaches currently being utilized by clinicians practicing play therapy, these include: client-centered, cognitive-behavioral, family and psychodynamic approaches (O'Connor, 1991; Reddy, Files-Hall & Schaefer, 2005). Play therapy has been found to be effective when clinicians are using a directive

(behavioral) approach as well as when utilizing a non-directive (humanistic) approach (O'Connor, 1991; Reddy, Files-Hall & Schaefer, 2005). While there are differences between the theoretical approaches to play therapy, there are commonalities that have been agreed upon as important, basic assumptions for any variation of play therapy.

It has been recommended that the play therapist possess several qualities in order to responsibly conduct play therapy. The first task of the play therapist is to develop and maintain a trusting, therapeutic relationship. The therapist should conduct play therapy in such a way that facilitates the child's development; this will take different forms depending on the child. The therapist may at times need to lead the session while at others will need to follow the child's lead, the therapist should work to understand the child's experience and reflect this understanding to the child through verbalization or action (O'Connor, 1991).

Play therapists will vary on their opinion of toys and play materials dependent on their theoretical orientation; for example psychodynamic play therapists tend to provide a limited number of carefully selected toys that have symbolic significance to that particular child (O'Connor, 1991). Depending on clinicians' personal theoretical orientation they will tend to conduct play therapy that tends to be more directive or with a style that tends to be more non-directive.

In directive play therapy, clinicians utilize more structure and create specific play situations, and then actively make interpretations and offer guidance (Jones, Casado & Robinson, 2003; Levy, 2008). Directive therapies are frequently more short term and symptom focused (Gil, 1991). Taking an action oriented approach, consistent with

directive play therapy and utilizing interpretations may allow a richer, more complex

relationship to develop between the child and the clinician (Levy, 2008).

In non-directive play therapy, the clinician allows the child to choose toys and

themes and the child has the freedom to direct the play how they want to. Interpretations

are used more scarcely in nondirective play therapy and directives are not used (Gil,

1991). Some clinicians argue that the use of language in play therapy interpretations may

limit opportunities to explore themes richly; as language is often unable to capture the

full dynamics of what is being enacted in the play (Levy, 2008).

Rasmussen & Cunningham (1995) suggest that clinicians do not have to choose

between directive or non-directive play therapy in order to be effective when working

with traumatized children, rather, they propose using an integrated strategy; incorporating

aspects of both approaches of play therapy. In establishing a relationship with

traumatized children using an integrated model, therapists would take a non-directive

stance, in an effort to create a comfortable therapeutic space. The non-directive strategies

identified as useful for work with traumatized children are accepting the child exactly as

he/she is, establishing a feeling of permissiveness in the relationship and empathizing and

reflecting the child's feelings (Axline, 1989; Rasmussen & Cunningham, 1995). In the

current study, clinician's play therapy style and possible adaptations of their methods

when working cross-racially will be explored.

Cross-Racial Therapeutic Dyads

Given the gap in research regarding play therapists' experiences conducting cross-

racial play therapy, literature relevant to cross-racial therapy with adults was reviewed.

In recent years there has been an increased attentiveness by theorists and researchers to

the impact of culture, religion, gender, sexual orientation, ethnicity, race, and other areas of identity difference in regard to the therapeutic relationship.

As psychotherapy became more widely accessible to all individuals in the United States, clinicians and researchers questioned the effectiveness of cross-racial therapeutic dyads. In the 1970s several studies supported client-therapist racial matching in order to facilitate the most effective therapy (Griffith, 1977). After an extensive review of the literature, Griffith (1977) found racial matching in the therapeutic dyad to be more effective because clients were more likely to offer self-disclosures and feel more connected to the therapist. Today, most clinicians and researchers agree that cross-racial therapeutic dyads can be effective as long as several key components are present.

In the 1930s and 1940s Harry Stack Sullivan explored the impact of the clinician on the therapeutic relationship in his own clinical work. Today Sullivan's theory is known as interpersonal theory, which emphasizes a two person psychology as opposed to the traditional one-person psychology. Sullivan recognized that clinicians were not objective observers but rather that the clinician's personality contributes to the interaction with the client. With this shift in thinking, clinicians own reactions to the client were brought to the forefront, known as countertransference. In interpersonal theory, an individual's identity is understood to be shaped through their interactions with others and emphasizes consideration of an individual's experience in past and present relationships (Berzoff, Flanagan & Hertz, 2002; Mitchell & Black, 1995). This framework is a key element to effective cross-racial therapy.

An essential starting place for clinician's conducting cross-racial therapy is an examination of their personal racial identity. This includes raising self-awareness,

specifically to his or her values and multi-layered social identities, as they may manifest in a therapeutic relationship. The worldview and values that the therapist brings to each therapeutic relationship will be impacted by the numerous aspects of his or her identity, including his/her racial identity (Yi, 1998). In the therapeutic relationship, the therapist must remain aware of his or her reactions to the patient, remain aware of transference and countertransference feelings, and remain aware of the use of stereotypes in the room to facilitate effective cross-racial treatment (Schacter & Butts, 1968). In general, a client's satisfaction with therapy is going to be more likely if they experience that the clinician is engaged, respectful, offers validation, conveys a caring attitude and offers appropriate self-disclosure in the services of the treatment relationship; essentially that the clinician conveys a commitment to develop a trusting, positive therapeutic alliance (Chang & Berk, 2009)

All clinicians bring their own personal reactions, attitudes and feelings into each therapeutic dyad and therefore it is critical to remain aware and open to race related subject matter that comes-up in the context of the therapeutic relationship (Miller & Garran, 2008; O'Connor, 1991; Scahater & Butts, 1968). Clinicians' conducting cross-racial therapy must remain attuned to a number of dynamics; these clinicians must be mindful of power and privilege dynamics, culture, values and worldviews and how both the clinician's and the client's social identities manifest in the therapeutic relationships (Leary, 1995; Miller & Garran, 2008).

As is consistent with all therapy, cross-racial therapy will likely raise a range of affects for both the client and the therapist (Miller & Garran, 2008); "some common emotions and reactions that emerge in cross-racial works are anger, rage, guilt, shame,

grief, and mourning" (pp. 232). Due to the historical and persistent racism in the United States, understandably a clinician's race/ethnicity is going to impact the nature of the therapeutic relationship. When considering the meanings of race in the therapeutic relationship, it is important to consider the "larger societal and cultural milieu" from which race relations are created (Yi, 1998, pp. 256). This indicates how racial stereotypes and power disparities broadly evident in US society may enter or be reflected in the cross-racial therapeutic dyad. (Yi, 1998)

While many of the elements that have been found to be effective in cross-racial therapy are consistent with any successful therapeutic relationship, there are specific impediments that may occur when conducting cross-racial therapy. Miller & Garran (2008) outline three significant obstacles that may hinder effective cross-racial therapeutic work; "internalized racism, inattention to power and privilege, and defensive racial dynamics" (pp. 236). *Internalized racism* can manifest in internalized feelings of "superiority and privilege or feelings of being less worth or responsible for one's own social oppression" (pp. 236). Clinicians must remain aware of unequal power and privilege within the clinical relationship as these are major components of racism. Defensive-racial dynamics include color blindness, color-consciousness, cultural transference and countertransference and cultural ambivalence (pp. 237-238). Ignoring or over-emphasizing salient aspects of the client's identity, including their race/ethnicity, can create impediments to building a therapeutic relationship (Gil & Drewes, 2006; Miller & Garran; O'Connor, 1991).

Defensive Racial Dynamics

Play therapists, especially European Americans, may feel uncomfortable when discussing race or racial differences in the therapeutic relationship. Some therapists may take a color-blind approach when working with clients of different races (Griffith, 1977; Gushue & Constantine, 2007; Miller & Garran, 2008; Scahater & Butts, 1968). They may ignore or avoid race-related content, or disregard the physical appearance or skin color of clients" (Gushue & Carter, 2000; Kerl, 1999 as cited in Gil & Drewes, 2005, pp. 73; Leary, 1995; Yi, 1998). Color-blind racial attitudes represent one form of contemporary racism, while not overt, this attitude denies the fact that white people benefit from inherent privileges in the United States (Gushue & Constantine, 2007). Some clinicians in an effort to avoid a color-blind stance may overemphasize racial or other differences; O'Connor (1991) points out that denying "differences", for example of culture, is just as "inappropriate" as exaggerating the differences (pp. 54).

There are a range of transference and countertransference feelings that may arise dependent on the therapeutic dyad. In cross-racial therapeutic dyads, clinicians may encounter transference or countertransference reactions related to unacknowledged racial differences in the dyad. "To work therapeutically with racial issues, practitioners must be aware of the potential racial meanings derived from social context and be comfortable with their own racial identity." (Gushue & Constantine, 2007, pp. 325). A clinician's examination of his or her countertransference reaction to a client he or she is conducting cross-racial therapy with can allow him or her to gain insight to racial or cultural biases (Holmes, 1992; Shonfeld-Ringel, 2001). A clinician could negatively impact the therapeutic relationship by adopting the position that he or she has worked through any

potential biases to other race/ethnicities and cultures and is therefore free of 'ethnic prejudices'; this stance could send the message to the client that conversations about cultural differences are "off limits in the treatment" (Perez-Foster,1998, pp. 260-261). Another potential area for countertransference reactions to arise that clinicians must remain conscious of is when the therapist's own "socio-cultural history has, for example, rendered their cultural group less esteemed or empowered than that of their clients" (Perez-Foster, 1998, pp. 262). A clinician's personal experience facing prejudice as a result of their racial/ethnic or cultural identity may impact their countertransference feelings in the therapeutic relationship. For example, negative feelings may arise for the clinician if they are working with a client from racial/ethnic or cultural group that has historically oppressed the racial/ethnic or cultural group the clinician identifies with. In this type of therapeutic dyad, Perez-Foster (1998) recommends remaining conscious of enacting personal, culture-driven conflicts in the clinical relationship.

Experiences of Clinicians of Color

A review of relevant literature highlights common themes that clinician's of color must be attuned to and have experienced when conducting cross-racial therapy with adults. Given the historical Black/White racial dynamics in the United States, the majority of the reviewed literature emphasizes the experiences of African-American clinician's experiences conducting cross-racial therapy with White clients. In the current study, half of the sample will include clinician's of color, these clinician's experiences conducting cross-racial play therapy will be explored and compared and contrasted to the White clinician's in the sample.

As is important for all clinicians, clinicians of color must remain aware of how their own race/ethnicity impacts their identity and how these elements of their identity are going to interact in relationships with clients. Clinicians of color may tend to be more likely than white clinicians to place a higher salience on race based on their own experiences with prejudice and bias (Yi, 1998). "Clinicians of color who work with clients of color must examine social identity to avoid over identifying with clients of color and also to avoid falling prey to biases and judgments held about other groups of color, as well as white clients" (Miller & Garran, 2008, pp. 229)

Some clinicians of color may be more conscious of race and the impact of race in the therapeutic dyad than white therapists. "For some racial minority therapists, race may become so important that it is forced on clients regardless of the clients' own positions and experiences concerning race" (Yi, 1998, pp. 250) . Clinicians of color may more regularly address the issue of race in the therapeutic dyad when compared to white clinicians. Clinicians of color are also more likely to feel comfortable discussing race in the therapeutic dyad when compared to white clinicians. Knox et al (2003) found that African-American psychologists routinely addressed race with clients of color or when race was part of the presenting concern. The African-American clinicians in Knox's study addressed race within the cross-racial dyad more than European American clinicians because they perceived discomfort from the client.

Experiences of White Clinicians

In the United States, White individuals experience privileges due to the inherent structures and socialization in this country. White privilege is constantly present and remains invisible to most White people (Miller & Garran, 2008). White individuals are

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less likely to experience "dissonance between their race and their social world" allowing their race to remain unconscious at times (Miller & Garran, 2008, pp. 90; Yi, 1998). White clinician's must remain conscious of their race and the privileges their race affords them, especially in the context of cross-racial therapeutic relationships. Because racism is an ongoing reality in the United States, White clinicians must be attuned to the impact race and racism have on individual's lives (Constantine, 2002; Gushue & Carter, 2000). Play therapists that are from the dominant white culture have not experienced the substantial, ongoing oppression and discrimination that people of color face, and therefore may have difficulty relating to the impact this can have for clients (O'Connor, 2005). For many White people, they do not grow up in a setting where they are regularly engaged in cross-racial interactions and therefore may struggle to maintain racial sensitivity when engaged with people of color (Laszloffy & Hardy, 2000). Additionally because of the potential lack of pre-education exposure and limited training specific to cross-racial interactions, White clinicians may feel uncomfortable about addressing the issue of race in cross-racial therapeutic dyads and resort to colorblindness (Knox et al, 2003). These factors indicate the range of defensive racial dynamics that could potentially arise for White clinicians in a cross-racial dyad. Minrath (1985) indicates that when conducting cross-racial therapy, "a discussion of the meaning of race and ethnicity in the relationship may curtail racial distortion, prevent stereotyping, and lead to the creation of a therapeutic alliance" (pp.23). Minrath additionally recommends that clinicians formulate the clinical issues keeping in mind the theoretical and sociocultural factors (1985).

Race in Play Therapy

Given the gap in available literature on play therapy that discusses the issue of race and cross-racial play therapy, as well as clinician's experiences conducting play therapy it remains unclear how race may impact the toys and play therapy space that clinicians make available when they are conducting cross-racial play therapy. Several play therapy theorists and practitioners have emphasized the importance of play therapists remaining aware of their own beliefs and the child's in order to avoid misinterpreting the meaning of a child's play when working cross-culturally. In order for clinicians to facilitate a culturally sensitive therapeutic experience play therapists working with clients whose culture differs from their own, must be conscious of their ethnocentric beliefs when interpreting the child's play (Holloway, Myles-Nixon, & Johnson, 1998; Kao & Landreth, 2001; Levy-Warren, 1994),

It is expectable that a child's play may vary based on their racial/ethnic or cultural backgrounds. A child's play will be influenced by a number of intersecting elements according to cultural-ecological models of behavior and development including physical and social aspects of children's immediate settings; historical influences that affect the way adults (and children) conceptualize play; and cultural and ideological beliefs relative to the meaning of play for subgroups of children" (Roopnarine & Johnson, 1994,pp. 4). Interpretations of the play must be adjusted to account for the norms each child has in order to avoid false conclusions based on their behavior (Coleman, Parmer & Barker 1993; Hinman, 2003) for example, "non-verbal signals can have different meaning in Western and non-Western cultures" (Shonfeld-Ringel, 2001, pp. 58). In the present study, clinician's considerations of these factors will be explored.

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The Playroom

In order for play therapy to be an effective medium for children, to express their inner lives, they must be provided with toys that they can relate to and communicate effectively with (Gil, 1991; Hinman, 2003; Ji, Ramirez & Kranz, 2008; Kranz et al, 2005; Landreth, 2001; Lebo, 1955; Vargas & Koss-Chioino, 1992). Throughout the last several decades authors such as Ginott, (1961, as cited in Kranz et al, 2005) Lebo (1955) and Axline (1989) have made recommendations to clinicians regarding what toys to have available to facilitate the therapeutic process in play therapy. Ruth Hartley (as quoted in Lebo, 1955) states that, " . . . . for each child the materials he uses have unique values dependent upon associations with his past and on his ability to project meanings and use symbols". For example, "with dolls, a therapist can assess children's attitudes about cultures different from their own and can stimulate discussion about ethnic identification, self-perceptions, and idealized or rejected self-images" (Vargas & Koss-Chioino, 1992, pp. 91).

Children from different racial/ethnic or cultural backgrounds may have more difficulty connecting to Eurocentric materials, if the materials do not reflect their previous experiences. If the toys in the playroom reflect primarily a Caucasian childhood, this may inhibit communication of children from different racial or ethnic backgrounds (Chang, Ritter & Hays, 2005;Hinman, 2003; Vargas & Koss-Chioino, 1992). This highlights the importance of creating a therapeutic space that is inviting and comfortable to all clients being served.

The survey responses of one study (Chang, et al, 2005) indicate that some clinicians observed differences in play when working with children of color. Participating

clinicians reported common themes in play therapy with racially diverse clients, including: "experimentation and awareness, difficulties within the play setting and safety concerns" (Chang et al, 2005, pp. 75). Clinicians, who participated in this survey, reported that, "children were often aware of and sensitive to cultural differences" and also that children noted "culturally specific play materials" (Chang et al, 2005, pp. 75). This study did not address how clinician's responded to their client's attention to differences within the therapeutic dyad. In addition to the toys available in the play room, play therapists have another opportunity to create an open, inviting, comfortable space for clients from all races and cultures by mindfully choosing decorations within the play room and waiting area. Through photographs, art work and decorative objects, play therapists can convey Western and non-Western value systems or alternatively they can create a neutral space in order for clients from broad backgrounds to feel comfortable (Hinman, 2003).

Summary

The reviewed literature has been used to outline some of the issues play therapy clinicians are facing in practice today. Play therapists must consider if directive or nondirective play therapy is the most effective for their clients. Play therapists must consider their own racial/ethnic identity and culture, the client's racial/ethnic identity and culture, and incorporate salient aspects of the client's identity through use of toys. Additionally, play therapists working cross-racially must consider if, when and how to address issues of racial difference in the therapeutic relationship. In the proposed study, clinicians' practical implementation of these concepts will be investigated.

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The current study will explore current gaps in the literature regarding clinician's experiences conducting cross-racial play therapy with children under age 7. Specifically, through semi-structured interview questions the participants will be asked about their play therapy approach, whether or not they are adapting their approach when working cross racially, whether or not they are adapting the play therapy space or toys when working cross-racially, their countertransference related to a specific case, and the discussion of race/racial difference in a specific case. This study is approaching this research from the framework that both the clinician's race and the child's race are going to influence aspects of the treatment relationship when utilizing play therapy with children under age 7.

CHAPTER III

METHODOLOGY

Based on a review of current literature, questions remain as to if and how clinicians are addressing race/ethnicity and culture in a cross-racial therapeutic dyad in play therapy, specifically with children under the age of 7. This exploratory, qualitative study sought narrative answers to the following questions: *(1) Are clinicians adjusting their play therapy interventions, toys and physical space when conducting cross-racial play therapy with children under age 7? (2) Are clinicians acknowledging and discussing racial differences in the context of cross-racial play therapy? (3)Do clinician's use specific techniques to bring in and address the client's and their own racial/ethnic identity in play therapy? (4) Is a child's race looked at in relation to the presenting problem?*

In order to address the research questions a cross-sectional qualitative study was conducted with master's level clinicians who are practicing cross-racial play therapy with children who are under 7 years old. The interview included two parts; a set of fixed demographic questions and a set of semi-structured questions. Given the limits of existing research on this topic, an exploratory qualitative research design was utilized because it creates the opportunity to, "give voice to respondents, using their own words to describe and interpret their social worlds and experiences" (Alexander & Solomon, 2006, pp. 253). Semi-structured interview questions were used to allow a narrative account of subject's experiences to be shared. All interviews were audio recorded and notes were

taken following each interview. Using the basis of grounded theory, all interviews were transcribed in their entirety and then individually analyzed for themes.

<p align="center">*Sample*</p>

In order to be considered for participation in this study, clinicians must have obtained at least a master's degree related to counseling, including Master's in Social Work (MSW) or a degree in Marriage and Family Therapy (MFT).   Participation criteria included: at least one year post graduation from a Master's level program practicing play therapy; current case load including children under age 7 from a different racial background than clinicians; and fluency in English as translation services were not available. There were no exclusions regarding the setting where participants were practicing. In an effort to obtain a more diverse sample, the participants were recruited for 1 of 2 groups: half clinicians who identify as clinicians of color and half who identify as White clinicians.

Recruitment was conducted using stratified snowball sampling.   Initial recruitment began with local clinicians who this researcher was connected to from current internship placement and previous work experience in the Bay Area. These clinicians were asked to identify possible participants who met participation criteria. Potential participants were emailed the recruitment letter (Appendix D). During my initial outreach effort I was offered the opportunity to attend a staff meeting at my previous employers, a non-profit agency that provides early intervention services in the Bay Area, in order to recruit potential participants in person. At this meeting I explained my purpose of research and distributed the recruitment letter (Appendix D). Staff members were given the opportunity to ask any questions about the study. At the time of the meeting potential

participants provided this researcher with their name and contact information. These

interested clinicians were mailed informed consents (Appendix A) and were followed up

with by phone or email to schedule an interview time. Following this outreach, I fulfilled

the group for participants who identified as White. Potential participants were excluded

once the group that they identify with (clinicians of color or White clinicians) was

fulfilled. I proceeded to recruit specifically for clinicians of color who met the

participation criteria. I asked professional contacts and participants, at the time of the

interview, and to identify colleagues who met participation criteria. The recruitment

letter was distributed via email and in person and it was requested that these materials be

distributed among their colleagues who met participation criteria. Potential research

participants were screened by phone or by email to ensure that they met this study's

inclusion criteria. All interested participants who met sample criteria were mailed the

informed consent letter. The informed consent outlines the research for participants as

well as the potential risks and benefits of participation.

Data Collection

Data was collected using fixed demographic questions and a semi-structured

interview guide (Appendix B). 11 out of the 12 participants were interviewed in person

at their agency or office, 1 interview was conducted by phone in order to accommodate

scheduling conflicts. 1 pilot study was conducted with a MSW student practicing cross-

racial play therapy with children under age 7 in an effort to minimize the impact of

personal biases on the interview structure.

Prior to each interview, all participants received and reviewed the informed

consent letter (Appendix A) which offered explanation of their rights as human subjects

and described potential benefits and risks of participating in the study. Participants were also informed, prior to the interview, that for one aspect of the study they would be asked to discuss one specific cross-racial play therapy case where race was a "common theme" or where the "child seemed to be trying to communicate something about race". This was done in order to give clinicians the opportunity to recall case details and choose a case they were comfortable discussing.

As detailed in the approved HSR materials (Appendix C) confidentiality was maintained by assigning a numerical code to each participant, removing the clinician's name and all identifying information was disguised. Clinicians were informed that they could refuse to answer any questions or withdraw from the study up until a specified date. Over half of the interviews occurred in an agency based play room, with verbal permission these rooms were photographed and pictures of toys were taken, no identifying information is evident in the photographs. I will keep the informed consents, digitally recorded interviews, and transcripts for three years. During this time, transcripts, and signed consent forms will be kept in a locked cabinet. The digital recordings will be kept in a password protected computer during this time. After the three year period has expired, all material will be destroyed or, if kept, will remain in a locked cabinet.

Participants were given the opportunity to ask any questions regarding the interview or the signed informed consent prior to beginning the interview. At the time of the interview, participants were given a list of definitions (Appendix E) and relevant definitions for the interview were stated. Participants were encouraged to refer to the definitions at any point during the interview. Following the interview guide participants

were first asked a series of fixed demographic questions followed by the semi-structured

interview questions. Follow-up questions were asked as this researcher felt was

indicated.

All interviews were audio recorded using a digital voice recorder, following each

interview they were transferred to a password protected computer. This researcher took

notes following each interview. Interviews varied in length, ranging from 30 minutes to 1

hour.

Data Analysis

Following each interview, the digital files were transferred to this researchers'

password protected computer and were labeled with a numerical code. Using the basis of

grounded theory, each audio recording was transcribed in its entirety.   A mixed method

design was utilized to analyze the demographic data. Quantitative analysis was

conducted on demographic data including gender, degree, years of experience, setting.

Participant's narrative responses regarding any relevant training specific to cross-racial

play therapy was analyzed using qualitative analysis.   Qualitative analysis, using the

basis of grounded theory was used to analyze the narrative data from the semi-structured

interview portion.

The transcribed interviews were first read thoroughly in order to gain familiarity.

Transcription and coding were completed following each interview. Keeping with

grounded theory, I constantly compared new data to previously coded data and at times

had to revise my categories. I approached the coding process following the steps of

grounded theory; starting with the raw data, identifying the relevant text- the text that

relates to my research question. In the relevant text I identified repeating ideas – ideas

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that several participants repeated in different terms. Themes were then labeled, a topic that organizes a group of repeating ideas. Theoretical constructs were then used to capture several themes into a larger grouping. A theoretical narrative was then created, summarizing what I have learned about my research questions (Auerback & Silverstein, 2003).

Discussion

Given the limited sample size and overwhelming participation of female clinicians, the study will not be generalizable among all clinicians who are practicing play therapy cross-racially.   My hope is that the data collected will be representative of some play therapists experiences and help to indicate where additional trainings is needed for clinicians who are conducting cross-racial play therapy.

Aspects of my identity may have contributed to possible biases. I identify racially as White and am in training to be a clinician. I have worked in a number of settings with children and their families. My work experiences include working predominately with clients of color. As a result of these experiences I have formed ideas about cross-racial therapeutic dyads in play therapy that may result in personal biases. My bias may potentially be reflected in my interview questions. A pilot interview was conducted in an effort to gain feedback and minimize my personal biases.

Possible factors that may further limit the generalizability of this study include; selection bias, similarly, there may be an effect of 'social desirability' bias from clinicians who may feel inclined to give what they believe is the appropriate answer to the questions (Davis & Gelsomino,1994). In order to minimize these effects, I hoped to create a non-judgmental environment where clinicians feel at ease to be open and honest

during the interview process. In order to achieve this, I maintained confidentiality and removed identifiers from the data. By asking questions in a way that allows clinicians to draw upon their own strengths first hopefully they will feel more comfortable sharing the areas where they hope to receive more training and specific times when they have gotten stuck in the past.

One of the potential risks that clinicians may face by participating in this study is that they could experience feelings of self-doubt. Particularly, agreement to participate in the interview could raise feelings of self-doubt in relation to their ability to work effectively in a cross-racial relationship. This could potentially cause feelings of anxiety or depression in anticipation of the interview or following the interview.

CHAPTER IV

FINDINGS

In this chapter, the major findings from interviews with 12 clinicians practicing

cross-racial play therapy with children under age 7 will be presented. First, demographic

data was obtained from all participants. Using semi-structured questions (see Appendix

B for the interview guide) the interview elicited responses in relation to a specific cross-

racial play therapy case with a child under the age of 7 and how race was communicated

within the dyad, whether or not the racial difference was addressed, if race was central to

the presenting problem, and the clinician's countertransference feelings specific to race

with that case in order to explore how clinicians are acknowledging and discussing racial

difference within this type of therapeutic dyad. Participants were then asked to reflect

upon any observed differences in interaction style when working cross-racially. The next

segment of the interview explored clinician's theoretical framework regarding play

therapy, focusing on their use of directive, non-directive or integrated techniques to

explore if these clinicians are making adjustments to their interventions when working

cross-racially. The next segment of the interview explored clinician's theoretical

framework regarding play therapy, focusing on their use or directive, non-directive or

integrated techniques to explore if these clinicians are making adjustments to their

interventions when working cross-racially. Next, participants were asked about toys or

items that were used most regularly in their practice and whether or not they are making

any adjustments they made when working cross-racially. Participants in this study were

also given the opportunity to share any additional thoughts regarding their cross-racial work using play therapy.

Based on analysis of the interviews from the 12 participants in this study the findings indicate that:

- The majority of the participants did not make any changes regarding their play therapy approach when conducting cross-racial play therapy.

- The majority of the participants in this study did directly acknowledge the racial difference within the therapeutic dyad, for the case they presented on, once the child had verbally or non-verbally communicated something about race or the racial difference in the room. An unexpected finding that emerged in this section is that all participants in this study acknowledged that they regularly initiate a discussion regarding the difference in the room with the child's caregiver.

- All participants in this study discussed ensuring that they have figures or dolls that represent their client and significant people in their lives who represented a range of races/ethnicities for all clients but especially when working cross-racially. Slightly over half of clinicians reported they do not make adjustments to the toys when conducting cross-racial play therapy.

- Slightly less than half of participants in this study noted systemic or institutional aspects of racism that they viewed as connected to child's reason for referral.

The data from the interviews is presented below in the order it was elicited from the participants. First, a mixed methods analysis of the participant's demographic data will be presented. Questions about clinician's acknowledgement of racial difference and countertransference when working cross-racially were explored through their presentation of a play therapy case. Participants play therapy approaches in general and any adjustments to their approach when working cross-racially will then be analyzed. Next, participant's responses about their toys and any adjustments when conducting

cross-racial play therapy will be presented. Finally, analysis of participant's additional

comments and unintended findings will be presented.

Demographic Characteristics

12 clinician's currently practicing cross-racial play therapy participated in this

study. Participants included 11 master's level clinicians and 1 doctoral level clinician of

whom 11 are female and 1 is male. 2 clinicians specified that they had an emphasis in

art/expressive art therapy.
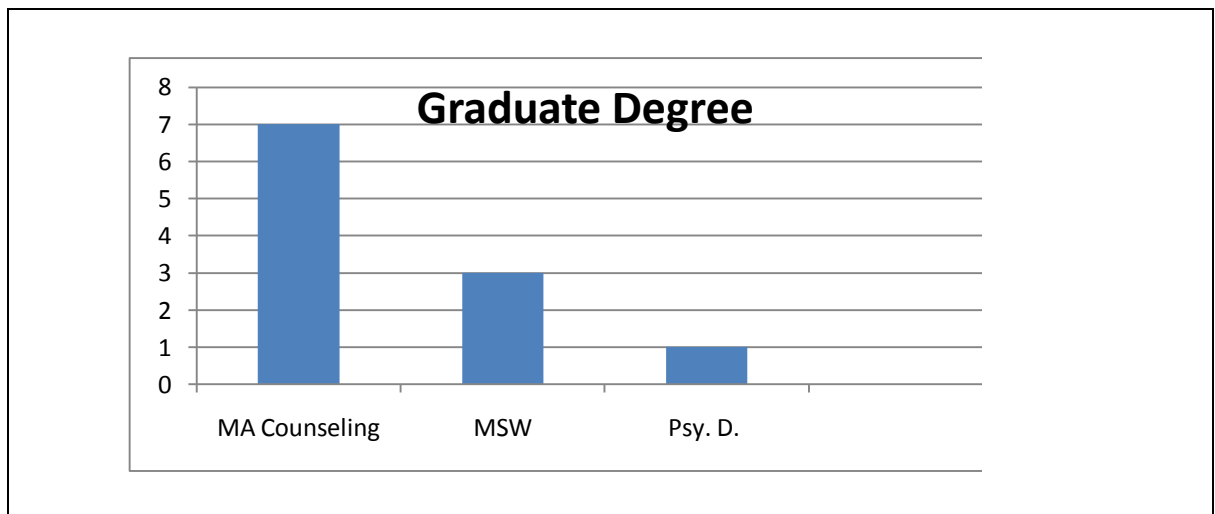
Figure 1

7 of the participant's identify as White/ Caucasian. Within this group 3 clinicians

specified that they identify strongly with their ethnic background: Jewish, Italian-

American and Mediterranean/Italian American. 5 participants identify as clinicians of

color; racial/ethnic background of these participants include: Middle-Eastern/Palestinian-

American, Mexican-American, Latina and Asian-American/Chinese-American.
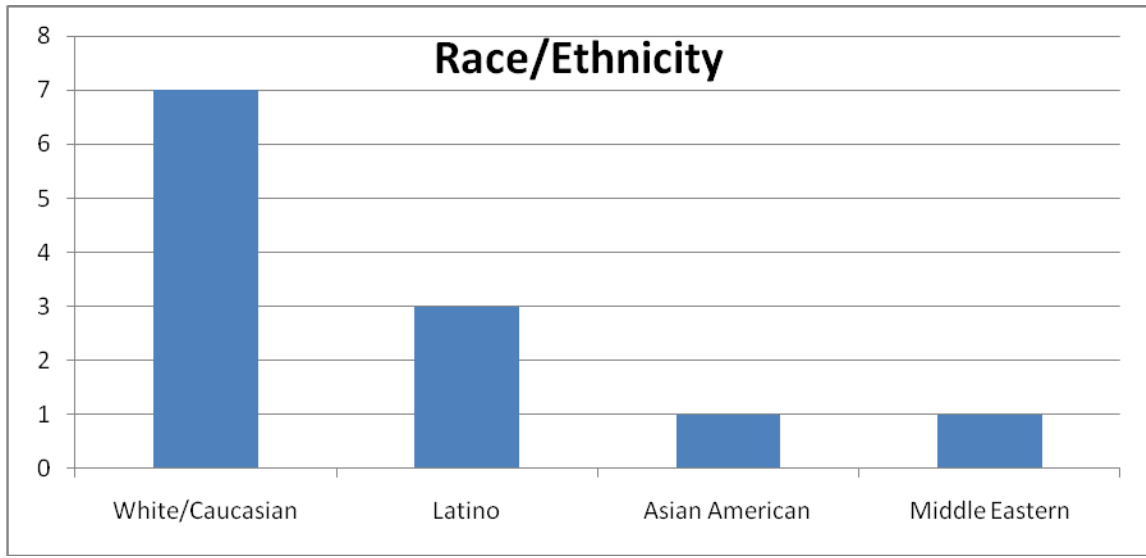
Figure 2

All participants are currently practicing in outpatient settings including private practice, clinic based, home-visits and school based settings. Years of practice post-degree ranged from 2-31 years and the average number of years of practice was 10. The mode was 8 and the median was also 8. All participants conduct long-term therapy while 3 of the 12 participants also have some short-term cases. Clinicians were asked if they had received any training specific to cross-racial play therapy throughout their education or career, 9 of the 12 participants said "no" but within this group some acknowledged that they had had "multi-cultural training" or had pursued books and articles on their own. 3 of the 12 clinicians reported yes, that they had had training opportunities such as "diversity class" in graduate school or a "diversity committee" that met once a month at a former job. Another clinician recalled a sand tray training that touched on issues related to cross-racial play therapy, "I was in this intensive sand tray training and there was a lot about cross-cultural sand tray images. Including Japan and

African countries about archetypical images of children in different countries about how they are the same or different".

Play Therapy Case

Case description

Clinicians were asked to *choose one cross-racial play therapy case with a child under the age of 7 where race was a common theme and briefly describe the case including the child's age, race, and reason for referral*. Clinicians were asked structured follow-up questions after they gave a brief case overview. First an overview of the cases will be presented. 66% (n=8) of the children that were presented on were identified as African-American. 25% (n=3) were identified as bi-racial; "African-American and Caucasian", "White and Pacific Islander", and "mixed race Caucasian there is a Puerto Rican component . . . dad is Portuguese". 1 out of the 12 children was identified as White. The age of the clients the participants presented on ranged from the youngest, who was 2.5 years old at the time of referral(n=2) to the oldest who was 6 at the time of referral (n=2). The majority of the children that participants discussed were between 4-5 years old. The majority of the participants (n=8) worked specifically as early childhood mental health clinicians and clients "aged out" of the program at age 7. The cases presented were 42% female and 58% male. The majority of these cases had some component of dyadic work.

The presenting problem was regularly described in terms of behaviors but 10 out of the 12 children that were presented on had explicit trauma that they had survived or been exposed to, for example, "exposure to domestic violence", "a lot of family trauma", "sexual and physical abuse", and "she was left alone with her younger sister in an

abandoned apartment, no furniture for hours and hours. . . . on one of these occasions the father overdosed. . .". Out of these 10 children, 50% (n=5) had been removed from their biological parents care and were in a foster or adoptive home.

The children displayed a range of externalizing and internalizing behaviors at the time of their referral.   7 out of 12 displayed externalizing behaviors described by participants as "acting out, anxiety", "behavioral problems and emotional problems", "oppositional behaviors", and "impulse control issues, aggressive acting out". 2 out of 12 were displaying internalizing behaviors at the time of referral which were described as "this child was so scared, he was terrified" or "shy and quiet". The reason for referral in the remaining 3 cases was specifically to address trauma and related PTSD symptoms.

Racial Differences and Communication

After participants explained a brief overview of their chosen cross-racial play therapy case, they were first asked a *follow-up question aimed at finding out how clinicians interpreted race to be communicated verbally or nonverbally within the therapeutic dyad, with the child*. 92% (n=11) interviewees reflected that the child communicated something about race or the racial difference in the room non-verbally. These clinicians interpreted the child's use of symbolic toys, art work or interest in physical differences such as hair to be a nonverbal communication about the racial difference that was present in the room. For example one clinician of color recalled her African-American client's use of non-representational toys to be a communication about the racial difference within the dyad "he gives me the white car, he uses the black one". Other clinicians spoke about their client's more literal observations of the racial difference in the room. For example, a White clinician describes an interaction with her

African-American clients, "the little boys went to the baby doll bin and started pulling out baby dolls and gave me the White one. . . and then gave their mom the African-American one (baby doll)". One clinician of color describes one of her biracial client's use of art as a communication about race, "in her drawings the way she portrayed herself was as a brown-skinned person, the way she would draw me and her mom would be different". Art was also described as an indicator that the child did not have a positive sense of self related to their racial identity, for example, one White clinician recalls her experience with her African-American client "there were templates of little figures and there were lots of different colors and he would always choose the white one, and he wasn't white". Other clinicians noted their stance that something is being communicated nonverbally about race whenever the dyad is cross-racial, a clinician of color describes how race was communicated, "non-verbally based on how we looked, she had red hair, very white skin, and I look different". Some clinicians reported how their clients noted physical differences non-verbally for example one White clinician said, "he plays with my hair a lot".

50% of participants (n=6) also recalled their client directly asking or noticing the racial difference in the dyad. Some participants reported that their clients also communicated something about race or the racial difference verbally as well as non-verbally. Often a non-verbal play communication was accompanied by a direct verbal statement, for example one clinician reported, "we would play restaurant and food items might be part of her identity in terms of her own background, she would say 'oh this is something my grandmother made who is Puerto Rican' ". Sometimes the client verbally expressed their negative self-image for example one White clinician described her

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experience with her African-American client, "she made comments about it over time, she talked about the difference in our hair, how she wished she could have hair more like mine than what she had. She always identified with the white dolls as opposed to the black dolls. She would say she didn't think they were as pretty as the white dolls". Some participants recalled that their client noticed or asked about the observable hair or skin color differences within the dyad directly, one clinician of color recalled her bi-racial client, "she would say your skin is this color, my skin is this color. . . my mom is blonde, I'm brown". Another clinician of color said, "I remember her asking me at the beginning where I came from". A different clinician of color described how her biracial client expressed curiosity about the clinician, "she would talk about her best friend who happens to look like me, she would say, 'she's Asian, I think she's Japanese, are you?' ". Sometimes the client's direct questions about observable skin color differences seemed to be communicating the implicit question of 'can you understand me even though you are different?' For example, one White participant recalled an African-American client asking her at the beginning of treatment, " 'are you black?' I'm clearly not black, I mean the color of my skin . . . it was maybe the 3rd time we met . . . in addition to asking me directly, "are you black?" he asked, "are you from the ghetto?", he asked, "do you hear guns where you live?"

1 of the 12 clinicians was unable to recall any verbal or non-verbal ways the child communicated something about race or racial difference in the room. This participant noted "I don't see race as an issue for the child but it was a major issue for the mom". With this particular participant and the particular case race was regularly discussed in a direct way with the caregiver while the child was present.

An unintended finding that emerged when this question was asked is that all participants mentioned that they had a direct conversation with their client's caregiver about the racial and/or cultural difference in the therapeutic dyad. Most participants also explained that in general this is something they do as standard practice with all clients from a different racial/ethnic and cultural background than their own, especially when conducting dyadic/family work. One clinician said, "whenever I meet families, initially I do a standard, 'hey we are from different cultures what do you think that will be like?' Parenting is so rooted in culture and values that it is inevitable that the conversation comes up". Some clinicians reflected on how their approach to addressing racial/cultural differences varies in their work with adults versus their work with kids for example, one clinician said, "I'm very used to talking about race with parents but I don't know that I totally address it with children intentionally unless it comes up through the play or comes up naturally then it will get addressed because I often feel that children that I'm working with don't see that, don't see the differences, they see that I'm different but they aren't feeling it from a sociocultural place that adults have. The defensiveness, I can feel that a lot more working with adults and working with their families". A few participants recalled moments when the caregiver initiated a conversation about the racial difference in the room, for example one White clinician recalled, "the mom came in and spontaneously made a comment which was, 'it's good for the kids to be with White people' ". Another White clinician shared a recent interaction she had with a parent, "I just had an interesting experience with a parent of a little boy that I have been working with for 2.5 years actually we're coming up on almost 3 years now. It's a parent that I've had a really hard time working with, and this is a family that has a lot of cultural pride,

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Dad wears a t-shirt that says 100% black family. I have really had a hard time working with this family and recently the mother said, "Can I ask you a personal question?" I said, "yeah OK, if I'm not comfortable answering it I won't" and she asked me, "I've been wondering is your husband black?" and I said "no he's not but what an interesting question, why do you ask?" and she said well sometimes you really seem like a black person to me".

The 2nd follow up question was intended to *explore whether or not therapists discussed the racial difference within the therapeutic dyad for the case they chose to share*. 42% (n=5) of participants in this study reported discussing the racial difference between themselves and their child client, under the age of 7 in the case which they presented on. These clinicians reported discussing the racial difference after their client had communicated something about race (their own or the clinicians) verbally or non-verbally. For example one White clinician said, "I talked with her when she would say things directly like wishing that she could have hair like mine or saying things like the Black ladies weren't as nice as the White ladies. We would talk directly about that and I would tell her it made me sad because I knew that when she grew up she was going to be a Black lady". Another White clinician shared the way they explored this conversation with their African-American client, "I think that when he was playing with my hair one time I said, 'you're noticing that I have light hair and a different color skin, I wonder if you're noticing that?' And he said, 'yeah, you're pretty' and I said, 'yeah you have dark skin, I wonder what that's like for you to be with me, someone who has light skin. What I'm imagining is that your family, the family you came from, I'm imagining your mom and your dad were both Black.' I have to talk very simple when I'm talking to a 4 year

old, he didn't necessarily respond so much verbally to those things but I think he's very curious about those conversations".

58% (n=7) of respondents said no, they did not directly discuss the racial difference in the dyad with the client that they presented on. A few of these clinicians recalled speaking generally about difference with their client. A clinician of color spoke about her experience of being able to "pass" for different racial/ethnic groups, she said, "I mean I don't generally have a statement, cause I can pass for a lot of different things, and really I don't know how important it is that they know specifically where I'm from unless they specifically ask me. So if the specifically ask me then I'll answer".

None of the participants reported that they proactively acknowledged the racial difference in the cross-racial therapy case they spoke about.

Clients race as central to presenting problem

Participants were asked to think about their client's reason for referral and presenting issues. They were asked whether or not they viewed the client's race as central to the presenting issues. 58% (n=7) of participants directly said "no" that they did not view race as any way connected to the child's presenting problem or reason for referral. 42% (n=5) responded that they did view race as connected to or playing a role in the child's presenting problem or reason for referral due to factors related to systemic or institutional racism. Clinicians noted the complexity of factors that contribute to a client's presenting problem as one clinician states, "it's sort of hard to untangle it, is race a part of the reason he is in foster care? For sure!" Other clinicians reflected on how their clients were impacted by systemic racism, for example on participant said, "I think it had a lot to do with his experience, his families experience, their access to good health care,

their sense of empowerment, the resources available to support them". Another respondent said, "in the global sense of how our culture works. . .the mom has been to jail, who's in jail more? And does drugs more? And who has less money?" A different clinician said, "I think it had a lot more to do with multigenerational sort of income problems and discrimination and racism in general, I think there is a lot of anger in general within the culture. . .if you trace it back, all the way to slavery, then there is residual anger that will continue on for years to come". Another clinician noted that for her client the community he was living in impacted his presentation, "there is a culture of violence where he has grown up. . . there is this whole basic history in the family of all these relatives who are male and Black who have been killed or shot or something with violence and that's what he sees as a 'role model'".

Countertransference

Lastly, in regards to the specific cross-racial case example, participants were asked to share significant countertransference that came up, specific to race. It is important to note that some clinicians (n=3) clarified that the countertransference feelings they reported experiencing would cross any racial line and were not specific to the client's race or cross-racial therapeutic dyad .

42% (n=5) of the clinicians (4 White clinicians, 1 clinician of color) in this study described an acute awareness to the impact of institutional racism and their clients transference related to their experiences within an oppressive system. One clinician spoke about her experience of being perceived as being part of the "system" by her client's caregiver and how she felt about this caregiver's perception of her, she described having "uncomfortable feelings knowing that the grandmother initially didn't trust me

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because I was part of the system. . . she made a comment once like "all those white folks thought they were dealing with an ignorant black woman and they were surprised to find out that wasn't me" she had assumptions about me that were incongruent with how I felt my role was with her granddaughter". Another White participant described her response after her African-American client asked if she was Black, "the first thing I felt when he asked me that question (are you black?) was a very intense sense of difference." One White clinician reflected on a situation unique to particular home-visit sites, "when I walk into the projects in particular, I'm very aware that I'm the White lady". One of the clinician's of color reflected upon the experience of being perceived as White and the feelings that arise in that situation, "the huge one is around the reporting issue and feeling like I'm sort of a White perceived professional investigating him and his foster parent and the power, feeling really uncomfortable with that power differential and feeling like I'm contributing, adding more problems instead of helping. . . there's that feeling that somehow I'm perpetuating some of the institutionalized racism that has partly led he and his family to their current situation". Another White participant described her experience with the African-American caregiver of her client, "I think sometimes the African-American mother looks at me like I don't understand, like 'how could you possibly understand me and where I come from?. . . .I feel like I'm in a power struggle with one of his mother's (the African-American mother)".

57% (n=4) of White participants expressed feelings of frustration and anger, specific to race or racism that was impacting their client's lives. Some of the clinicians of color identified feeling anger towards a client caregiver but expressed that these feelings were not specific to issues related to race.   One clinician described her experience

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working with clients who live in a city that is predominately African-American, low socioeconomic status, and has a very high violent crime rate, "I think the biggest experience of countertransference with me when working in this culture is a lot of anger, a lot of anger, and even actually sometimes rage". One participant reflected on the inherent systemic racism and the feelings of anger she experienced about how her client was being treated within this flawed system, "I just felt terrible at the lack of resources there were that should have been available to him and a lot of my anger actually went towards the social worker I don't think he was African-American but he was dark and I felt like he was not looking out for the kids best interest . . . just feeling horrible about the whole situation but I don't think it was specific to his race but more how race impacts children in this society, in this county and in the schools, he was in 3 different schools, 2 of them were horrible and I felt like sure if he had been at (a higher SES neighborhood school) it would have been a whole different story but he was at these schools that were really struggling". One additional clinician, a clinician of color, reported experiencing feelings of anger towards the client's caregiver but clarified that this feeling would occur across all racial lines.

43% of White participants described feelings of inadequacy. None of the participants of color described experiencing these feelings in relation to the case they presenting on. One therapist described, "feeling inadequate, as a therapist in some ways to respond appropriately (to questions about race or racial differences)". Another described her perception of, "feeling a little bit judged by them or that I'm never going to be good enough". A different participant wondered, "did I do something wrong?" when reflecting upon a shift in the therapeutic relationship with her clients caregiver.

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One of the clinicians of color reflected on how their own experience as an immigrant impacted their work with a caregiver who was also an immigrant, " I have a lot of strong feelings towards the dad and to be honest I'm not sure if they were because of race or culture or just his choice not to be active in her treatment and to really dismiss it even though she had very clear symptoms at a very young age, so for him to choose not to look at it but at the same time I could be empathic to his experience, because I thought of him as an immigrant to this country and how difficult it was for him and how hard it was for him to find a job and how he was treated here so I could feel both sides".

2 out 12 participants reported experiencing positive countertransference which was not specific to the client's racial background.   For example, one clinician said, "my countertransference towards her, as it is with many single, working mom's, is hat's off to her".

2 of the 12 clinicians reported experiencing protective countertransference. For example one clinician said, "I wanted to bring her home quite a lot. . . I would feel scared for her a lot of the time".

<div align="center">*Play styles and Play therapy approaches*</div>

Play styles

This section of the interview explored if *the clinician's participating in this study observed any differences in children's play styles when working with children from a different race/ethnicity than their own*. 100% of the White participants identified that it was difficult to draw comparisons to children of their own race clinically because of their lack of experience with same race clients.   If White participants did have any White clients on their case load they have 1 or 2 and this had been consistent throughout their

professional experience for example, "I don't have a lot of experience working with children who are the same ethnicity as I am, right now I have 2 clients who are White and even then there's a class difference so it's really hard to say because I don't have a lot of experience working with people who are not of a different ethnicity". Another White clinician said, "most of my experience has been with African-American families and bi-racial families". Additionally, they noted the cultural and socioeconomic differences of the same race families they did have on their case load, "most of the children I work with are from a race difference than my own, I have very few Caucasian clients and even in these cases there are a lot of cultural differences". In general, participants in both groups were cautious to make causal statements about differences in interaction style based on a child's race or ethnicity.

25% (n=3) of the clinicians described observing children from a race different than their own to be more constricted in their movements or reserved in their play than children from other races. One clinician of color described the observation that, "Caucasian kids seem in terms of self-expression that their arms go out to here (side) half way or here half-way (in front of bodies) but never up here (above head) it's kind of more in their bodies". A White clinician noted the different value systems some cultures have in regards to play and recalled her experience working with Chinese children and their families, "in Chinatown, the kids would come in very constricted in their play. . .play was not valued and was not necessarily seen as a necessary part of their lives". 33% (n=4) of the clinicians shared observations of African-American children being more expressive verbally and physically. A clinician of color observed that, "with self-expression it seems to me the African-American kids are more able to move around larger and outside

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of the 1 foot or 1.5 foot range limit or bubble outside of their body, to be more expressive". A White clinician observed in her experience that "with African-American children in general there is a bit more dancing, kind of playful dynamic". Another White clinician noted differences when working with African-American families, "I think it was a little bit of a shift for me understanding the enthusiasm that a lot of the Black parents or kids that I work with have that it so different from White families I know".

58% (n=7) of the clinicians discussed the impact of socioeconomic status and cultural differences when thinking about observed differences in children's interactional or play styles, highlighting the interconnectedness of external factors that impact the child's presentation and play styles. One clinician of color reported, "I work with a lot of really low income families so although some of it is intertwined, some of it could be race and culture in terms of what they are exposed to in terms of toys but I think it could also be limited income and what their exposed to". Another clinician of color expressed, "I think the differences that I find are much more based on socioeconomic factors and even then I would say no, I think it's more based on how much was available to a particular child in their very young existence, in early infancy, did they have a caregiver who gave them something, and I think this goes across all races". Another clinician responded that, "I think class and educational level in the family is important too and how verbal the child is". One clinician through her observations in a school based setting recalled that, "those parents who are private pay are functioning on a much different level (than children whose pay is subsidized) so for me that's where the disparity comes in, in terms of those kids (Caucasian) are able to articulate much more and they have an expectation

of things where the other children don't. . .at this one school the only private pay families are Caucasian families, talk about disparity".

2 out of 12 clinicians noted that they could not assume the meaning of certain toys/figures with their current clients who are living and being treated in city with a very high violent crime rate. Both of these White clinicians spoke specifically about seeing regular incorporation of police figures in the play of children they work with in this particular city, "I see a lot of handcuff play and police car play". The other clinician observed that "around here the police are not protectors so there is ambivalence about the police, they are people to be frightened of as well as protectors".

Play therapy approach

Participants were asked to *describe their play therapy style, whether they utilized a directive, non directive or integrated approach in their general practice*. Clinicians who reported using an integrated approach were asked to describe the model they utilized on a continuum for example 70% non-directive and 30% directive. 92% (n=11) of clinicians interviewed described using an integrative style, although the degree that participants used each style varied widely across participants. 1 participant reported using a 100% non-directive unstructured approach especially at the beginning of treatment and may make adjustments based on the child, "I really am a classic, unstructured, psychodynamically based play therapist although I think when I get kids who have more disturbance and are a little bit more primitive in their presentation I tend to be a little bit more behavioral because you can't make interpretations around play if there is no play".

75% (n=9) of the clinicians interviewed described using 70% through 95% non-directive approach when conducting play therapy. Many clinicians in this group talked

about being very directive with limits and maintaining structure and consistency in the treatment but predominately using a non-directive, child-centered approach. For example, one clinician said, "I tend to be non-directive but I like to provide containment with children who have been really traumatized, one of the things I do is make it predictable". Another clinician described how a child's symptoms or history may impact their style, "I would say 70% non-directive, 30% directive and what I mean by that is that I'm very careful about the toys I bring into someone's house, so in that sense I'm directive. . . also if it's a specific trauma case I may be really specific around directive play therapy". One clinician described specifically how she incorporates directive activities into her practice, "I'm really on the non-directive end of the continuum but there are exceptions. Frequently I facilitate art projects or I introduce an activity into a session so I would say it's probably 20% directive and 80% non-directive".

2 out of 12 participants reported utilizing more directive techniques than non-directive techniques but did report incorporating aspects of both approaches into their work.

3 participants out of 12 specified that their approach is consciously altered to accommodate and facilitate the treatment at its different stages. One clinician described their approach in detail, "I use an approach that changes with stages of therapy . . . at the beginning stage of establishing rapport or engagement I do 100% directive .. . then I think I'm probably 75% directive for the next stage, which is still very much the assessment. . . as I get to the middle part of therapy, I'm probably 50-50, that's a solid 50 on both sides because in my mind I always have the goals we are working on . . . near the end stage of therapy I would say 80% directive and 20% non directive". Another clinician who tends

to be more non-directive explained, "I really follow a child's play especially early in the therapy when I'm getting to know a child and trying to gather information. . . as I get to know a child better and as we develop a shared symbolic language and I'm more confident that I'm able to accurately interpret the meaning of play then (I directly interpret the play)."

Participants were then asked *whether or not they make any adjustments to their previously described play therapy methods when conducting cross-racial play therapy*.

75% (n=9) of the participants reported no conscious adjustments to their play therapy approach when working with children from a different racial/ethnic background than their own. Several clinicians also explicitly expressed that any adjustments to their approach is dependent on the child and their specific presentation, not based on the client's race, ethnicity or culture. For example, "no, it's definitely what's coming up, what's happening, it's really the presentation of the child when I'm assessing, it might change over time. . . so it varies but it's not directed by ethnicity". Another participant said, "no, I wouldn't say it shifts at all, I do that in all, I think I work the same in all cases regardless of ethnicity or anything like that".

5 of the interviewees reported that they do make some adjustments when working cross-racially, especially in the context of dyadic or collateral work with the parents. One clinician discussed ways she is more directive in her toy selection when working cross-racially, "I try to bring a wide range of people or dolls, if I'm working for example with an African-American family I wouldn't only bring Black dolls, I try to bring a range and see what the client is going to go towards, what it brings out, so in that sense its directive because I am thoughtful about bringing more than one ethnicity" the same clinician also

spoke about adjustments when conducting home visits, "I'm really careful about not bringing too many really flashy, bright, fun toys into a home that might have limited income or if they don't have a lot of toys what does it mean? A lot of times I'll have a conversation with the parent, "I can bring toys or I don't have to bring toys, what's your choice? What would you prefer?". . .I try to be mindful in that sense, also the culture of where they live, what's their income? What's their experience?" A White clinician reflected that she tends to adopt a more non-directive style when working with children and families when she is acutely aware of the background differences between her and the client, "I think I feel more secure when I have more background, in intervening in play, and I probably feel I have less background with people whose background feels different from mine". A few clinician reflected that in their experience working with African-American families they have tended to be more directive, for example, "I think African-American families tend to be a little bit more responsive to direction sometimes and a little bit more strategic, talk straight, boom, boom, boom, this is how its gonna go, that's been my experience. I think that they are also looking for this plus this equals an answer so the psycheducational piece plays a role with a lot of families especially when doing anything about parenting. . . I tend to feel that African-American families I feel like I get shown respect more or quicker if I'm a little bit more directive, if I'm too floaty or mushy, gushy with them they almost think it's funny".

Play Room

In this section, interviewees were first asked *to describe toys or items that are used most regularly in their practice of play therapy*. All participants were then asked to describe any adjustments they make to the available toys when conducting cross-racial

play therapy. Several of the participants in this study regularly conduct home visits and therefore spoke about the toy bags that they bring on home visits. Common toys that all respondents spoke about in home based and office based work were representational objects including action figures, baby dolls and figures for the doll house, symbolic items such as puppets, animal figurines, cars, trucks and play food. Non-symbolic items that clinicians discussed included legos, blocks, board games and sensory objects. For clinicians conducting office based work the sand tray was a popular toy that was regularly used with children under age 7. 1 participant who conducts home based visits never brings toys on home visits. All clinicians who bring toys or items when conducting home-based work (n=7) spoke about modulating their toy bag based on the child's developmental, psychological and behavioral needs.

Participants were then asked to describe any adjustments they make to the available toys when conducting cross-racial play therapy. All participants explained that all of their clients have access to all of the toys available when using a play room. 7 clinicians reflected that they do not make any adjustment to the available toys but they are conscious of ensuring that they have dolls or figures available that are representative of the child's race but in general try to have a wide variety of racially/ethnically diverse figures for all clients to choose from. 6 of these 7 clinicians reported that they aim to have dolls or figures from at least 2 races so the child can choose which figures they identify with. For example, one clinician said, "Any of the people figures that I have, I do make sure that they are not just one color that they are not just all Caucasian families but they are different shades of skin". Another clinician similarly said, "in terms of baby dolls I certainly try to make sure there's at least 2 different shades, one darker and one

lighter". One clinician who modulates the toy bag for home visits reflected providing art supplies and dolls that are representative of the child's race but that she does not usually bring options when bringing dolls to home visits, "If children are African-American I may not take African-American and White dolls (would just take African-American), but I could, it would be interesting, that's something to think about because I mean it would tell me a lot about this world they live in and how they feel about it."

Two additional themes emerged from this question:

- Figures not being racially representational and the difficulty of finding dolls that reflect a range of racial/ethnic backgrounds

- The lack of control over toys and space when working within an agency and shared rooms.

Several participants expressed their frustration or observations about not being able to find figures that are racially representative of their clients. For example, "I do try to have African-American dolls and am very frustrated that there aren't Asian looking dolls, I've been looking for years! I have some figures that I use, they look pretty multi-ethnic, it was a struggle (to find them)." Another clinician expressed similar frustration about finding toys for her toy bag, "I couldn't find any Black babies that were small enough to fit in my toy bag. They had medium sized regular ones but they didn't have the little ones, I've looked everywhere and that was the best I could find. I think that's been the hardest part, they don't have, I've also looked for Black action figures or Hispanic action figures and I've had to make them out of Black Barbie's. I've made costumes or things like that and they're not as exciting as Superman". Another clinician said, "I try to have a wide range (of figures) but it's hard. I have a mixed-race African-

American, White and Native-American little girl that I've seen in play therapy for a long time and I wanted lots of powerful female figures and it was hard to find ones that were of color, some of it is that I'm limited by what I can find, by what's out there. I've tried to find a range of dark looking ones. I really don't see that many White clients or any blonde kids and yet some of the figures are blond, and sometimes I don't put them out or they're not chosen". Some clinicians also spoke about using dolls whose skin color reflected the child but other physical features, such as hair, was not accurately represented, for example, "I brought him an African-American girl and she had, her hair was not representative of the culture because it was just straight and down but he loved it, he played with her and cut her hair". Similarly another clinician said, "I have a small Black Barbie girl that I recently purchased, she's very cute, although I've heard a lot of people have problems with her because she has long straight hair, she doesn't have Black hair. She has Black (complexion) but she has White lady hair, and that's been brought up by my client, how beautiful her (the Barbie's) hair is and it's different."

Several clinicians noted that they have to work with what's available at the agency and the shared office spaces. Those clinicians who also conduct play therapy in a private practice or home-based setting commented on the additional control they could offer in regard to toys in these settings. Noting the lack of control over what is available in the shared play rooms one clinician said, "I will think about my toy bag because that's one I have some intention behind, I choose what toys I put in there". Additionally, some clinicians commented on the frustrating state of the shared rooms and comments clients had made regarded the state of disrepair of some of the rooms, "I think there's a lot of neglect, I think a lot of these play rooms, just look around, there's not a tremendous

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amount of care. I think there's a lot of stuff that's broken or a lot of things that have pieces missing and I think that in of itself actually communicates something that I have mixed feelings about. . .that's part of the reason I do most of my work in the community" she also added, "I think there is very little consistency about the representational diversity of the toys (at the clinic)." A different clinician at the same clinic said, "I feel like the rooms here could actually be better, more multi-culturally equipped. I had an African-American mother come in here the other day and she sits down. . and she's looking around the room. . . and she was like, 'I know this organization is in the middle of the ghetto but do all the rooms have to look ghetto too?' I thought about it and . . . yes, our rooms are ghetto! This whole place is ghetto! Can we do something about that!"

Added Comments

For the final section of the interview participants were asked to share any other thoughts or reflections about their cross-racial work utilizing play therapy. While the responses varied several main themes emerged:

- The importance of examining personal biases, maintain self-awareness and the   potential impact of biases on cross-racial work.

- The increased comfortability of approaching potentially difficult conversations over time.

- Clinicians not consciously making adjustments in their cross-racial work.

Additionally among White participants, a theme of growing up with a colorblind attitude was expressed. Some clinicians of color reflected upon feeling more at ease establishing relationships with clients of color because of similar experiences.

3 clinicians reflected on the importance of examining personal biases and potential impact when conducting cross-racial work, stressing the necessity of self-reflection. For example, one clinician reflecting upon personal assumptions said, "we all have them and to try to figure out what they are and whether or not they are impacting our work with kids". Another clinician spoke about how this became so evident to her through clinical experiences, "it had been a slap in the face a lot for me, of reality and it's been really difficult and its forced me to find my own spirituality and my own center doing this work, looking at my own assumptions that come up all the time, the little subtle things that happen".

Related to the previous theme, some clinicians spoke about adapting their approach to dealing with racial differences over time. For example one clinician reflected on the anxiety she experienced as a new clinician, "the big thing is that number one I've had a lot of anxiety and discomfort about racial differences and I think as I become more confident and more experienced I'm more willing to really own that and think about it and talk about it, to challenge myself a little bit in my work". A different clinician said, "I used to hide who I was, when I first started doing this".

4 clinicians reflected that after participating in the interview they became aware that they were not making any specific adjustments based on a client's race. One clinician wondered if this was negative, "makes me wonder, is there something I'm missing cause I'm not getting a big sense of doing things really differently" while another participant reflected that they were still able to meet their clients' needs using the same general approach, "still tailor it to whatever is going on, whatever the person needs". One clinician reflected how for her, her approach is really adjusted to meet the needs of each

individual case, "I don't think in those terms, in terms of the same thing for this kid or that kid, I just try to respond to each child's situation and part of it is their immigration or racial background and part of it is their psychological issues".

60% of the clinicians of color (n=3) spoke about how their racial/ethnic background impacts their work cross-racially as well as with same race/ethnicity clients. 2 of the Latino clinicians reflected on their work with clients who were also Latino and expressed that it may be easier to connect with families who have similar experiences such as growing up bilingual. One bilingual clinician said, "I work with a lot of Latino kids which doesn't necessarily meet your criteria of cross-racial but we definitely talk about culture and language with them and probably I have a better sense of them and what it's like to be them so it may be that it is easier to talk with them about their experience because I've shared some of it or am more aware of what it's like to grow up bilingual". One clinician reflected on how she is white perceived by some families, "even though I'm Latina, to them, I was just a white girl, she said it didn't matter but I wasn't ever entirely convinced of it and I think part of it is also that I represent some kind of system and the family had had so much trauma related to systems that I think that was the other part too". Another clinician of color wondered if her cross-racial work may have been easier because she is not Caucasian, "I think being an Asian therapist has been easier working with kids who are of color, I actually think it's been easier, I think it would have been harder for me, I'm supposing, I have no idea but I think it would have been harder had I been a Caucasian woman working with African-American children for example. I think it really softens it and I think ultimately over time what really matters with kids is the relationship".

A few White clinicians reflected on their experiences growing up with a colorblind perspective and how this has impacted their cross-racial work. For example one clinician reflected, "White people don't talk about race as much as the Black children that I work with. . .pretending like it wasn't there wasn't really a choice because the kids were really bringing it into our sessions and what we talk about".

Two clinicians noted the importance of having agency support to model how to approach conversations about race clinically. One clinician said, "I would say if in a program the clinicians are talking about it I think it models an ability to be able to talk about it with your clients. So, if there is no conversation about it you are less likely to be even thoughtful or confident to bring it out". A different clinician expressed her desire for more agency support, "I won't say that there isn't really any support for that but I think I would appreciate more external challenging, more really honest discussion, the safety to be vulnerable about these things".

A few clinicians noted the unconscious aspect that race may play in the therapeutic relationship, noting that the impact of race is not something they consciously when working with this age group, one clinician said, " I think probably it's more of an issue clinically that I realize". 2 clinicians spoke about adopting an educational approach to their cross-racial work, making conscious efforts to educate themselves about cultures they are unfamiliar with, one clinician recommended to "learn as much as you can about the culture you are in".

Summary

The findings presented in this chapter are the results of 11 interview questions with 12 therapists currently practicing cross-racial play therapy with children under the

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age of 7. In general, participants in this study expressed their child client's

communicated something about race non-verbally.

- 42 % (n=5) of participants in this study reported discussing the racial difference between themselves and their child client, under the age of 7, in the case which they presented on, after the child introduced the topic.

- 58% (n=7) of participants directly said "no" that they did not view race as any way connected to the child's presenting problem or reason for referral.

- The majority of the participants did not make any changes regarding their play therapy approach when conducting cross-racial play therapy. The participants in this study reported a conscious effort to ensure a range of racially/ethnically diverse dolls and figures were available for all of their clients but especially when working cross-racially to try to have representative dolls or figures, but no additional toys were brought in or removed from the room.

Implications from these results will be explored in the Discussion Chapter.

CHAPTER V

DISCUSSION

The purpose of this study has been to explore the experiences of clinicians who practice cross-racial play therapy with children under age 7, specifically exploring the questions*: (1) Are clinicians adjusting their play therapy interventions, toys and physical space when conducting cross-racial play therapy with children under age 7? (2) Are clinicians acknowledging and discussing racial differences in the context of cross-racial play therapy? (3)Do clinician's use specific techniques to bring in and address the client's and their own racial/ethnic identity in play therapy? (4) Is a child's race looked at in relation to the presenting problem?* The discussion of the findings will address these questions in relation to relevant literature on the topic. Implications of the findings for clinical social work practice will be explored. Limitations of the current study will be acknowledged.   Finally, new questions and possibilities for future studies that have emerged in the course of this study will be introduced.

Play Therapy Case

Consistent with the literature, the 83% of the participants in this study presented a case example on children who were in treatment for symptoms related to trauma. These children displayed a range of aggressive or withdrawn behaviors.   Previous research has shown that children who survive childhood maltreatment face emotional, behavioral, social and cognitive impacts. Further research is needed to explore how a child's symptomolgy impacts communication and responses about race and racial differences.

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Racial Communication and Response

11 of the 12 clinician's interviewed for this study reported that their client under the age of 7 communicated non-verbally something about race or the racial difference in the therapeutic dyad. 50% of participants (n=6) also recalled their client directly asking or noticing the racial difference in the dyad. The participants in this study reported that their clients tended to be very concrete in their observations about race or racial difference for example, a White participant described an interaction with her African-American clients, "the little boys went to the baby doll bin and started pulling out baby dolls and gave me the White one. . . and then gave their mom the African-American one (baby doll)". This is consistent with developmental level of children under age 7; at this stage children will tend to be concrete and literal in their thinking (Tatum, 1999). Also due to children's developmental level at this age they lack the cognitive ability to verbally express what they are emotionally feeling (Landreth, 1991, pp.13). Through the use of symbolic play, the child translates images of people, things and places that he or she hold in their mind into a behavioral sequence of pretend play (Hinman, 2003). While children under age 7 may not have the language yet to communicate their observations, questions, or anxiety related to race and racial differences, the current findings indicate that within the safety of therapy, children are able to use play to explore these areas.

Research has found that children begin to notice and categorize difference very early, that there are development tasks and steps "in the construction of identity and attitudes" and "societal stereotyping and bias influence children's self-concept and attitudes toward others" (Derman-Sparks, 1989, pp. 1). This appears to be consistent

with what clinicians in the current study noted, with 11 of 12 participants recalling their client's efforts to explore race and racial differences within the therapeutic dyad through their play or verbally.   Additionally, 2 clinicians spoke about their client's caregiver expressing clear statements regarding their client's racial identity, indicating that children under the age of 7 are impacted by stereotypes and attitudes related to their gender and race. For example one clinician reported the client's mother expressed a desire for "something better for their son" and another parent referred to her son as a "budding African-American male". These statements reflect the caregiver's experiences and indicate the messages these children are receiving about their race and gender from their families and communities.

This study found that children are consistently bringing up race or racial differences non-verbally in therapy but that how a clinician responds is case dependent and likely influenced by the clinician's play therapy approach. Given the lack of education and research in this field, clinicians responded to their client's questions or acknowledgements about race and racial difference in a range of ways. 42 % (n=5) of participants in this study reported discussing the racial difference between themselves and their child client, under the age of 7, in the case which they presented on.   These clinicians reported discussing the racial difference after their client had communicated something about race (their own or the clinicians) verbally or non-verbally. It remains unclear how these responses are perceived by the client and impact they have on therapeutic relationship.   Previous research indicates that play therapists, especially European Americans, may feel uncomfortable when discussing race or racial differences in the therapeutic relationship. In the current study, the factors underlying a clinician's

decision to or not to acknowledge the racial difference in the room were not explored. However, some clinicians indicated their choices were impacted by their play therapy approach of non-directive play therapy. For example, one clinician explained her interpretation of her client's play, "nonverbally he plays with the cars and he always picks a black car and he gives me a white car, a white truck and I actually haven't interpreted that or said anything about that but one of my hypothesis is that he notices that we're different colors . . . because I don't know and I guess I can explore. I like to give kids a little while to use their own words and I'd rather use their own language about how they perceive the differences". Future research is needed to explore the potential benefit of clinicians integrating a more directive approach in order to acknowledge differences within the cross-racial therapeutic dyad.

An unexpected finding that emerged in this section is that all participants in this study acknowledged that they regularly initiate a discussion regarding the racial and/ or cultural differences within the therapeutic dyad with the child's caregiver. In the current study, the interview guide intentionally excluded questions pertaining to clinician's experiences addressing race and racism with a child client's caregiver. This was done in an effort to maintain the study's focus of clinician's experiences addressing these issues with children. So, while clinicians were not directly asked about their acknowledgement of the racial difference within the dyad with their client's caregiver, all participants shared their incorporation of this approach into their practice. There could be several factors that contribute to clinician's choice to utilize this approach including considering the developmental level of caregivers and the ability to communicate in a more verbal manner, the awareness and experiences of racism and bias, and perhaps these participants

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received greater training about approaching conversations about race, racism and racial differences with adult clients.

Race and presenting problem

Slightly less than half of the participants noted systemic or institutional aspects of racism that they viewed as connected to child's reason for referral. 66% (n=8) of the children that were presented on were identified as African-American. Out of the 10 children who presented for treatment of symptoms related to trauma, 50% (n=5) had been removed from their biological parents care and were in a foster or adoptive home. While this could be understood by a number of factors, it could also point to an example of institutional racism. Previous research has indicated that institutional racism is evident in the child protective system in the United States as demonstrated by the large racial disparities within this system. African-American children are not more likely to be maltreated when compared to White children however a disproportionate number of incidents involving African-American children are substantiated when compared to White children (Sedlak & Broadhurst, 1996 as cited in Wells, 2008). Clinicians who are working in areas where systemic and institutionalized racism is rampant must consider the historical and persistent racism that children and their families have experienced in order to complete a thorough assessment and treatment plan.

Countertransference

Previous research on cross-racial therapeutic dyads has indicated that an essential starting place for clinician's working cross-racially is an examination of their personal racial identity. In order to facilitate effective cross-racial therapy Schacter & Butts (1968) found that the therapist must remain aware of his or her reactions to the patient,

remain aware of transference and countertransference feelings, and remain aware of the use of stereotypes in the room. In the current study, clinicians reflected a range of emotional reactions when asked to discuss their countertransference feelings, specific to race, in regard to one cross-racial play therapy case.   The clinicians in this study were open and forthcoming about the challenging as well as positive feelings they experienced regarding a client they were utilizing cross-racial play therapy with.   5 of the clinicians (4 White clinicians, 1 clinician of color) in this study described an acute awareness to the impact of institutional racism and transference regarding their client's experiences within an oppressive system.   57% (n=4) of White participants expressed feelings of frustration and anger, specific to race or racism that was impacting their client's lives. 43% of White participants described feelings of inadequacy.   The experiences of these participants indicate the complex, layered emotions that are present in both the clinician and the client when working cross-racially and support Schacter & Butts' recommendations for facilitating effective cross-racial therapy.

3 clinicians noted that the countertransference they described was not specific to race and they would experience similar reactions with clients of all races. Clinician's countertransference experiences when conducting cross-racial play therapy may include similar emotional reactions as when conducting any therapy. However, in some cases it appears that a clinician's countertransference experience is impacted by the client's race and their experience of racism within our society and institutions. Clinician's countertransference experiences when working cross-racially with children under the age of 7 appears to be similar to clinician's experiences of working cross-racially with adults.

Play and Interaction Styles

100% of the White participants identified that it was difficult to draw comparisons to children of their own race clinically because of their lack of experience with same race clients. This finding highlights the importance of providing clinicians with access to trainings specific to cross-racial play therapy, as this is the dominate clinical experience of some clinicians.

Many clinicians noted they were not comfortable attributing observed differences solely to racial/ethnic or cultural differences. Roopnarine and Johnson (1994) state that a "child's play will be influenced by a number of intersecting elements according to cultural-ecological models of behavior and development including physical and social aspects of children's immediate settings; historical influences that affect the way adults (and children) conceptualize play; and cultural and ideological beliefs relative to the meaning of play for subgroups of children" (pp. 4). 58% (n=7) of the clinicians discussed the impact of socioeconomic status and cultural differences when thinking about observed differences in children's interactional or play styles, highlighting the interconnectedness of external factors that impact the child's presentation and play styles. This serves as a reminder that a child's race and the clinician's race is only one layer of each individual's identity within the dyad. While it is important to be attuned to the racial dynamics within the therapeutic dyad, clinicians must not forget the other elements impacting their own and their clients identity.

Previous research has indicated that it is expectable that a child's play may vary based on their racial/ethnic or cultural backgrounds. In the current study, 25% (n=3) of the clinicians described observing children from a race different than their own to be

more constricted in their movements or reserved in their play and 33% (n=4) of the clinicians shared observations of African-American children being more expressive verbally and physically than children from other racial backgrounds. Further research is needed to understand if and how a child's play and interaction style is impacted by his or her racial background.

Play therapy approach

The majority of the participants did not make any changes regarding their play therapy approach when conducting cross-racial play therapy. This study consisted of participants who identified as utilizing a predominately non-directive play therapy approach. In nondirective play therapy the therapist allows the child to lead the play and the therapist makes no effort to impact the child's behavior; the underlying theory is that "the child's behavior at all times caused by the drive for complete self-realization" and therefore the goals are self-awareness and self-direction of the child (Landreth, 1991, pp. 32). A clinician's theoretical approach will most likely impact their understanding and response to racial difference within a cross-racial therapeutic dyad.

Toys and Space

In order for play therapy to be an effective medium for children, to express their inner lives, they must be provided with toys that they can relate to and communicate effectively with (Gil, 1991; Hinman, 2003; Kranz et al, 2005; Landreth, 2001; Lebo, 1955; Vargas & Koss-Chioino, 1992). All participants in the current study reported a conscious effort to ensure a range of racially/ethnically diverse dolls and figures were available for all of their clients. However participants emphasized the importance of having representative figures when working cross-racially but did not bring additional

toys into the room or remove items from the room. Slightly over half of clinicians reported they do not make adjustments to the toys when conducting cross-racial play therapy.

Previous research has indicated how the use of dolls and figures can facilitate the therapist's understanding of the child's racial identity development; "with dolls, a therapist can assess children's attitudes about cultures different from their own and can stimulate discussion about ethnic identification, self-perceptions, and idealized or rejected self-images" (Vargas & Koss-Chioino, 1992, pp. 91). Participants in the current study shared examples of how representative figures or art supplies facilitated a child's expression of self perception. One clinician recalled using skin color crayons to facilitate a client's understanding of his multiracial background, "this one little boy, his dad is Hispanic, he has an Indian grandmother, his mom is Black, he was really concerned about color, he said 'I'm White'. Because for a while he didn't think mom was related to him and his dad was abusive so he was relating to his dad but there were problems with that. So we did a lot of work with me bringing in all these colors (crayons) and one day I had him draw all the people in his family and they were all different colors and then he was able to say, 'it's really hard being different'. When working with children under age 7 clinicians should consider art as an effective way to assess and explore a child's racial identity development.

Additional Themes

Research has indicated that some clinicians of color may be more conscious of race and the impact of race in the therapeutic dyad than white therapists. Clinicians of color may more regularly address the issue of race in the therapeutic dyad when

compared to white clinicians. Clinicians of color are also more likely to feel comfortable discussing race in the therapeutic dyad when compared to white clinicians. In the current study 3 of the 5 clinicians of color spoke about how their racial/ethnic background impacts their work cross-racially as well as with same race/ethnicity clients.

Many White people, do not grow up in a setting where they are regularly engaged in cross-racial interactions and therefore may struggle to maintain racial sensitivity when engaged with people of color (Laszloffy & Hardy, 2000). A few White clinicians reflected on their experiences growing up with a colorblind perspective and how this has impacted their cross-racial work. For example one clinician reflected, "White people don't talk about race as much as the Black children that I work with. . .pretending like it wasn't there wasn't really a choice because the kids were really bringing it into our sessions and what we talk about". This indicates the necessity of White clinicians remaining aware of and attuned to their own biases and any verbal or non-verbal communication about race and racial differences that the child is introducing.

Implications for Social Workers

While the 12 participants in the current study may not be representative of all current play therapy clinicians, some of the findings may be generalizable to clinicians practicing cross-racial play therapy with children under age 7. The current findings, and support from previous research, indicate that children under the age of 7 are aware of racial differences. All clinicians, must be conscious and aware of racial dynamics that are present in the room with all clients, including children under age 7. As Derman-Sparks states in the Anti-Bias Curriculum (1989, pp. 7), "ultimately, the colorblind position results in denial of young children's awareness of differences and to non-

confrontation of children's misconceptions, stereotypes, and discriminatory behaviors, be they about race, culture, gender, or different physical abilities" (pp. 7). Many participants in the current study offered several examples when race and racial difference had been brought up verbally or non-verbally when working cross-racially with children under the age of 7. Given the developmental level of children under age 7 it appears to be important that clinicians remain aware of non-verbal communications that may indicate anxieties, questions or observations regarding race and the racial difference within the dyad. Children under the age of 7 are often referred to therapy due to complex factors, and in this study predominately symptoms related to experiencing trauma. It remains unclear what the recommended approach is for responding to a child's play or comments related to race and racial differences within the dyad. Responding to a child's questions, observations, and anxieties related to race and racial difference could provide an opportunity to combat biases and negative racial attitudes that children of this age may be exposed to.

All White participants in this study noted their lack of same-race clinical experiences. The clinicians of color in this study were more likely to have same race clinical experience if they were bilingual but still carried a case-load of some cross-race work. If this finding is generalizable to other clinicians utilizing play therapy with children under the age of 7 this indicates the necessity of cross-racial play therapy training. It is important clinician's be offered techniques and theories to consider when approaching cross-racial play therapy work. It is not enough to train clinicians to work-cross racially with adults, as children are much more likely to communicate and process information non-verbally. Clinicians must be offered cross-racial training specific to play

therapy in order to provide a racially sensitive and open environment where young children can explore their racial identity and understanding of racial differences.

Since children under the age of 7 are more likely to communicate their internal experiences non-verbally it is important that therapists provide toys and an environment that facilitate this process. In order to provide an environment that encourages self-exploration and racial identity exploration, clinicians should ensure that their clients have access to figures and toys that are representative of a range of diverse racial backgrounds. Additionally, participants in the current study shared how art supplies can be used to assess and explore a child's racial identity and self-perception.

Strengths and Limitations of current study

The strengths of the current study include the recruitment of a diverse sample including a range in clinical experience, racial backgrounds, and clinical setting among participants.

Limitations of this study include the relatively small sample size; the responses obtained from the 12 participants in the current study may not be inclusive of the experiences of all clinicians practicing cross-racial play therapy.   Despite efforts to recruit a diverse sample by recruiting for 2 groups of participants – one group of clinicians of color and one group of White clinicians, there was limited gender diversity. Additionally, although the experiences of some clinicians of color were obtained none of the participants identify as African-American, which is the racial group most of the previous literature on cross-racial therapy refers to. Some of the participants of color made reference to being able to "pass" as a number of different races/ethnicities which may impact their experiences as clinicians of color practicing cross-racial play therapy. It

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is also important to note that the 2 groups in this study are not equal – there were 7 White clinicians and 5 clinicians of color who participated. I fulfilled the White participant category easily and quickly and had a much more challenging time recruiting clinicians of color who met participation criteria. This is consistent with the disparity and lack of diversity that exists within the professional clinical field; the clinical profession is dominated by White, woman clinicians. Finally, all participants were currently practicing in the same geographic region. The experiences of these clinicians may differ from clinicians practicing in more conservative, less diverse regions in the country.

It is also important to consider the possible selection bias of participants in the current study. All of the White participants practiced at the same agency and some were familiar with me from the time I was employed at the same agency. The White participants in this study were recruited in an agency wide meeting and therefore may have experienced pressure to participate. The clinicians of color in this study were recruited individually, without agency sanctions.

Bias of Researcher

As was acknowledged previously in the paper I, the researcher, designed the interview guide from my position as a White, female, clinician in training and therefore the questions may contain personal biases. Additionally, in-person interviews could have been impacted by my presentation and professional relationships to some of the participants.

Conclusions

Following this study, it is clear that the participants did not receive education or training specific to cross-racial play therapy. Additionally all White participants reflected

upon their lack of same race clinical experience throughout their clinical career. If this is a common experience among white clinicians, it seems essential that there is greater focus on education regarding cross-racial play therapeutic dyads.   Several new questions emerged from the responses of participants in this study.

For future research studies it would be valuable to explore the experiences of African-American clinicians who are conducting cross-racial play therapy as much of the existing literature about clinician's experiences conducting cross-racial therapy with adults focuses on the Black/White racial dynamic.

Given the large number of non-directive play therapists who participated in the current study, future research may explore similarities or differences among directive play therapists who are working cross-racially with children under age 7, specifically in relation to whether or not and how directive clinicians are responding to any non-verbal introductions of race in therapy.

Given the high percentage of children who were presented on for the current study who were referred due to symptoms related to experiencing trauma, a future study could focus specifically on cross-racial play therapy with traumatized children. In the current study, a few clinicians commented that their priority was to focus on symptoms and healing related to traumatic experiences and noted that initiating discussions of race was therefore not part of the treatment plan. Future studies could explore the relation between race, racism, and trauma to determine if acknowledgement and exploration related to race and racial differences in the therapeutic dyad is valuable in healing from traumatic experiences.

Despite the limits of this study, the narratives obtained of 12 participants practicing cross-racial play therapy with children under age 7 may be relevant and generalizable to some clinicians who also are working in a cross-racial therapeutic dyad with this age group. The study provoked new insights and reflections among the participants and indicates the importance of conversations among clinicians, education and personal self-reflection when conducting cross-racial play therapy. It is important agencies are providing opportunities for conversation and education regarding cross-racial play therapy. Additionally, clinicians need access to toy resources that are representative of their clients.

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Appendix A

Informed Consent Form

Dear Potential Research Participant:

My name is Rebecca Fox and I am a student at Smith College School for Social Work in Northampton, MA. I am conducting a study focused on clinicians' experiences when conducting play therapy with children under age 7 who are from a different racial background than the clinician (cross-racial play therapy). The data from this study will be used in my Master's thesis, and for future presentation and publication on the topic. You are being asked to participate in this study because you are a clinician currently practicing cross-racial play therapy with children under age 7. To be included in the study, you must be a psychotherapist at the Masters level or above who has been conducting play therapy for at least one year post graduation from your Master's program. You must also speak English, as no translation services are available for this study.

If you choose to participate in this study, you will be asked to sit for an in-person interview, lasting approximately 60 minutes at your office or agency. Interviews will be digitally recorded. This study seeks answers to questions regarding clinicians experiences and interventions when conducting cross-racial play therapy with children under age 7.   You will also be asked brief, demographic questions regarding your age, professional degree(s), years in practice, and client demographics. Additionally, if possible, I will take photographs of your play therapy room and the available toys. There will not be compensation for participation in this study.

There are potential risks to participating in this study; specifically the possibility that participation will bring up difficult feelings as you reflect on your experiences as a play therapist. You can choose not to answer any question and/or to stop the interview at any time.

Participation in this study may allow you to explore your experiences related to cross-racial play therapy in greater depth. Your contributions will provide important information to other providers providing similar services.

Confidentiality will be kept by assigning interview tapes a code and removing all identifying information. Some illustrative quotes will be used for publication but will be changed to eliminate identifying information, thereby protecting your privacy. I will be the main handler of all data including tapes and transcripts, however my thesis advisor(s) will also have access to this information should it be necessary to assist in the completion of this study. Any person working with the data or assisting with transcription will be required to sign a confidentiality agreement. I will keep the tapes and transcripts for three years, in compliance with federal regulations. During this time, tapes, transcripts,

and signed consent forms will be kept in a locked cabinet. After the three year period has expired, all material will be destroyed or, if kept, will remain in a locked cabinet. The data will be used for my thesis and may be used for future presentations and publications.

Your participation in this study is voluntary. If at any time during the interview you do not want to answer a question or you wish to discontinue the interview, that is your absolute right and I will honor your request without any repercussions to you. You have the right to withdraw from this study at any time (before, during or after the interview) up to April 1, 2010, when the report will be written. My contact information is listed below. Please contact me and/or the Chair of the Human Subjects Review Committee at (413) 585-7974 if you have any questions or concerns.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

_____
Signature of Participant   Date

_____
Signature of Researcher   Date

If you have any questions, or wish to withdraw form the study, please contact me at:
Rebecca Fox
Children's Hospital Oakland, Center for Child Protection
747 52nd Street Oakland, CA 94609
925-XXX-XXXX
rfox@smith.edu
PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS

Appendix B

Interview Guide

Demographic Questionnaire

Degree:

Years of practice:

Race/ethnicity you identify yourself as:

Are you currently conducting play therapy with children under age 7?   Yes_____
No_____

Are you currently conducting play therapy with children who are from a different
racial/ethnic background than your own (cross-racial play therapy)?   Yes _____
No_____

Setting where you are conducting play therapy? (private practice, agency, inpatient,
outpatient, short term, long-term)

 During your education and subsequent training opportunities, have you had any classes
or trainings that addressed cross-racial play therapy work specifically?

Semi-Structured Interview Questions:
Before we begin the interview I just want to emphasize that I am simply curious to hear
about your experiences conducting cross-racial play therapy. My hypotheses will be
developed based on an analysis once I have completed the interviews.
Here is a list of definitions that you can refer to throughout the interview. I am using
these definitions throughout my study.
(list of definitions)

Before beginning the interview I would like to provide you with the definition of a cross-
racial therapeutic dyad that I am using for the purposes of this study. Definition: *Cross-
racial therapeutic dyad:* A cross-racial therapeutic dyad is understood as clinicians
engaging with clients who have racial or ethnic identities that differ from their own
(Miller & Garran, 2008).

- I would like to start by asking you to think about and choose one cross-racial play
  therapy case you have had with a child under the age of 7 where race was a
  common theme in the treatment. Can you tell me a little bit about the case
  (including the childs age, race, presenting problem, treatment modality,
  interventions, goals)

Follow-up: How was race introduced and communicated, **verbally or non-verbally,** between you and the child?

Follow-up: Did you discuss your racial difference from the clients?

Follow-up: Was the client's racial/ethnic background central to the presenting problem?

Follow-up: Can you describe any significant countertransference feelings, specific to race, that came up for you with this case?

Definition: Countertransference: totality of the clinician's experience with the patient. The therapist's feelings toward a client and the feelings that the client elicits within the clinician.

- Have you noticed differences in play or interaction styles, when working with children from different racial/ethnic or cultural backgrounds than your own?

- Do you use a particular play therapy approach such as directive or non-directive, as defined (I will read the definitions to interviewees)? If you use an integrated model can you describe it to me on a continuum (example: 70% non-directive, 30% directive)

  Definitions: Directive – the therapist is more active –guiding and interpreting the play – includes CBT, art therapy and Bibliotherapy.

  Non-Directive: Responsibility and direction of the play are left to the child

  Follow-up: Is race/ethnicity a consideration when you decide on treatment interventions/ approach (example: directive vs. non directive)?

  If yes: Follow-up: Describe any ways you consider and address racial differences when approaching work with children from a different race

- Look around or imagine your play room. Describe the toys or items that are used most regularly

  Follow-up: How do the selection of available toys vary when conducting cross-racial play therapy?

- Is there anything else you would like to share with me regarding your cross-racial work utilizing play therapy?

Appendix C

HSR Approval Letter

January 11, 2010

Rebecca Fox

Dear Rebecca,

Your amended materials have been reviewed and you have done an excellent job in their revisions. We are now able to give final approval to this interesting study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

I wonder if you'll find that many therapists never deal with race at all in their work with children of a different race than their own. It will be interesting to find out. Unfortunately, maybe those who never deal with it will also not want to join the study! Good luck with your recruitment and your study.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Diana Fuery, Research Advisor

Appendix D

Recruitment Letter

ATTENTION!!! Master's levels clinicians practicing cross-racial play therapy with children under age 7.

I received your information from a colleague who thought you may be interested in participating in a study about clinician's experiences of conducting cross-racial play therapy with children under age 7. I am currently conducting my Master's thesis project for my Master's degree in Social Work at Smith College School for Social Work.

For this research I am interviewing Master's level clinicians who are currently practicing play therapy with children under the age of 7. You have at least 1 year, post-degree, experience practicing play therapy and are currently conducting play therapy with children from a different racial background than own. The interview for this study will take between 50 - 60 minutes, take place in-person, and will be comprised of demographic and semi-structured interview questions.

You may find participation in this study has several benefits. You may experience increased awareness which may help to inform the work you do. Participation in this research will also help the field of social work because it helps to fill a gap in the existing literature on practicing cross-racial play therapy with children under age 7.

To learn more about participation please contact me, my information is below. I will also follow-up with you within one week. Thank you for your consideration!

Rebecca Fox
Second Year Masters Student, Smith College School for Social Work
(925) XXX-XXXX
rfox@smith.edu
747 52nd Street, Oakland CA, 94609

<u>**This research is advised and supervised by:**</u>
<u>**Smith College School for Social Work, Lilly Hall, Northampton, MA 01063**</u>

Appendix E

Definitions

Countertransference : Totality of the clinician's experience with the patient. The therapist's feelings toward a client and the feelings that the client elicits within the clinician.

Cross-racial therapeutic dyad: clinicians engaging with clients who have racial or ethnic identities that differ from their own (Miller & Garran, 2008).

Cross-cultural counseling: "Working with people from different cultural backgrounds, and they may or may not be of the same race" (Miller & Garran, 2008, pp. 227).

Culture: An, "ideological dimension of the human condition that guides and motivates behavior" (Vargas & Koss-Chioino, 1992, pp. 2).

Cultural responsiveness or sensitivity: The clinician's ability to "acknowledge the existence of, show interest in, demonstrate knowledge of, and express appreciation for the client's ethnicity and culture . . . [and] . . . place the client's problem in a cultural context" (Atkinson & Lowe, 1995, p. 402 as cited in Knox, Burkard, Johnson, Ponterotto & Suzuki, 2003, pp.466).

Directive play therapy: The therapist is more active, guiding and interpreting the play, includes CBT, art therapy and Bibliotherapy

D*isplacement:* Not interpreting connections from the play to the child's life – can be an effective way to bring about symptom relief (Webb, 1991).

Ethnicity is a "socially defined group based on *cultural* criteria, such as language, customs, and shared history"(Tatum, 1997, pp. 16).

Internalized racism can manifest in internalized feelings of "superiority and privilege or feelings of being less worth or responsible for one's own social oppression" (pp. 236).

Nondirective play therapy: Responsibility and direction of the play are left to the child

Play therapy: "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development"

Race: a social construction of group identity which has historically been used for domination of one identifiable group over another identifiable group and is "particular to a certain time, place and cultural context" (Altman, 2010, pp. 75, Miller & Garran, 2008). In the United States **race** is typically used to describe individuals with similar skin colors (Altman, 2010).

Racial sensitivity*:* in therapeutic relationships is a more specific term defined as the "the capacity to anticipate how others may think and feel racially, and to adjust and accommodate one's own behaviors accordingly. Racial sensitivity requires empathy and the capacity to relate, especially cross-racially, in ways that make others feel racially understood and comfortable" (Laszloffy & Hardy, 2000, pp. 37).

Symbolic play: the child translates images of people, things and places that he or she hold in their mind into a behavioral sequence of pretend play (Hinman, 2003).

Therapeutic alliance is defined as a strong, positive relationship between the therapist and the client (O'Connor, 1991, pp. 10).