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Sarah Flashman
Exploration into Pre-clinicians'
Views of the Use of Role-Play
Games in Group Therapy With
Adolescents

ABSTRACT

This qualitative study examines pre-clinicians' beliefs and experiences with adolescent group therapy and role-play games (RPGs) as therapeutic group treatment. Twelve pre-clinicians in a community mental health agency were asked about their thoughts and experiences of group therapy and the use of RPGs in adolescent group therapy. The larger themes found in this study were participants' experiences with group therapy, use of group therapy, and RPGs in adolescent group therapy. These results indicate that pre-clinicians rely heavily on experience, rather than research, when making clinical decisions. Furthermore, this study shows that pre-clinicians have little knowledge about RPGs, but view them as an effective mode of adolescent group treatment.

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES
IN GROUP THERAPY WITH ADOLESCENTS

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY
GAMES IN GROUP THERAPY WITH ADOLESCENTS

A project based upon an independent investigation, submitted in partial fulfillment of the
requirements for the degree of Master of Social Work.

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2015

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

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EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES
IN GROUP THERAPY WITH ADOLESCENTS

TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	ii
TABLE OF CONTENTS.....	iii
LIST OF TABLES.....	iv
CHAPTER	
I INTRODUCTION.....	1
II LITERATURE REVIEW.....	3
III METHODOLOGY.....	15
IV FINDINGS.....	23
V DISCUSSION.....	51
REFERENCES.....	70
APPENDICES	
Appendix A: Smith HSR Approval Letter.....	75
Appendix B: Mental Health Partners Approval Letter.....	77
Appendix C: Consent Form.....	78
Appendix D: Interview Outline.....	81

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES
IN GROUP THERAPY WITH ADOLESCENTS

LIST OF TABLES

Table

1. Themes, Subthemes, and Coding Groups Table	25
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EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

CHAPTER I

Introduction

Recent research has demonstrated that some mental health clinicians have used role-play games (RPGs) with adolescents to increase their social skills and change their maladaptive behaviors, but their use has not been generally accepted in clinical practice (Enfield, 2007; Rosselet & Stauffer, 2013; Zayas & Lewis, 1986). RPGs are defined as games in which multiple players take on the role of a character in a group setting, and co-create a story through role-play (Sargent, 2014). As an adventure unfolds, the game implements psychodrama, a psychodynamic group based modality that brings meaning to the group social interactions (Moreno, 1946) in a fantasy world by allowing players to assume identities as characters and meet challenges and make choices as their characters (Rosselet & Stauffer, 2013). Case studies have documented the effectiveness of RPGs (Enfield, 2007; Rosselet & Stauffer, 2013; Zayas & Lewis, 1986), but researchers have often been participants' clinicians and have not done quantitative or comparative research.

This study examines pre-clinicians' experiences with group therapy to better understand if either the structure, or the substance, of a RPG group creates barriers to pre-clinicians' use of RPGs in adolescent group therapy. This is important to examine to better understand why, though RPGs seem to be an effective mode of treatment, they are not more commonly researched and used in clinical setting. Twelve pre-clinicians, defined as students providing mental health services to clients through an internship or practicum, currently seeking a clinical degree, were

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

asked a series of open-ended questions in individual interviews. Participants were asked about their experiences with group therapy, whom they believe group therapy is effective for, their current knowledge of RPGs, and their opinions about how RPGs could be used in group therapy with adolescents.

This study will benefit the field of social work and other related fields with respect to clinical practice, future research, and training. First, this study contributes to the research supporting the use of RPGs in adolescent group therapy and furthers the field's understanding of why RPGs are not widely used in adolescent group therapy. I explain the potential benefits of this novel therapy modality, while providing insight into possible limitations and barriers to the use of RPGs. Most importantly, this research supports the need for further investigation into the utility of therapeutic RPG groups, by examining the current literature supporting the use of RPGs in adolescent groups and showing that pre-clinicians similarly support the use of this therapy. Finally, this study provides insight into how pre-clinicians make clinical decisions. This has significant implications for education; it shows that clinical decisions are influenced by clinicians' experiences in education, their personal lives, and the clinical settings in which they work.

The following chapters explore the foundation for this study and its relationship to the current literature; the methodology used; the demographic and qualitative findings from semi-structured interviews; and finally a discussion that makes significance of the research findings.

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

CHAPTER II

Literature Review

This literature review explores current research regarding adolescent group therapy and the use of RPGs in therapy by first discussing the utility of adolescent group therapy. I will next discuss the use of evidence-based modalities that employ games in adolescent therapy, including RPGs and their function outside of therapeutic treatment. Subsequently, I will discuss the current research around using RPGs in therapy with children and adolescents. Finally, I will summarize the limited available literature on clinicians' perspectives of treatment options, and its influence on adolescent group treatment. This literature review led me to seek to further explore clinicians' perspectives on using RPGs in group therapy with adolescents, the topic of this thesis.

Group Therapy with Adolescents

Group therapy does not have a generally accepted definition, primarily because the words “group” and “therapy” are both fairly ambiguous words (Dagley, Gazda, Eppinger, & Stewart, 1994). For the purposes of this study, however, group therapy is defined as an intervention provided simultaneously to three or more individuals intended and designed to alleviate psychological distress, or change behavior (Dagley et al., 1994). Group therapy, under this definition, is a well-established and cost-effective mode of treatment for a variety of psychological ailments in both children and adults (Scheidlinger, 2000; Hales, 2008).

Another benefit of group treatment is that it can be delivered in a variety of settings and, depending on the intervention provided, can meet the needs of an assortment of clients. Studies have shown that there is an array of group interventions that are effective for children and

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

adolescents in a wide range of settings A meta-analysis of the group literature by Hoag and Burlingame (1997) looked at 56 outcome studies of group therapy with children and adolescents published between 1974 and 1997. They found that over 60% of the research studies they examined used behavioral or cognitive behavioral orientation (Hoag & Burlingame, 1997). However, it is unclear whether these were traditional manualized curricula such as dialectical behavioral therapy (DBT) or cognitive behavioral therapy (CBT). The primary mode of delivery was through schools, totaling 74% of the studies examined. The school setting may have influenced the struggles clients were being treated for, which were identified as generic “behaviorally disordered,” “social skills” (20%), and “children of divorce” (12%). It is unfortunately unclear what modalities were used with which clients.

A second, more recent, meta-analysis of child and adolescent group treatment in a school setting used a different method to categorize group modalities. Matta (2014) analyzed 98 studies published between 1997 and 2012, which were coded for descriptive variables, and found that 29.9% of groups used “mixed treatment” modalities; 15.4% used cognitive behavioral modalities; 9.4% used “other modalities”; 8.5% focused on social skills; 7.7% used child centered play, and 6% were considered psychoeducation (Matta, 2014). This is significant because it shows that clinicians use a variety of interventions in the same setting to meet different clients’ needs.

Though their methods of grouping differ, both studies found that group treatment created a statistically significant difference in symptom severity, thus showing that group treatment is effective for treating mental health difficulties for children and adolescents. Matta (2014) found that group treatment had medium to large winsorized (used to transform outliers to limit extreme values in statistical data) effect, and a medium effect when compared to a control group (Matta,

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

2014). Similarly, Hoag and Burlingame (1997) found that those in group therapy were better off than 73% of those in control groups. In fact, another meta-analysis done by Tillitski (1990) showed that group treatment was more effective than either individual treatment or control groups with adolescents.

Although exactly why group therapy is such an effective mode of treatment for adolescents is unknown, there are four reasons suggested by the literature. First, Zaya and Lewis (1986) state that interacting with others in group therapy encourages the development of empathy, and helps group members understand how to thrive when interacting with others. Second, Webster-Stratton and Reid (2003) further emphasized the complexities of creating and maintaining friendships, and postulated that group work assists young people in navigating this struggle. DeLucia-Waack (2009) more blatantly states that, in schools, adolescent groups can be extremely effective in teaching social skills, while thirdly assisting adolescents in their own self exploration through connection with other adolescents.

Finally, research further suggests that the fact that adolescents are undergoing identity development makes group therapy especially effective. Erik Erikson (1968) argued that adolescents construct their identities through seeing themselves in others. He used adolescent love as an example, stating that adolescent love was an “attempt to arrive at a definition of one's identity by projecting one's diffused ego image on another and by seeing it thus reflected and gradually clarified” thus making relationships essential (p. 132). This means that adolescents use their relationships with peers to see and clarify part of their own identity. Furthermore, Leader (1991) argues that adolescents use therapy groups in many ways to help them develop their identities, much like they, as younger children, did with their families earlier on in life. In DeLucia-Waack's (2009) training video, produced by the Association for Specialists in Group

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

Work, a participant expresses that it is helpful to hear that others feel the same, showing that normalizing an experience can be helpful for adolescents, and may contribute to positive identity development. Groups, of all forms, become essential for identity development and interpersonal exploration during adolescence (Leader, 1991). By creating a “safe and controlled environment” in the form of a therapy group, adolescents can “freely examine their individual problems and impact on others” through a “corrective emotional experience” (Leader, 1991, p. 83).

DeLucia-Waack (2009) makes the third suggestion of why group therapy is suitable for adolescents, claiming that adolescents are more likely to listen to peers than an adult therapist. This training video’s assertion is supported by Piaget’s theory of egocentrism in adolescence (Inhelder & Piaget, 1958). Piaget’s theory states that young people believe that their thoughts are the most important. They thus believe that those who have similar life views, other adolescents, are more likely to be correct than those who are different from them.

Finally, DeLucia-Waack (2009) argues that most adolescent problems stem from relationships with others, for example, interactions with peer groups and confrontations with authority figures. This suggests that interventions should be similarly interpersonal and thus group therapy is an especially effective intervention. Groups help facilitate connection between otherwise isolated or segregated adolescents (DeLucia-Waack, 2009) and can even be effective to reduce withdrawal in children with psychosis (Gratton & Rizzo, 1969). As with therapy groups, games can be used in treating adolescents and children to meet the need for socially acceptable safe interaction with peers. Games can provide a structured environment in which to explore an individual’s identity and how they relate to others.

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

Games in Treatment

In adolescent group therapy, it is common for clinicians to use games and other modes of play to engage young clients and lessen the anxiety around processing emotions and experiences (Coyle, McGlade, Doherty & O'Reilly, 2011; Misurell & Springer, 2013; Misurell, Springer, Acosta, Liotta, & Kranzler, 2014). Therapy games are defined as structured activities with directive outlined rules and roles. This includes board games, as in Oren's (2008) study, or games created with therapeutic intent, like those used in Springer and Misurell's (2013) example of Game Based Cognitive Behavioral Therapy (GB-CBT). According to Matta's (2014) categorizations of group therapy, game based therapy would be under mixed treatment modality, which incorporates different modalities, depending on the game. For example, playing a board game in a psychoanalytic group incorporates child centered play to facilitate group process and open conversation. Consequently, a game might be used in a more manualized manner to teach psychoeducation material which is often taught in evidence based practice. For children ages 6-12, categorized as latency aged youth, organized games can create a bridge between imaginative play therapy and more traditional talk therapy. This is demonstrated in the case of computer games where clinicians and adolescents reported that the game helped to create a "fun experiential process" (Coyle et al., 2011, p 2937). In addition to helping the therapeutic process, games of all types can decrease dropout rate and increase positive associations during group and individual treatment (Coyle et al., 2011; Misurell et al., 2014). Misurell et al. (2014) found that attendance during one GB-CBT study was 82% for individual sessions, a significant increase when compared to the 58% attendance rate at other community mental health clinics. The striking increase in engagement demonstrated the need for more research on how clinicians can use therapeutic games.

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

Though the research is still sparse, researchers have found promising results from two different modalities, GB-CBT and RPGs, which are based in psychodrama. GB-CBT utilizes games to increase engagement while providing CBT to manage symptoms, and provide psychoeducation. GB-CBT integrates CBT and play therapy to allow children to learn and practice skills in an age-appropriate manner (Misurell & Springer, 2013). In this promising new model a series of games teach children and parents Trauma Focused Cognitive Behavioral Therapy (TF-CBT) modules including: elements of psychoeducation, and collaboration through role-modeling, behavioral rehearsal, token economies, psychoeducation, social skills training, gradual exposure, and personal safety training (Misurell & Springer, 2013). These modules are split into two broad interventional topics: “social-emotional skill building and child sexual abuse specific skills” (Misurell et al., 2014, p. 250-251).

The games of all types are structured, directive, goal-oriented and designed to enhance learning skills through experiential learning (Misurell et al., 2014). Token economies are used as interval reinforcement regardless of behavior, and as rewards for specific behaviors. The games, along with a strength-based approach, fosters teamwork, cooperation, and shared experience, as the participants work together to learn skills and enhance coping abilities (Misurell & Springer, 2013). Though the research surrounding this model only presents initial outcome data, it shows that GB-CBT helps to alleviate many internalizing and externalizing symptoms that sexual abuse survivor's experience. Additionally, the effects are maintained at least three months following termination of the game-based intervention (Misurell & Springer, 2013). RPGs combine games, which have shown to be effective and engaging in group therapy, and role-play. Role-playing games creates a game out of psychodrama, which “enables us to re-experience the original traumas in the ‘here and now,’ develop new roles to cope with the hurt, and repair sociometric

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

wounds,” through the examination of group interactions (Lipman, 2003, p. 4). Psychodrama was created by Moreno (1946) with a psychodynamic basis and group based modality. Psychodrama has been generally accepted by psychodynamic practitioners because it aids clients in discovering inner thoughts, while helping to develop empathy in a safe, mediated environment (Kipper, 1992). Psychodrama taught different ways of relating and communicating by bringing outside social situations into group to be replayed with the intervention of the group facilitator (Kipper, 1992).

The primary difference between Moreno’s psychodrama groups and a fantasy role-play group is that the participants construct the social situations in a made up reality, rather than in the room directly. RPGs, when used in a therapeutic setting, are a form of directive play therapy that implements psychodrama in a fantasy world. In RPGs players take on the role of a character other than themselves. The “dungeon master,” or game master, acts as a liaison between the players and non-player characters, describing the world they travel in, and interpreting dice rolls as needed (Sargent, 2014). Players begin by creating a character, and role-play this character for the duration of the game as they encounter roadblocks and challenges in the mission designed by the game master. Each player has a role in this mission, which establishes a sense of distinction and appreciation of the skills group members possess while increasing participant’s self esteem (Zayas & Lewis, 1986). RPGs use a fantasy world to simulate difficult social situations, similar to those simulated in psychodrama by Moreno, and require that group members support each other through these situations thus promoting teamwork. Each participant however, acts on his or her own through his or her character.

Each group member creates a character that she role-plays in the game, thus creating distance between the client, and the themes or behavior patterns that arise in the game. Rosselet

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

and Stauffer (2013) state, “their characters serve as transitional objects between their person and the space of the game, helping them to establish a sense of self representation and control within the scenario” (p. 177). As players encounter conflicts and interactions similar to those they face in everyday life, they can use their characters, just as a puppet or teddy bear is used in children’s play therapy, to establish control and try out new social patterns through a transitional object. As players try different methods of interacting, play out their fantasies, and work together to achieve a goal, they use their characters as models and experiment in a safe environment (Rosselet & Stauffer, 2013).

Though there is limited research demonstrating the benefits of RPGs in group therapy, research shows that RPGs can be helpful for those who play it recreationally. Two different research studies have shown that RPGs provide players with a pathway to get their needs met (Sargent, 2014; Adams, 2013). First, Sargent (2014) found, in a qualitative survey of recreational players, that RPGs were an effective tool to address “personal thematic content” and build social and emotional skills while creating an enjoyable shared experience in a collaborative community. Second, Adams (2013) did a thematic analysis of an online RPG and argued “Dungeons and Dragons is an immersive fantasy role-playing game which allows players to fulfill real-world social needs through interaction during imaginative play” (p. 69). Adams (2013) found the following themes to be present in typical game play outside of a therapeutic context: democratic ideologies, friendship maintenance, extraordinary experiences, and good versus evil. This demonstrates that players satisfied a variety of needs through playing this game online—the need for democratic participation, the need to belong, the need for spontaneity, and the need to be moral. This study begins to show how individuals can use RPGs to fulfill needs, but these groups were not led with the intent of being therapeutic.

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

Zayas and Lewis (1986) previously used RPGs with a group of latency aged boys in a neighborhood center and found it effective to teach problem solving and increase mutual aid. Research shows that RPGs can be used to address group members' desire to strike off on their own, the importance of planning ahead, and group problem solving using individual strengths. However, researcher bias makes the results of this study unreliable. This article makes the assumption that RPGs require mutual aid, increases ego functioning and self-esteem. Furthermore, it assumes that all of these skills would translate from fantasy to real life, but does not provide direct evidence of this (Zayas & Lewis, 1986). Other researches have since used RPGs in a similar fashion (Enfield, 2007; Rosselet & Stauffer, 2013) to build the research showing the benefits of RPGs.

Enfield (2007) enhances the current literature by stating that characters in RPGs are like superheroes in that they go on missions, save innocents, and become heroes. The case study follows four boys, ages 9-11, presenting with struggles around attention, aggression, and previous trauma. The adventure was specifically designed to help these clients act out relationships with an adult female figure, because that is something they were all struggling with. Participants worked together to solve difficult problems and showed progress in their teamwork, communication, and impulse control (Enfield, 2007). Improvements also translated into improvement in their peer relationships, academics, and assertiveness. This study echoes the benefits found by Zaya and Lewis (1986)--increasing mutual aid, ego functions, and social skills. Yet it similarly presented a bias because the researcher was also the participants' clinician, and thus hopes for positive results.

When compared to the two previous studies, Rosselet and Stauffer (2013) discovered similar benefits and had analogous limitations. This study differed from the previous studies in

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

setting and population as it used RPG groups during a weekend retreat for 8-16 year old gifted children. Rosselet and Stauffer believed that RPGs, as semi-nondirective play therapy, can create a distorted, but recognizable, reality for children to work on their “self-concept and to further develop their personal identity and awareness of social rules and functions” (Rosselet & Stauffer, 2013, p. 173), but they did not provide evidence for this. This study did provide a detailed form for the game, which other studies failed to do. Participants were in groups of six, with one game master who mediated group problem solving, and kept notes on game play and interaction. The game master used these notes to provide feedback to the group and individual players. The researchers used an individual case study to show how the game made one participant aware of his maladaptive revenge seeking behavior and made him change his behavior in the game and with peers.

Though this showed that the self discovery made in the game translated to change outside of the game, the fact that only a single example was presented leaves it unclear if this was an isolated incident or an overall strength of this mode of treatment. The suggestive, but indecisive, nature of the all of above studies may be why clinicians have overlooked RPGs but demonstrates the need for further clinical study of RPGs. To explore what might lead clinicians to using RPGs in group therapy we must first explore what influences clinicians' clinical decisions, and their opinions of group therapy in general.

Clinician Opinion of Group Therapy

There has been limited research done on clinicians' opinions of group therapy as a modality of treatment for adolescents, and none researching clinicians' opinions of using RPGs in adolescent psychotherapy. However, a major source of research regarding clinicians' attitudes towards adult group therapy, has involved 12-step groups for substance use. This research found

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

that “clinicians can play an important role educating clients about recovery mutual aid groups, redress misconceptions and concerns about such groups, suggest particular group meetings...” (Laudet & White, 2005, p. 2). A similar statement could likely be made about any mode of treatment, but especially group treatment, and especially with adolescents. Group treatment can be very overwhelming and new for adolescents as they are branching out into the world away from their family (Leader, 1991). Additionally, adolescents rely on the therapist to provide information about possible groups and support for seeking treatment as they move away from looking to their family for support (Leader, 1991)

Though there is limited research regarding what helps clinicians make decisions or referrals to group therapy, there is research regarding what helps clinicians make clinical decisions in individual therapy, and these principles may also apply to group work and the use of RPGs in therapy.

A study of 25 psychologists done by Stewart, Stirman, and Chambless (2012) found that clinicians value peer networks of their choosing as references for interventions, and rely on clinical experience for information over clinical research. Furthermore, research shows that when clinicians are taught to use an evidence-based practice as a sole means of treatment, rather than as a part of treatment, they become more resistant and are less likely to use the modality (Stewart et al., 2012). Although this study lacks variability, and hence limited in generalizability, the results have been replicated in other studies (Cook, Schnurr, Biyanova, & Coyne, 2009).

Larger studies found similar results in addition to finding that endorsements by mentors, theoretical preference, personality style, and emotional compatibility influenced willingness to try evidence-based practices (Cook et al., 2009; Pignotti & Thyer, 2012; Stewart et al., 2012). One large ($n = 2,607$) quantitative web based survey done by Cook et al., (2009) found that

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

mentors and the adaptability of the intervention significantly influenced clinical decisions to use evidence based practice. Another survey of 400 clinicians across the United States found that past clinical experience, theoretical preference, personality styles, and emotional compatibility most impacted clinical decisions (Pignotti & Thyer, 2012). However, the finding that most clinicians identify with more than one theoretical orientation complicates these results (Cook, Biyanova, Elhai, Schnurr & Coyne, 2010). All of the previous studies looked at clinicians in general, but Aarons (2004) looks specifically at child and family mental health providers.

In this study Aarons (2004) found the intuitive appeal of the innovation, organizational requirements, openness to change in general, and perceived differences between current and new practices greatly affected a clinician's decision to adopt a new practice. Additionally, research showed that pre-clinicians endorsed especially positive views on new clinical practices. This was a quantitative study that surveyed 322 child and family clinicians, and found that internships are an especially opportune moment to introduce new clinical practices. However, even with this select group, clinical experience and the flexibility of a modality, rather than research drives clinical decisions (Aarons, 2004; Cook et al., 2009; Pignotti & Thyer, 2012; Stewart et al., 2012).

Unlike general group therapy, RPGs are not widely used in clinical practice; therefore, it is unclear what will help clinicians decide if RPGs should be used in adolescent group therapy. For these reasons clinicians' opinions of group therapy and RPGs, is crucial to the success and research of RPG therapy with adolescents. This research will therefore survey pre-clinicians on their experiences with group therapy, which will influence their use of group therapy, and their opinions, or the intuitive appeal of RPGs.

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

CHAPTER III

Methodology

The purpose of this study is to explore pre-clinicians' training in group psychotherapy, their views on group therapy, and the use of role-play games (RPGs) in group psychotherapy with adolescents ages 12-19. For the purposes of this study RPGs are defined as tabletop RPGs in which players create a character using or pencil and paper, while working with a game master and other players to create an adventure (Sargent, 2014).

This study explored the following questions:

1. What are clinicians' thoughts and experiences around adolescent group therapy?
2. What are clinicians' thoughts regarding the use of RPGs in adolescent group psychotherapy?

Because this is an exploratory study, there is no hypothesis for the outcomes for either of these questions.

Research Design

To investigate this question I used a qualitative exploratory design to examine the experience and thoughts of pre-clinicians around using RPGs in group therapy with adolescents. A qualitative approach provided a more in-depth understanding of the experience of each participant (Steinberg, 2004), a necessity because there is currently no literature to guide a more targeted quantitative approach. Additionally, a qualitative approach is most beneficial for this research question because it provides room for interpretation and a further understanding of the

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

nuances of pre-clinicians' experiences (Steinberg, 2004). The present literature suggests that clinical experience guides clinical decisions (Cook et al., 2010; Cook et al., 2009; Pignotti & Thyer, 2012), but it is currently unclear if pre-clinicians have any clinical experience with RPGs. Therefore, this study seeks to explore participants' current understanding of RPGs, prior to understanding how they form opinions about this novel therapy.

Because of the lack of literature regarding clinicians' opinions of group therapy and RPGs, the research design must aim to understand participants' experiences. To do this I selected a qualitative exploratory design that, because of the fluidity of the design, allows for a full understanding of the intricacies of the participants' experiences (Steinberg, 2004). More specifically, I surveyed relevant people, pre-clinicians, using open-ended questions in individual semi-structured interviews to gain insights and ideas regarding clinicians' opinions of using RPGs in group therapy with adolescents (Steinberg, 2004).

Though there are several benefits to this approach, including achieving a well-rounded picture of participants' experiences, and fully understanding the basics of pre-clinicians' opinions, there are also three limitations for both the qualitative approach and the exploratory design. The first significant limitation to doing a qualitative analysis is that the results may be subject to my bias as a clinician who uses RPGs in group therapy with adolescents. Second, a qualitative content analysis leaves more room for bias than a quantitative approach as I was interpreting the results through my own lens. Third, the results collected were only generalizable to the population under consideration because of the small sample size. An exploratory design has similar benefits in that it facilitates understanding pre-clinicians' experiences, but there are also three limitations to address. The first limitation is that no theory can be proven or disproven with this method of research. Because there is no hypothesis given, nothing can be proven in an

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

exploratory design (Steinberg, 2004). Second, the results from this study are not be generalizable to other clinicians, but may lend knowledge that can inform future studies. Third, I used non-random convenience sampling in this investigation, which leads to potential sample bias, making the results not generalizable to the general population of clinicians, or even pre-clinicians (Steinberg, 2004). However, as this is an exploratory study I do not need to target any specific group of pre-clinicians and therefore surveyed those who are convenient.

Sample

Participants in this study were 12 pre-clinicians interning at a community mental health agency that commonly uses group therapy for adolescents. Pre-clinicians were used because this is a population of clinicians that I had access to, represents a population that recently learned group theory, and have been shown to be more open to novel treatment modalities (Aarons, 2004). However, experienced clinicians have been shown to have more detailed treatment plans, (Eells, Lombart, Kendjelic, Turner, & Lucas, 2005) and be more attuned to group process (Kivlighan & Quigley, 1991) than inexperienced clinicians. Although there may be further differences between novice clinicians and expert clinicians, by using interns I could ensure that they have recently learned group theory. Furthermore, because all interns able to participate had the same group training through the mental health agency there was an understanding that the agency encouraged the use of group therapy. This ensures that all participants have at least a basic understanding of group theory in their recent memory.

Inclusion Criteria

Participants had to be current interns at the same mental health agency and seeking a degree in a mental health field. This is to ensure that their place of practice is and level of experience is similar. Additionally, all participants must have previously attended an agency-

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

required training on group therapy to ensure that they know that their agency supports the use of group therapy.

Exclusion Criteria

Participants cannot be currently researching this topic (e.g. I can not be interviewed), have a previous clinical degree, and may not hold a caseload outside of the identified community mental health setting. No other exclusion criteria are indicated.

Recruitment Procedures

To access this population I used non-probability methods of convenience sampling (Steinberg, 2004). This method was chosen because this study was not aiming to gain a wide variety of experiences, but rather, this study sought to begin to explore clinicians' experiences with group therapy and their views of using RPGs in group therapy. There are two benefits of non-probability convenience sampling (Steinberg, 2004). The first is that it assures that all of the participants have a similar level of clinical education and experience. Secondly, it provides familiarity with the researcher, which is important because trust is a key component in qualitative interviews. However, it also leaves room for variance in clinical orientation, as interns come from different schools and are seeking different degrees in clinical fields. The primary limitation of this sampling method was that there was limited variability in regards to regional diversity, race, gender, and experience level in the sample.

I presented the opportunity to participate in this study to all of the current mental health interns at an intern training session to decrease the possibility that interns would feel coerced to participate. This process received approval from the Human Subject Review at Smith College (Appendix A), and the mental health organization where participants interned (Appendix B). To further minimize the possibility that participants feel coerced all interns were all given the

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

opportunity to sign the consent form (Appendix C), mark that they would like to participate, or would not like to participate, and provide a personal email to ensure that the mental health agency is not aware of who choose to participate in this study, before returning the form.

Risk of Participation

Participants may have felt uncomfortable talking about their experiences since they are not yet skilled at facilitating group therapy and implementing interventions. Participants may have also felt uncomfortable talking about personal experiences with RPGs for fear of being judged. I sought to minimize this discomfort by explaining that I came to this project because of experience with RPGs. I let the participants know that they could choose not to answer any question, or stop at any time. If someone looked uncomfortable, I asked him or her if they wanted to stop and the request was honored immediately. The final risk was that someone from the agency will read this thesis and be able to identify individuals who participated from speech pattern or content in quotes, even though participants are all identified as “a participant” with no further identification. Participants were informed of this possible risk on the consent form provided.

Benefits of Participation

Research shows that talking about a person's experience in a narrative form helps individuals form meaning of their experience (Pennebaker & Seagal, 1999). Participating in this study was therefore likely helpful to participants in that they were given a chance to form a narrative around their experiences with group therapy. With questions like “describe your previous experience with group therapy, including what you have heard other clinicians say and your own personal experience either attending or running a group therapy session,” participants were given a space to explore their narrative around group therapy. Additionally,

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

participants learned what RPGs are and may have found that they were interested in learning more about the use of RPGs in therapy.

Benefits to the Researcher and Social Work

With this study I was fulfilling my graduation requirement for my masters in social work. Additionally, this study contributes to the literature understanding why RPGs are not consistently used in group therapy. Though there is significant research showing that RPGs can be an effective and highly engaging mode of adolescent group treatment, it is not widely used, and there is no manualized treatment. This study will contribute to this research, which has not directly addressed why RPGs are not being used, and may lead to future research and the development of a more manualized treatment modality using RPGs.

Precautions Taken to Safeguard Confidentiality and Identifiable Information

Consent forms were handed out during an all intern training, which all interns were required to attend, to ensure that no intern was singled out. When handing out the consent form I gave all of the interns the form and instructed them to check the box next to their choice and sign at the bottom of the page. This was to ensure that other interns were not aware of who was participating in the study. This also means that all those asked to fill out the consent form handed the consent form to me, with the appropriate box checked. Participation was kept confidential and I am the only person who knows who participated in the study. This was to ensure that participants did not feel pressure from supervisors, the agency, or peers to participate in this study. At the beginning of the interview, I reminded the participant to exclude any identifying information regarding their client(s) they may decide to talk about. After the interview finished, I transcribed sections of the conversation, and coded any identifying information within the interview. The recording of the interviews were then placed on a password protected flash drive

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

and deleted from the portable recorder. Though many safeguards have been put in place to protect the identities of participants, it is possible that those who read the finished paper may be able to decipher the identity of participants. Participants were informed of this through the consent form and verbal reminder at the time of the interview.

I also protected confidentiality is through storage and use of materials. The data collected from this study is used to complete my Master's in Social Work (MSW) thesis and the results of the study may also be used in publications and presentations. All participants were informed of this through the consent form. To protect the confidentiality of participants all research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.

Data Collection

Interviews lasted between 15 to 35 minutes and were audio recorded using a hand held audio recording device, with written permission given on the informed consent. See appendix D for the full interview outline. The interview was conducted in-person in a soundproof room of the participant's choice. Participants were asked about their social identities including gender, age, or religion (all of which have been implicated in influencing people's opinions of RPGs (Ewalt, 2013). I then explored all aspects of the use of RPG in group therapy with adolescents. This included exploring participant's experiences with group therapy for any client, group therapy with adolescents, their perceptions of pen and paper RPGs and who plays them, their thoughts about using RPGs in therapy, and what they perceive as the barriers to them conducting this treatment in their practice. All questions were open-ended questions with follow up

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

questions, as I saw fit, with the hope of gaining as much knowledge as possible. Because this is an exploratory study looking at participant's experiences the validity or truth of his, her, or his responses are not of concern. The personal identity of participants were be protected by not using names or identifying information in this study.

Data Analysis

Data was initially collected during an interview with participants. I began the coding process by taking notes during the interview itself. Listening to a voice recording of the interview then enhanced these notes. Using the voice recording and notes taken during the interview I began by coding each individual question for themes and important issues using content analysis, before assessing for overall themes, sub-themes, and coding groups (Saldaña, 2013). This was done using an excel spreadsheet. Once all questions were coded individually each interview was assessed for overall themes via content analysis (Saldaña, 2013). Finally, once all interviews were coded an intratranscript analysis was done, using the already coded interviews, with content analysis to asses for themes that come up repeatedly in different interviews (Saldaña, 2013).

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

CHAPTER IV

Findings

This chapter will present the findings of twelve pre-clinicians and their experiences and beliefs about group therapy as well as their knowledge, experiences, and outlooks on using RPGs in group therapy with adolescents. This was done through recorded in person semi-structured interviews using open-ended questions about participants' experiences with group therapy, knowledge of RPGs, and beliefs about RPGs. The findings are organized into two broad sections based on the overarching research questions: experiences with group therapy and participants' knowledge and beliefs about RPGs in adolescent group therapy.

This chapter is organized into the following four sections: (1) demographic information participants provided, (2) experiences with group therapy (3) benefits and limitations of group therapy (4) knowledge and appropriate use of RPGs in adolescent group therapy. The themes, sub-themes, and coding groups addressed in sections 2-4 can be found in Table 1. Specifically, in section one I will present demographic data including age, race, gender, and place of origin. Section two, experiences with group therapy, will be divided into two subsections, (a) education and (b) in-vivo experiences. Section three, the use of group therapy, will be divided into four subsections: (a) comparing group to individual therapy, (b) types of group therapy, (c) who does well in group therapy, and (d) the benefits and limitations of group therapy. Section four, RPGs in group therapy, will have five sections, (a) current knowledge of RPGs in group therapy, (b)

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

who a RPG group would be good for, (c) whom to refer and why, (d) how to use RPGs in group therapy, and (e) barriers to using RPGs in group therapy.

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

Table 1

Themes and Subthemes Table

Question	Theme	Subtheme	Coding Group	
	1. Demographics			
1. What are clinicians' thoughts about group psychotherapy with adolescents?	2. Experiences with group therapy	a) Educational experiences with group therapy	i. Course structure ii. Experience of education	
		b) In-vivo experience	i. Experiences being a client ii. Experiences outside of a clinical setting iii. Facilitating and co-facilitating groups iv. Challenges with facilitating groups v. Positive sentiments around leading groups	
	3. Use of group therapy	a) Comparing group to individual therapy	i. Group as better than individual therapy	
		b) Types of group therapy	i. The substance provided to client ii. Milieu groups	
		c) Who does well in group therapy	i. Who benefits from group therapy ii. Whom group therapy is not good for	
		d) Benefits and limitations of group therapy	i. Normalizing ii. Having peer input iii. Self-exploration iv. Limitations	
	2. What are clinicians' thoughts regarding the use of RPGs in-group psychotherapy with adolescents?	4. RPGs in adolescent group therapy	a) Current knowledge of RPGs in group therapy	i. Lack of knowledge ii. Other relevant knowledge
			b) Whom a RPG group would be good for	i. Age ii. Personality traits iii. Level of ability
		c) Whom to refer and why	i. Self-exploration ii. Trauma iii. Social struggles iv. Disengagement v. General benefits	
		d) How to use RPGs in group therapy	i. Adapt the treatment	
e) Barriers to using RPGs in group therapy		i. Client barriers ii. Clinician barriers iii. Institutional barriers		

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

Demographics

Participants reported their age, gender, ethnicity, race, religion, place of origin, and the school they are currently attending. Participants' ages ranged from 24 to 63 with an average age of 34.08. The most common age represented was 35 and the median age was 29. 10 participants identified as cis-female and 2 participants identified as cis-male. All 12 participants identified their race as white, with one participant identifying as Hispanic. Ten participants were from the United States, one was from South America, and one was from Northern Eurasia. Participants reflected a wide range of religious and spiritual beliefs. All but one participant were currently seeking a master's degree in counseling, social work, or psychology; all were currently enrolled in a degree-seeking program.

Question One: What are Clinicians' Thoughts About Group Psychotherapy With Adolescents?

Experiences with group therapy. When participants were asked to "describe your previous experience with group therapy, including what you have heard other clinicians say and your own personal experience either attending or running a group therapy session," they expressed two major sub-themes. Participants discussed how their education influenced their feelings about group therapy, and in vivo experiences of group therapy, including their personal non-clinical experiences being in a group and their clinical experiences with group therapy. All but one participant mentioned their formal training in group therapy when asked about their experiences with group therapy. Nine participants discussed their own experiences being in groups, and 10 out of 12 participants discussed their endeavors being a clinician in group therapy. Participants overwhelmingly spoke of their experiences, rather than the content of what

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

they learned, even when discussing clinical groups in the context of their educational experiences.

The first sub-theme, *educational experiences with group therapy*, was referenced by all but one participant. When speaking of their education, all participants spoke of their feelings around the class, and not the educational material. In general, group therapy classes caused mixed feelings, leading to mixed feelings about group therapy. The aspects of their education that most influenced their experiences with group therapy are seen in the coding groups: the structure of their class—specifically the use of role-play in those classes—and their experiences of their education. Surprising, only two participants expressed a desire for additional experience. All of these coding groups circle around the participants' experience, not the content of the class, suggesting that the overall, experience of their education, rather than educational content they are introduced to, influences pre-clinicians views of group therapy. This sub-theme was comprised of three total coding groups: structure of education, wanting more experience, and experience of group class. All but wanting more experience (because that was only supported by two participants) will be further elaborated on.

In terms of the first code, *course structure*, seven participants discussed the education they received in their current graduate level program surrounding group therapy and further discussed the structure of those classes. Half of the participants reported being in a process group as a school requirement, explaining that students were to “learn how to run groups by being part of a group.” A process group is defined as “a small group in which the ongoing interpersonal communication process is itself a primary object of attention” (Cohen & Epstein, 1981). Many participants also discussed having role-play as part of their group therapy class to “practice running groups” through an experiential with students as group members. Along with the

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

structure of these clinically based master's level classes, participants discussed their experiences in these classes.

In terms of the second coding group, *experience of education*, the presence of role play in the class caused mixed emotions, and that these experienced indirectly influenced how they thought about group therapy. A majority of the participant reported having positive feelings towards their experience in group class with one participant stating "our instructor did some wild things that just brought out the unconscious of the group which was just completely fascinating." This participant further expanded on how the group therapy professor led the role-play in class.

It was a free association, so as the group leader he would just say sometimes they would be random, sometimes they would be somewhat related to what the person was saying, but he was just like bringing up... I don't know if he was pulling out imagery as people were talking like, actually I think that's exactly what he was doing was as people were talking he was noticing what imagery he was having and then he would reflect that back to the group and then it would just like people would play off of it and have their own responses and their own imagery and it was just like pretty wild.

This participant, because of this experience, was very partial to process-based groups that drew from the unconscious. Not all participants had a positive experience, however; many experiences were mixed. For example, one participant stated that her group class was "a healing experience" but also stated that when this participant led the group it was "kind of weird."

Other participants expanded on their negative feelings towards the experiential, or role play aspect of the group class citing personal conflict, and personality differences. Personal conflict arose in one participant's role-play in group class, declaring that it "ended terribly," but did not elaborate. Personal differences such as being introverted, or getting nervous in groups

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

also caused participants to have negative experiences in group classes. One participant stated "personally, it was a little nerve wracking" because "I have had bad experiences in my life with group dynamics." This participant believed that "the academic formalized part of it made it a little more anxiety provoking." It is unclear if this is the case for other participants who had negative experiences, but it is clear that the role-play, or experiential aspect of group classes conjured mixed emotions in these participants.

The second sub-theme, *in-vivo experience*, was also consistently mentioned in how pre-clinicians think about group therapy. These experiences will be broken into five coding groups: experiences being a client, experiences outside of a clinical setting, facilitating groups, challenges with groups, and positive sentiments around leading groups.

The first coding group, *experiences being a client*, impacted participant's overall experience with group therapy with participants reporting attending and having positive experiences with process groups, support groups, and community groups. One participant stated, "I personally benefitted a lot from it." Another participant stated that participating in group therapy gave this participant the opportunity "to have care modeled for me" and to "try on care or for me to try on different things that are being explored by the group." It seems that a pre-clinician's own experience with being a participant in group therapy is essential to their experience with group therapy as a whole. Similarly, participants felt that their experiences being in groups of all types were important in explaining their experience with group therapy.

The second coding group, *experiences outside of a clinical setting*, specifically, being in a group outside of a clinical setting, brought up mixed emotions for participants. Only one participant expressed very negative feelings, stating that his or her shy personality made being in a group very difficult. A total of eight participants remarked on their non-therapeutic group

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

experience, and of those eight, six positive feelings towards being part of a process group. The group of participants who expressed these positive feelings were impassioned about their experience; they mentioned positive feelings towards being in a process group 19 times total, and repeatedly expressed sentiments such as having “an awesome experience.” Though a group therapy was specifically asked about, participants felt that their nonclinical experiences in groups also affected their experience with group therapy. These informal groups included groups around business, community groups such as “a sister circle,” and groups of people in general, with one participant stating “I would consider the informal groups therapy.” In general, participants expressed mixed feelings about their personal experiences with groups that seemed to influence how they felt about group therapy in a clinical setting. This shows that a pre-clinician’s informal experience in groups may also influence his or her experience with group therapy, and their overall thoughts about the utility of group therapy.

Though pre-clinicians have just entered the field, participants discussed the general coding groups of facilitating and co-facilitating groups, the challenges with facilitating groups, and some participants expressed positive sentiments around leading groups. All of these coding groups were surrounding participant’s experiences being group facilitators.

Within the coding group of *facilitating and co-facilitating groups*, co-leading groups in their clinical practice was brought up by almost all of the participants discussed when asked about their experience with group therapy. These experiences included half of the participants who had “co-facilitated” groups in their field placements with other clinicians and pre-clinicians as well as three participants who led groups prior to attending their current schooling program including a support group, a “mandated DUI group,” and a psychoeducation group. In fact, five participants had previously led psychoeducation groups. Participants had led a variety of other

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

groups including groups around boundaries, social skills, “community based groups,” “a group for people with severe mental illness,” and a “manualized CBT exposure” group. It is clear that when just learning to facilitate groups, these experiences are challenging for pre-clinicians.

The fourth coding group was the *challenges with facilitating groups* and these included engaging individuals and managing conflict. Many other participants simply echoed “being a facilitator is tough,” which seems to be linked to their uncertainty about how to navigate group dynamic. As one participant stated, “managing the conflict in the group is something that I'm still learning how to do,” while another said “I think the skill building and psycho-ed are probably easier and maybe a little less messy. It allows for pre-planning and execution.” These sentiments suggest that pre-clinicians' confidence is linked to preparation for leading groups. Though pre-clinicians faced challenges in groups, they maintained an overall positive outlook on their experiences with group therapy.

This was shown in the final coding group, *positive sentiments around leading groups*, which came up for the majority of participants with half of the participants explicitly stating that they liked groups, or found groups effective for specific types of people, like children. Although participants reported fewer positive feeling specifically towards leading groups, in general, pre-clinicians feel positively towards their group experiences while being a clinician.

The use of group therapy. The theme *use of group therapy* was divided into four sub-themes: comparing group to individual therapy, types of group therapy, who does well in group therapy, and the benefits and limitations of group. Each of these sub-themes was comprised of coding groups that will be further elaborated on. All of these general thoughts about group therapy arose when participants were asked the following questions: “whom do you think group therapy is effective for? What, do you see are the major benefits and imitations of group

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

therapy,” and “What types of group therapy have you heard about or experienced?” I did not directly ask about how their experience might or might not support these claims.

The first sub-theme was the *comparing group to individual therapy* and was addressed by the majority of participants. Within this sub-theme only one coding group emerged, *group as better than individual therapy*. Five participants believed that group therapy "can potentially be more beneficial for clients" than individual therapy. Though many believed that group therapy can be more beneficial than individual, this shows that participants struggled to see group therapy as a stand-alone treatment. Group therapy is not what participants first thought of when they thought of general therapy, but they believe it could be just as, if not more, effective for treating clients. It is notable that the effectiveness of a treatment modality does not make it stand-alone. Regardless of participant's frame of reference, they recognized that group therapy is highly accepted by naming the types of group therapy then knew.

The second sub-theme, *types of group therapy*, has been organized into two coding groups: the substance provided to client, and milieu groups, (defined as groups that commonly led by bachelor's level clinicians or other milieu staff). This was a direct question asked of participants, to better understand what types of groups pre-clinicians are exposed to, and how they categorize those groups.

The first coding group, *the substance provided to client*, consists of what is done or taught within the group and was brought up by all of the participants. The most common substance of group mentioned was “process groups”, which was also the primary type of group mentioned in participant's education. The second most common was participants expressing that there were “lots of forms” of groups, referring specifically to the substance of groups. These

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

participants seemed to be overwhelmed by the question and often struggled to identify specific types of groups.

There was, overall, a large variation in the types of groups pre-clinicians seemed to lead. Groups discussed included “social skills” groups, Dialectical Behavioral Therapy, Cognitive behavioral therapy, “Skill building,” “Support” groups, “psychoeducation” groups, “Substance use groups,” “Parenting,” “Around a struggle,” “psychodynamic,” Psychodynamic role play, Role play, and Relaxation. Other groups were mentioned that are commonly run by milieu staff, and these were identified as milieu groups.

The second coding group, *milieu groups*, which would likely not be led by the participants in a clinical setting, was brought up by a surprising majority of participants. These groups included Alcoholics Anonymous, “milieu groups,” “wellness groups,” “Theater of the oppressed,” “team building,” and “yoga.” This suggests that participants believed that they would not be the primary people leading groups after graduation, even in a clinical context.

The second sub-theme, *who does well in group therapy*, was divided into two coding groups: who benefits from group therapy and whom group therapy is not good for. Most participants stated that they believed that group could benefit anyone, but then many participants gave caveats. One participant explained this, stating “I really potentially think that anyone could benefit,” further explaining that with an immensely skilled therapist anyone could benefit from a group but that “takes a lot more skill on the part of the therapist, not to allow someone to hijack the group.” Given that participants had different ways on answering this question, I will first discuss the few participants who gave concrete answers for whom group therapy is effective for, then I will discuss the people participants felt that group was not effective for.

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

In terms of the first coding group, *who benefits from group therapy*, a majority of participants stated that group therapy was effective for everyone, but then gave caveats. A few participants did focus on what and whom group therapy is effective for. Two reported that group therapy taught social skills or “really helps social interactions,” and is helpful for individuals with "trouble connecting." Another participant believed that group could be used for the dissemination of information, stating “I think it's a great way to disperse information to more than one person at one time and it allows for sharing of the information.”

With respect to the second coding groups, *whom group therapy is not good for*, participants mentioned two groups--those who need treatment specifically around trauma, and those with severe mental illness. Two participants expressed that they believed that group therapy is not good for those with complex trauma and for processing trauma. One participant expanded on this stating

If you really want to get into the details of trauma and you know going through exposing yourself to the memory and gradually not being as emotionally reactive to you as you let yourself grieve, seeing what feelings come up; and I really think that's not best done in a group.

Similar to trauma, several participants mentioned that they did not feel that group therapy would be beneficial for those with severe mental illness because this population would either not benefit or be hazardous in groups, because of concern for self or others. For example, one participant explained this by stating that some clients this participant works with "feel nervous around their peers because they're worried they're going to hurt them or like what's going to happen if they lose control." However, group could be ineffective for anyone, even those without severe mental illness or trauma, because of individual differences. Group therapy can be

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

triggering and cause dysregulation for some, while others may not feel that a group meets their needs, and another subset of individuals may not even be willing to participate in group therapy. Though participants felt that group therapy may not be effective for all populations, they saw it as beneficial for the majority of mental health client.

All participants, regardless of their previous experiences with group therapy, noted the benefits of group therapy. This is part of the third sub-theme, *benefits and limitations of group therapy*. This sub-theme has been grouped into four coding groups: normalizing, having peer input, self-exploration, and limitations.

The first coding group, *normalizing*, helps to explain that an experience is normal and helps clients in group therapy to understand that they are not the only ones struggling. This was an expressed benefit for five participants, with one participant eloquently stating “it can really get home to someone, in a gut level way, that I'm not alone in what I'm going through because other people are going through similar things.” Not being alone in a struggle brings hope as one participant stated, “seeing people who have just started the healing process then there's people who have really done a lot of work and come a long way and this helps people see that there's hope.” All of these benefits however, circle around one essential aspect of groups, that peers are present and interacting.

Having peer input was the second coding group and was described as a benefit by the majority of participants, because they believed that the safety group therapy provides creates a conducive environment to learn from other group members, including giving and receiving feedback. One participant expressed this by stating “it's a good environment for giving and receiving some feedback from people who have agreed to confidentiality and trust.” Similarly, one participant expressed that

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

The most powerful moments in the DBT groups were not when the therapists were talking, but when the clients were sharing their experience and ways of coping with challenges with each other, so there's that social learning piece, peers learning from each other.

Four others felt that simply hearing what peers have to say is valuable with one participant explaining that "listening to other people's experiences and their pain" can be a benefit of group therapy. Additional participants expressed that groups can "heal relational pain" and one participant stated, "people are always looking out for each other." This support likely leads to connection within the group, which was a common comment among the participants. Similarly, though slightly different, one participant stated that group therapy could be an "opportunity for corrective experiences," meaning that if a client has had negative experiences while connecting with others, the group could provide an opportunity to create community in a positive way. However, participants also believed that groups could assist with internal exploration as well as external expansion.

The third coding group was *self-exploration* and was discussed by over half of all participants as trying out different ways of being and examining social patterns. Three participants responded that participants explore ways of being, with one participating saying group members can "try out different ways of being, and actually see people respond to that." One respondent gave a specific example of trying out different behaviors by saying "oh wow that person just did x,y,z, maybe I'll try what they just did." Another participant stated that group therapy provides "opportunities to perhaps broaden identity and broaden ideas of what a person could be like or could not be." While these participants believed that group can help and

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

individual grow, other believed that it was important for group members to reflect on their behaviors and social interactions within the group.

Examination of social interactions was another part of *self-exploration* that was mentioned by one third of participants. One participant responded that, in group, you can "see what you're putting out there" and examine "what arises in you when you're with another person in the room, and talk about it in that moment." Another participant expanded on this idea stating,

While being in the group it kind of heightens and is like a magnifier for your own behaviors which may or may not get in the way of individual interpersonal relationships, but in the actual group people notice patterns, behaviors which can at times be really tough to recognize individually, but that can be really transformative.

These participants believed that group therapy, and reflection on what was happening in group therapy, could help group members "learn how they are in groups." However, learning how you are in groups, and being in a group in general can be a double-edged sword, and participants brought up many limitations of group therapy.

The final coding group was *limitations*, which were discussed by all of the participants. The limitations discussed were individual differences, and group therapy as a trigger. Individual differences encompasses many different aspects of a client's experience including motivation, level of dysregulation, and challenges specific to different communities and types of groups. Overall, nine participants mentioned individual differences as a possible limitation to group therapy. The first of these individual differences is that a client may not want to come to group at all, and three participants expressed that they feel that motivation, or lack there of, is a limitation of group. One response to the question was that it's "more about who's willing to actually

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

participate,” showing that this participant felt that motivation was a large limitation. If clients are motivated to attend group, there is still the risk that they will be triggered by the group modality.

Three other participants expressed concern that group therapy can be triggering to individuals. These respondents expressed that group therapy has an increased risk, but only one participant provided a reason for why this might be saying "if the person running the group doesn't know very well how to engage with introverts without exposing them so much then they will totally get dysregulated." Nevertheless, it is clear that, for some, group therapy can be too much and, as one participant described it “an aggressive form.”

One reason that clients may get dysregulated is because they feel that they do not get their needs met within a group. The fact is that with multiple people in the room there is limited time for each group member to get their needs met. As one participant explained,

Very powerful things come up for individuals in a group, and maybe limitation is that it's usually not appropriate for the whole group to spend a lot of time or even listen to what happens or what came up for individual.

Another participant further explained this sentiment, “there are times when you really do need an individual therapist,” suggesting that participants believed that group therapy is not effective for all clients all of the time.

Question Two: What Are Clinicians' Thoughts Regarding the Use of RPGs in Group Psychotherapy With Adolescents?

RPGs in group therapy. After asking about group therapy as a whole, I began to ask participants about one specific form of lesser-known activity used in group therapy--RPGs (RPG). There were five sub-themes that arose when participants were asked about using RPGs: current knowledge of RPGs, who a RPG group would be good for, who refer to RPG group

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

therapy and why, how to use RPGs in group therapy, and the barriers to using RPGs in adolescent group therapy. Overall, RPGs were fairly unknown to these pre-clinicians, yet participants still stated that they also believed that RPGs could be used in group therapy with adolescents in a variety of settings to affect positive changes in adolescent identity development, engagement, and social development. The first sub-theme discussed was *participant's current knowledge of RPGs*.

Participant's current knowledge of RPGs in group therapy was assessed by asking "what is your current knowledge or experience with RPGs as part of group therapy" before and after being given a definition of RPGs. Only one participant changed their answer after hearing the definition of RPGs stating that what they thought were RPGs, specifically online game treatment modalities, were not actually RPGs. All of the other participants stated that the definition had no affect on their current knowledge. Some participants did report knowledge of RPGs, generally acquired through discussion with this researcher, but a large majority reported a lack of knowledge and experience with RPGs. Likely due to this lack of knowledge, participants discussed other clinical practices they knew more about that resembled RPGs in some way, such as using role play in individual therapy, and using games in therapy. Finally, participants discussed their feelings about role-play and RPGs both in and out of therapeutic setting.

The first coding group in this sub-theme was *lack of knowledge*. All of the participants expressed that they had either a lack of knowledge, or a lack of experience, with five stated they had both a lack of knowledge and experience. Additionally, participants were fervent in stating that they had a lack of knowledge, citing this coding group 35 total times throughout the interviews. Participants expressed their lack of knowledge in different ways; while some simply stated, "I have no knowledge," or "none," others stated "I've never done role play group," and

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

that their knowledge was “very limited.” Yet participants did not all stop at saying that they didn't know much, some went on to explore their not knowing.

Some participants expanded on their lack of knowledge, either looking into their thoughts about not knowing, or explaining more about what they lack knowledge about. Participants were not settled with simply stating that they knew nothing of the subject, and wanted to qualify their answer by showing interest, or explaining the parts that they did not understand. One participant expressed that he or she was curious about the game stating, "I would have been interested in learning." Another participant reported a lack of knowledge specifically about what a client would experience while playing a RPG. This participant explains that, with a client participating in group therapy using RPGs, "I can't say that she is experiencing like on a visceral level any of it," showing a lack of knowledge of the client's experience more specifically.

The second coding group was *other relevant knowledge*. With all of this lack of knowledge four participants made associations with what they did know using role play in group therapy or individual therapy. These role-plays included asking clients to take on specific aspects of themselves or others, such as “speaking as your anger,” or playing out very specific social situations, like how to introduce yourself. Even though participants used role-play in their practices, they did not incorporate the game aspect into their role-play.

Games, without the role-play aspect, were also part of the coding group, *other relevant knowledge*, and talked about as being a useful therapeutic tool. Three participants had used games in group therapy, or had heard of using games in group therapy. These games included “online games” and groups that just happened to be centered around games. As one participant stated, “sometimes [were] groups structured around games.” But this same participant stated that these games were “not table top games.” Participants clearly wanted to make associations

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

between RPGs and other modalities that they had more familiarity with. Even with this lack of familiarity, participants still discussed whom they thought could benefit from RPGs.

The second sub-theme was *whom a RPG group would be good for* and participants discussed the coding groups of age, personality traits, and level of ability. The question that will be incorporated into this sub-theme was “what types of people do you think would enjoy or benefit from RPGs? Though all participants answered this question, many qualified their answer, and some participants stated that they believed it could be helpful or enjoyable for anyone. One participant went so far as to say “like I’m just b-sing this answer,” demonstrating that the participant’s lack of knowledge caused them to make assumptions around the possible uses of RPGs. Another participant with a wider knowledge of RPGs stated “if I sat here long enough I could come up with an adventure to help with any struggle,” showing that pre-clinicians who knew more about RPGs saw it having great potential.

The first coding group, *age*, presented as very important when pre-clinicians thought about who would benefit from RPGs in group therapy. Adolescence turned out to be the most common age group mentioned, with nine participants stating that they believed RPGs would be especially effective or enjoyed by adolescents. The second most common group were kids, with seven out of twelve participants naming kids as a specific group who would enjoy or benefit from RPGs. Finally, three participants also identified adults as possibly enjoying or benefiting from RPGs. Though age can often determine what type of therapy a clinician uses, a client’s personality also greatly influences that choice.

Personality traits, the second coding group, arose through participants speaking of specific aspects of clients, including their mental health struggles and a client’s overall personality. Participants believed that these personality traits play a large role who would benefit

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

or enjoy RPGs in group therapy. All of the participants mentioned personality traits as something that would influence if a client would benefit or enjoy RPGs in group therapy, with the most common trait being those who struggle with social situations due to mental health concerns. The second most common trait discussed was creative or imaginative people. One participant explained this group as "people who are interested in fantasy," while another participant stated that "someone with a good imagination" would benefit. Though some believed that those who enjoy play would benefit, others believed that those who struggled to play, or rather, struggled to find enjoyment, would benefit. More general characteristics of people included a client's desire for social interaction.

Half of all participants mentioned whether a person is introverted or extroverted as important. However, both ends of this spectrum were mentioned, with three participants stating that extroverts would benefit or enjoy, while a different three participants believed that introverts would benefit from or enjoy RPGs. Three participants stated that they believed "playful people," classified as an extroverted trait, would like or benefit from this therapy. While those who believed introverts would benefit mentioned "shy people" or a more extreme as one participant stated, "social phobia comes to mind." This wide range of personality traits is different from the more uniform coding group, *level of ability*.

A client's *level of ability* to understand the game seems essential for RPG therapy to work, but only four participants mentioned this coding group. This included needing a certain level of "ego strength," and the ability to comprehend the game. One participant explained, "people chose and create their characters as some reflection of themselves, so to be able to be able to manage that seems like a good ego strength." Another participant stated that clients who "can grasp the concept of being another character" and have the "ability to see others as other

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

characters” would benefit. Having the mental capacity to understand the game restricts whom pre-clinicians would refer to a RPG group, but participants discussed other groups that they would refer to an adolescent RPG group.

This sub-theme addresses *whom to refer and why* including what benefits participants believed would come from using RPGs in group therapy. The questions that corresponded to this sub-theme were “when, if ever, would you use RPGs in group therapy with adolescents?” and “what do you see as the benefits of using RPGs in group therapy?” These questions brought up the coding groups of self-exploration, trauma, social struggles, disengagement, and general benefits.

Self-exploration was the most common coding group addressed by participants regarding the benefits of RPGs was. Overall, participants expressed that RPGs would be useful for clients who are struggling with identity development and personality formation. For example, a participant reported, "it would be a very safe way for them to explore different identities." In addition to trying out identities, participants believed that group members would be able to try out different behaviors stating a RPG is “going to let you act out your behavior and then you can see how it works in various situations." One participant more explicitly shared that he or she believed that the game provides “immediate feedback” in the form of “consequences” for action in the game. This likely leads to participants being able to observe their behaviors.

Another part of this coding group was being able to critically examine behaviors was mentioned by three participants with one participant stating "the person could have the opportunity to reflect on the behavior or intention that is normally maybe too shameful or too intuitive and bring that to the surface and talk about." Another participant discussed their own experience stating, "it teaches me a lot of my own patterns." Four participants stated that they

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

believed the games works at an unconscious level, and, of these respondents, two stated that they believed an individual's projections in particular would be illuminating, stating "it's a great way to work with projections and understand client's projections through the characters they are creating." Other participants addressed this idea that the game would bring up the unconscious in a more roundabout way by stating that they believed the game was "related to real life" or by explaining that they felt the practice was "jungian." Finally, three participants touched on the fantasy aspect of the game as being helpful for identity development. This fantasy aspect of the game also seemed to influence participant's belief that trauma or "tough stuff" would be addressed will using RPGs.

This brings me to the second coding group, *trauma*, or working through difficult topics. Half of all participants thought RPGs would facilitate effective trauma treatment. As one participant explained "there's that safety aspect of not having to bare their whole selves to people but they can still process through things." This, one step removed aspect of the game was important to the participants,

I feel it's a lot easier to talk about another character's trauma history even if it's based on your own history than it is to go and talk about your own trauma history or open yourself up and make yourself vulnerable to a therapist or other group members.

Other participants brought up other struggles that they believed would be impacted positively by RPGs, specifically social struggles.

The third coding group, *social struggles*, was identified by four participants when asked what the benefits of RPGs would be. Two participants stated that RPGs would benefit those with social skill struggles or would teach social skills more generally, while two participants mentioned teaching empathy in particular. One participant summed up this coding group well in

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

his or her statement "it was a very exciting way to learn social skills and practice them." This excitement piece touches on RPGs being helpful for clients who do not easily engage in traditional talk therapy.

Participants mentioned the coding group of *disengagement*, by speaking of client enjoyment and the disengagement of clients in traditional therapy, and directly mentioned that RPGs would assist with connecting to or engaging clients. Combining these three groups, all but one participant mentioned this coding group. One participant expanded on this stating that RPGs might make it so that group therapy was "maybe something people look forward to doing." Another participant explained that they would use RPGs with "those that are maybe like hesitant" and that RPGs are "an ingenious way of reaching a certain group of kids that might not normally talk about their feelings." This touches on something that was echoed by four other participants, games can be a way of connecting to youth. One participant explained, "They love all those games," referring specifically to adolescents. However, this brings to light the fact that participants believed that traditional talk therapy was hard to sell to adolescents and children. In addition to these more specific benefits and populations that coincide, participants described more general benefits of using RPGs in group therapy.

The final coding group, *general benefits*, refers to benefits that are inherent in the RPG modality and could potentially benefit anyone. The most common of these general benefits was that an individual gets to be someone else in the game. One participant denoted "it's like Halloween, you put on a costume and you get to play a part you get to be someone different for a night and it's like acceptable because everyone else is doing it" and

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

You're playing out someone else, even though your character has desires, wants, needs, they want to say something but you get to say it through them instead of having to own it or take on the responsibility of those same desires or needs.

This one step removed aspect, participants believed, made clients more able to discuss their own struggles because it is through a character. By being someone else, such as a hero, clients can fulfill a desire to be powerful and effective. Similar to this, one participant stated that the game was an escape from a harsher reality, while another participant saw the exact opposite stating "I think just being present in a game like that can be helpful for anyone, just to maintain focus." The combination of these responses meant that participants felt that being present in a world, or identity, other than their own was valuable for clients.

The second *general benefits* identified was that RPGs could be a tool to deliver other evidence based modalities, such as play therapy. Three participants compared RPGs to play therapy with one participant stating

Doing sand tray with somebody, you might not always understand the purpose of it but like knowing that it has meaning to them in some way or another, you might not always know like oh this kid is always picking fights with everyone, you know it's just kind of one of those things.

Another participant, rather than comparing RPGs to another therapy, stated, "it could be a delivery tool for things that do have an evidence base." This idea, though only explored by one participant, shows the versatility of this form of therapy, which was echoed by one other participant stating "it's not overtly this is what you need to do this is how you're going to do it." Overall, participants clearly felt positively towards the form and utility of using RPGs in group therapy, showing that, were it further researched and taught, it would likely be used by pre-

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

clinicians. However, the question of how to use RPGs will be discussed next, and this began to illuminate the challenges those participants felt about using RPGs in therapy.

The sub-theme *how to use RPGs in group therapy* was explicitly asked after participants identified RPGs as a possible mode of adolescent group treatment. Many participants brought up their lack of knowledge of RPGs and struggled to answer this question. The most prevalent coding group in this sub-theme was that participants wanted *to adapt the treatment* to the client. Meaning that, as RPGs gain research backing, it will be important to ensure that the games are adaptable to the clients' needs. They expressed this in a few different ways, for example 5 participants expressed that it was important to adapt the adventure to the clients. One participant stated "depending on the nature of the adventure it could be adapted for other diagnoses" showing that the adventure needed to be adapted to the client for this participant. Four other participants expressed that having a client make their own character was important. One participant explained that the character creation aspect of the game is important because the therapist or other participants could then ask and comment "why are you taking on that role, what does that role do for you, that's interesting that you chose that characteristic." With all of these positives identified, it is remarkable that pre-clinicians have very little exposure to RPGs. Therefore, the barriers to using this type of therapy are next examined.

Barriers to using RPGs in group therapy is the final sub-theme discussed and clearly affects clinical practice demonstrated by the fact that participants had limited to knowledge and experience with RPGs. This sub-theme was addressed by two questions (1) "What would stand in the way of your using RPGs as a therapeutic intervention?" and (2) "Do you see impediments to using RPGs in group therapy?" These barriers will be broken into three coding groups, client barriers, clinician barriers, and institutional barriers.

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

The first coding group, *client barriers*, was discussed by all of the participants. Buy in was the most common of these client barriers, which came up in all of the interviews. However, buy in came up in two different ways, eleven participants felt that there needed to be buy in, and that this might be difficult to achieve. Taken as a whole, participants were concerned with clients' motivation for treatment, and that the game might be used as an avoidance technique, rather than a facilitator of treatment. One participant explained, "just getting kids to try stuff can be really hard," while another participant was more specific, saying that there's "more selling with the parents than if it was a more traditional group." Many participants specifically felt that an individual's expectations of therapy would be a barrier to achieving buy in from both participants and parents. One participant explained, "I think there is this idea that therapy needs to be this really serious thing" and another explained further that the problem is "parents thinking that it's not serious treatment." Both of these participants explained that they believe these ideas are "flawed," but they believed they would still exist as a barrier for clients. However, the flip side of this was also expressed, that participants might have too much buy in, and get lost in the game.

The majority of participants believed that clients need to be interested in the group, but also hold a grasp on reality to benefit from RPGs. Three participants were concerned that clients could disconnect the play from therapy, with one participant expressing "maybe it's not really what's happening for them because it's a fantasy world." One participant was concerned that the game itself could become a defense saying "the game might become something which perpetuates an adolescent's defenses for experiencing what actually going on, emotionally, behaviorally." The escape that was previously considered a benefit has a flip side of possibly becoming maladaptive. On the part of the clinician however, there were other barriers reported.

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

The second coding group, *clinician barriers*, was discussed by all of the participants showing that, for RPGs to be more widely used, clinicians need to be educated on RPGs and supported through using them. Many of the participants cited their lack of knowledge, which was previously discussed when participants were asked about their current knowledge, as a barrier to them leading a RPG ($n = 8$). Three of these participants stated that they needed to experience a RPG themselves before trying to leads clients through a RPG. Four participants more explicitly stated that they felt unclear of the form regarding how much process would occur. One participant expressed this sentiment by stating "would there be a debrief needed? I don't know." Three other participants expressed that they would need to be taught how to perform this type of treatment. One participant stated "I'd need a manual or to shadow or watch somebody before doing it," demonstrating that there would be many ways for this clinician to learn. However, some participants felt that the lack of research was a barrier, which would also be a barrier to clinicians learning the treatment. The final set of barriers goes above the clinician to the institution.

Institutional barriers is the final coding group and the barriers discussed were specific to a community mental health setting. This is because all of the participants were practicing in a community mental health agency and seeing only Medicaid or self-pay clients. Meaning that participants were exposed to the fact that Medicaid needs evidence based practice to bill for services. It is therefore not surprising that a majority of participants mentioned institutional barriers. It is furthermore not surprising that the most common institutional barrier mentioned was the ability to bill insurance, or get paid for the services provided. One of these participants, along with others, stated, "yeah insurance might not pay for it," which is often because the practice is not evidence based. This shows that participants made the assumption that RPGs are

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

not evidence based, and could therefore not be billed for. However, the idea that RPG therapy is not evidence based is flawed, as I was able to use cognitive behavioral interventions in a RPG therapy group, and bill Medicaid for the service. Four participants further invalidated RPGs as treatment by stating that they believed other clinicians would look down on the practice. This leads me to believe that the participants themselves may look down on the practice, as they assumed it was not evidence based and that other clinicians would look down on it. Finally, two participants expressed that forming any group can be difficult, and another two participants shared that they believed a lack of resources would be a barrier to using RPGs in group therapy with adolescent.

Overall these findings show that there are many barriers that may stop pre-clinicians in a community mental health setting from using RPGs in group therapy, not the least of which is a lack of knowledge. However, even with this lack of knowledge and the many other barriers participants all believed that RPGs could be used in group therapy with adolescents, and discussed many specific benefits and populations who they would use RPGs with.

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

CHAPTER V

Discussion

The purpose of this study was to explore pre-clinicians' experiences and views of group therapy and the use of RPGs with adolescents in group therapy. This study contributes to the literature supporting the use of RPGs in adolescent group therapy by clarifying the possible benefits and barriers to this novel form of group treatment. This study was the first of its kind to survey pre-clinicians regarding their views and experiences of RPGs and group therapy with adolescents and was done through content analysis of 12 semi-structured interviews with pre-clinicians. The two research questions addressed were:

1. What are clinicians' thoughts about group psychotherapy with adolescents?
2. What are clinicians' thoughts regarding the use of RPGs in-group psychotherapy with adolescents?

The two major themes that arose around research question one regarding group therapy were: (1) participant's experiences with group therapy, and (2) the use of group therapy. There was only one major theme that arose from the second research question regarding RPGs in group therapy, RPGs in adolescent group therapy.

Because this is the first study that has examined pre-clinicians' opinions about RPGs, and there is scant literature in the area, the results will be compared to the research around therapeutic RPGs and how clinicians make treatment decisions in other clinical settings. This study supports previous research showing that RPGs are an effective treatment option for

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

adolescent group therapy. The findings also shed light on what has previously stopped clinicians from using this mode of practice, and how they make more general clinical decisions.

In this section I will first synthesize the findings of each research question, examining my findings in light of the literature around group therapy, how clinicians make decisions, and the literature on therapeutic RPGs. I am using this literature to provide context to my findings because there is very little research regarding how clinicians make decisions around group therapy with adolescents and what they think about RPGs. Additionally, because there is very little research showing how RPGs can be used in therapy, I will use literature supporting the general use of games in therapy with children and adolescents. Following this synthesis of findings around both research questions, I will analyze the strengths, limitations, and implications of this study, as well as recommendations for future study.

Question One: What are Clinicians' Thoughts About Group Psychotherapy With Adolescents?

The first research question sought to explore pre-clinicians' views of group therapy with adolescents by asking participants about their experiences with group therapy and their views of group therapy. Two overall themes arose from this line of questioning (1) experiences with group therapy, and (2) the use of group therapy. Experience with group therapy found two sub-themes that will be discussed: (a) educational experiences with group therapy, and (b) in-vivo experience of group therapy, which was essential to pre-clinicians' overall experience with group therapy. This discussion will concentrate on three sub-themes that arose around the use of group therapy: (a) comparing group therapy to individual therapy that (b) types of group therapy (by touching on the coding group milieu groups) and c) benefits and limitations of group therapy.

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

All of the participants discussed their formal education with group therapy, primarily their master's level schooling. Participants reported both positive and negative experiences in group therapy class, all around participating in group role plays or other experiential teaching techniques, such as having pre-clinicians participate in a group to learn how to lead a group. These experiences are essential to pre-clinicians' understanding of group therapy as they are often the first time that pre-clinicians experience or learn about group therapy practices. The positive experiences were often regarding how pre-clinicians felt that their group class was healing for them personally, and not around the content of the class. The negative, often-uncomfortable, experiences were specifically concerning because of the literature shows that personal experience is the greatest indicator of if a clinician will adopt a new practice (Cook et al., 2009; Pignotti & Thyer, 2012; Stewart et al., 2012). Therefore, the fact that many pre-clinicians had negative experiences may shed light on why different modes of group treatment, such as RPGs, have not been more widely researched and used.

Participants also reported that their experiences with groups in their personal lives influenced their overall experience with group therapy. This contradicts the current literature, which identifies clinical experience (Cook et al., 2009; Pignotti & Thyer, 2012; Stewart et al., 2012), peer influence (Stewart et al., 2012), adaptability of the practice, and personal differences (Aarons, 2004) as the primary mediators in clinical decisions. However, because the group surveyed were pre-clinicians, it is possible that their lack of clinical experience leads to using personal experiences. This suggests that when pre-clinicians lack clinical experience, they may turn to personal experience to understand clinical treatment modalities. If these experiences remain painful for clinicians it may lead to them shying away from clinical situations that are

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

similar. Therefore, it is essential that clinicians understand how their personal experiences with groups influence their clinical beliefs and practices.

Though participants had less experience leading groups than the general population of clinicians, these clinical experiences still made a large impact on their overall experience with group therapy. The fact that almost all of the participants discussed their clinical experiences with group therapy supports the limited previous research around what influences clinicians' clinical decisions, which shows that clinical experience is essential (Cook et al., 2009; Pignotti & Thyer, 2012; Stewart et al., 2012). However, not all participants reported positive clinical experiences with group therapy, and as the research emphasized the importance of clinical experience, it is likely that these negative experiences will deter clinicians from using group therapy in the future.

This research further supports the literature stating that clinical experience not research influences clinical decisions (Aarons, 2004; Cook et al., 2009; Pignotti & Thyer, 2012; Stewart, et al., 2012). No participants discussed how research or evidence based practices influence their experiences with group therapy, showing that experience, and not research, contributes to clinical knowledge. Additionally, participants focused on their experiences of their formal education, rather than what they learned, which further emphasizes the importance of experience.

These experiences with group therapy, clinical and otherwise, likely influence participants' clinical decisions as well as their overall views of group therapy. The first view discussed is that group therapy is seen not as a stand alone, but rather, in comparison to individual therapy. This shows that group therapy is not what participants traditionally think of as therapy, and thus needs to be compared to "real therapy," or individual talk therapy. This frame of reference is likely an impediment to clinicians running groups and referring their clients

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

to groups. Additionally, it shows that pre-clinicians believe that they should first and foremost be conducting individual therapy, rather than group therapy.

The notion that pre-clinicians and clinicians should not be conducting group therapy is reaffirmed by pre-clinicians discussing milieu groups, and groups they led before entering a masters program, when they were asked about the types of group therapy they knew about. Milieu groups are groups that would not traditionally be led by master's level clinicians. The research supports this belief, as two studies found that clinicians are often not the ones leading groups (Matta, 2014; Hoag & Burlingame, 1997).

The first of these studies found that, in schools, where adolescent therapy groups often takes place, only 24.8% of groups were led by master's level clinicians, and of that, 12% was "school counselors," which were not represented in this sample (Matta, 2014). The second meta-analysis of adolescent group therapy also found that masters level clinicians were often not the ones leading group therapy, especially in schools (Hoag & Burlingame, 1997).

The fact that master's level clinicians are not leading groups in the field, and believe that they should not be leading groups is highly problematic, and contradictory to the fact that the majority of clinicians are taught group therapy in their masters education. Group therapy has been shown to be an effective mode of treatment for adolescents (Hoag & Burlingame, 1997), but this same study found that the level of education of the facilitator had no significant effect on the treatment outcome. The fact that a clinician's education may not be essential for leading groups likely deters clinicians from leading groups, including RPG groups. Though it is problematic that participants do not see it as their place to lead evidence based groups, it is supported by literature, and it is possible that clinicians do not need to be leading a group for them to be effective.

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

The question of who is leading a group is just as important as who is in the groups, but participants didn't seem to know whom really attended or benefited from groups. The fact that participants, when asked who group therapy is effective for, made a list of who group therapy is not effective for, shows that participants do not fully understand what group therapy is effective for. This leaves pre-clinicians with an unclear list of who to refer to groups, or what populations to lead groups for--possibly leading to either no referrals, or no groups. Unfortunately, due to the lack of research around the frequency of use, it is unclear how often group therapy is used.

Furthermore, the list participants did make, those who shouldn't attend group, is not supported by literature. Participants believed that the primary limitation of groups is that they are ineffective for those with severe mental illness, such as those currently hearing voices, and clients with trauma who might be easily triggered. However, Gratton and Rizzo (1969) found that group therapy could be used with children experiencing psychosis to help minimally decrease symptoms. Furthermore, group evidence based modalities, such as GB-CBT, have are effective with children who experienced sexual abuse (Springer & Misurell, 2013). The lack of knowledge of who to send to group, and misconceptions of who group therapy is ineffective for is surprising because all participants are currently attending schools and all but one participant received school classes on group therapy.

The fact that participants struggled with basic questions surrounding group therapy, and demonstrated incorrect knowledge, shows that they are using clinical and personal experience, rather than research that was presented in their courses. Though they are presumably taught the research-based practices in school, they use other knowledge, such as a range of personal experiences, to make clinical decisions and construct their views of group treatment.

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

Though pre-clinicians demonstrated unfounded knowledge of group therapy, their analysis of the benefits of adolescent group therapy were founded in the research. The first benefit that participants discussed was that groups help participants to normalize an experience. DeLucia-Waack (2009) showed that participants benefit from knowing that they are not the only ones thinking or feeling a certain way. This shows that adolescent group therapy helps participants by normalizing their experience, just as participants believed. Furthermore, another study focusing on the beliefs of current bereavement counselors, found that this subset of therapists believed that group therapy was “normalizing of grief” (Vlasto, 2010, p. 62). This study explained that normalizing did not decrease a person’s pain, but rather, helps group members understand that the “pain can be endured” (Vlasto, 2010, p. 64). Some participants of the current study explained this by saying that group therapy created hope. Though the Vlasto (2010) study was not specific to adolescents, it demonstrates that the participants had beliefs similar to other clinicians with more experience and in different settings.

Group therapy is normalizing, and helpful because group members provide input, which participants identify as a separate benefit of group therapy. DeLucia-Waack (2009) also supported this, stating that when an adolescent hears feedback from a peer it is more meaningful than when it comes from an individual therapist. Vlasto (2010) similarly found that bereavement counselors believed that group therapy “generates a culture of honest sharing” (p. 62). The sharing that occurs within a group can increase connections, and the connection to peers is another benefit that participants see in group therapy, which is supported by the literature. Group participants in DeLucia-Waack’s (2009) video stated that they felt connected to other group participants, and felt more connected to their peers as a whole because of the group. Vlasto

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

(2010) found similar results that therapists believed the social contact obtained through therapy groups is beneficial to clients.

The connection and peer input may have led to the final benefit that participant's discussed, self-exploration. It is unsurprising that the research around adolescent group therapy supports this assertion, as it supported the three benefits previously discussed. DeLucia-Waack (2009), very clearly states that she sees adolescents learn about themselves in groups, and the research supports this assertion (Rosselet & Stauffer, 2013). Group participants learn about themselves, as a group facilitator and other group members give them feedback and ask group members to reflect on what, in the group, worked for them.

Question two: What are Clinicians' Thoughts Regarding the Use of RPGs In Group Psychotherapy With Adolescents?

Unlike group therapy, pre-clinicians had little to no experience or knowledge of RPGs, but participants still tried to pull from other theories they knew about to formulate opinions. This shows that pre-clinicians, when faced with a new treatment option, may try to pull from treatment modalities that they know. These two treatment modalities are games in adolescent group therapy and role-play in group and individual therapy. Games are commonly used via play therapy in groups and individual therapy with children and adolescents with great success (Misurell & Springer, 2013; Misurell et al., 2014; Phillips & Landreth, 1998). Role-play is similarly used in group therapy to help adolescents reenact difficult social situations (Lipman, 2003). The fact that pre-clinicians used evidence-based examples when they were presented with a treatment modality they had no previous experience with shows that pre-clinicians, when lacking experience, may turn to research to form an opinion.

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

This finding is different from that discovered in the first research question, that pre-clinicians use their experiences to construct their clinical views on group therapy. When pre-clinicians have limited clinical and lots of personal experience they seem to draw from personal experience, but when they have no personal experience, they draw from research and synthesize their knowledge to provide an evidence base for novel treatment modalities. This significant in that it may point to how new treatment modalities are constructed and gradually gain an evidence base.

For a modality to be applied in clinical settings it must be viewed as potentially beneficial for a specific population and in the case of RPGs participants believed they would be most effective with children and adolescents. This is highly supported by the literature, which only looks at the use of RPGs with children and consistently shows positive results (Enfield, 2007; Rosselet & Stauffer, 2013; Zayas & Lewis, 1986). However, the research also suggests that adults who are interested in RPGs benefit from game play as well (Adams, 2013; Sargent, 2014). Participants may have been swayed by the topic for this thesis, which is centered on adolescents, and was outlined on the consent forms. Furthermore, participants and research alike associates RPGs with play therapy, an evidence based practice for children, and therefore participant may have assumed that RPGs would be most effective with children (Rosselet & Strauffer, 2013).

Likely because participants associated RPGs with play therapy, RPGs have an intuitive appeal, demonstrated by participants bringing up benefits that are supported by the literature. These benefits included helping clients cope with trauma, develop identity, engage with treatment, and learn social skills. All of these benefits are supported by the limited research done on the use of RPGs with adolescents.

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

The first of these evidence-based benefits was that RPGs help adolescents cope with trauma. Enfield (2007) used RPGs with a traumatized client in a RPG group for latency aged boy with great success. Unfortunately, the fact that there was only one client is a significant limitation of this study. Outside of a clinical setting, RPGs are similarly used by players to process difficult thematic content (Sargent, 2014). Overall, this research shows that in a clinical setting RPGs can be used with trauma survivors, and that those who like to play the games actively use them to process difficult topics, just as the participants thought.

The second benefit of RPGs was that participants believed it could help clients develop a sense of identity by aiding client in self-exploration. Rosselet and Stauffer (2013) using a case study method provided evidence to support this assertion. In this case study the therapeutic use of RPGs aided an adolescent boy in discovering maladaptive social patterns, which led to changes in his behavior. This single case study is supported by adolescent group literature, which shows that adolescent group therapy promotes identity formation and self-discovery (DeLucia-Waack, 2009; Erikson, 1968; Leader, 1991).

The third benefit was that RPGs could increase engagement with therapy. Though there has not been any research around engagement in RPG therapy, broader group literature supports the claim that RPGs would be helpful for unengaged clients. Participants first addressed this by mentioning how adolescent clients are often unengaged in traditional talk therapy. This assertion is supported by the research showing that clients attend only 58% of their appointments (Misurell et al., 2014). When this is compared to GB-CBT, which found an 82% attendance rate (Misurell et al., 2014), it is clear that games helped to increase engagement. Though these findings did not address RPG group therapy, the fact that games seemed to increase the attendance rate demonstrated that RPGs would likely similarly increase engagement. Moreover, the fact that

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

participants believed that RPGs would make therapy more engaging, speaks to the fact that they believed it would be enjoyable and effective for clients.

The fourth benefit that participants described, improving social skills, was the benefit that research backed most thoroughly (Enfield, 2007; Rosselet & Stauffer, 2013; Zayas & Lewis, 1986). The fact that participants mentioned the most common use of RPGs is very surprising, given their current lack of knowledge and experience with RPGs. However, pre-clinicians seemingly psychic abilities may be related to the fact there was a RPG group used to teach social skills at the agency where all of the participants were interning. If participants had seen flyers or heard about this group they may have used this little knowledge to make the assertion that RPGs can teach social skills. If this is the case, it speaks to the importance of institutional and peer support, which are often considered when clinicians make treatment decisions (Aarons, 2004; Stewart et al., 2012).

Though the benefits aligned with how participants stated they would personally used RPGs, it did not line up with who they thought would more generally benefit or enjoy RPGs. Participants believed that personality traits and level of ability were important individual differences that would determine in people would benefit or enjoy RPGs. Though personality traits were never addressed by the literature, Rosselet and Stauffer (2013) specifically used RPGs with “gifted children,” not because of their mental abilities, but because the researchers believed that this specific population struggled with social skills. Therefore the assertion that personality traits and level of ability play a role whom would benefit from RPGs is not supported by the research.

It is however, interesting to note that personality traits and level of ability did not seem to play a role in whom participants would refer to a RPG, and what benefits it would provide. This

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

shows that when pre-clinicians are making referrals to group therapy, they may not think about whom that group may or may not generally benefit. Though the current research does not support participant's assertions about who would generally benefit from RPG group therapy, this finding is quite startling because it could lead to clients being sent to a group that might not be beneficial for their personality type or level of ability.

Participants continued to show incongruence in their responses regarding the perceived benefits of RPGs by stating that RPGs, a group based modality, would benefit survivors of trauma. This directly contradicts what participants said earlier about group-based modalities being triggering for clients struggling with trauma. Though this assertion is not supported by the literature, as groups are commonly used with trauma survivors (Misurell & Springer, 2013), it means that participants felt that the substance of a RPG group would be beneficial for trauma survivors, but that the group dynamics might be triggering. This further shows that the group modality may be a barrier to using RPGs to help client cope with trauma.

The two possible limitations that participants discussed, unlike the benefits, were not supported by the literature. Participants believed that personality traits might make some clients unsuitable for RPGs. Participants also believed this about group therapy in general, and it was a coding group under the sub-theme of who would generally benefit from or enjoy RPGs. However, as previously stated, the limited literature around RPGs does not mention personality traits and it is therefore unknown if they play a role in the modality's effectiveness.

The second limitation seems to coincide with participant's general statement about client's needing a certain level of ability to comprehend and not get sucked into the game in an unhealthy way. Because the current literature surrounding role-play does not present the possible limitations of RPGs, and only focuses on the successes, it is unclear if this limitation is

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

supported. It does however, seem that a participant must be able to have the cognitive ability to understand the game to be able to participate. It is therefore disconcerting that none of the current literature addresses this.

Considering pre-clinicians found all of these possible uses and benefits of RPGs, it is surprising that it is not a widely known, used, and taught treatment modality. Therefore, participants were asked about the barriers that may stop this from happening. Because those surveyed were pre-clinicians, and currently working with clients, participants showed great concern regarding what a client would experience in a RPG. It is interesting that, when discussing limitation and barriers, a client's perspective was of great importance. This contradicts the literature, which showed that clinicians' preferences for treatment (Cook et al., 2009), clinical experiences and aspects of the treatment modality (Pignotti & Thyer, 2012) influenced clinical decisions, rather than the client perspective. Additionally, having limited knowledge of the subject, they made large assumptions that were not supported by literature.

One of these assumptions, the belief that adolescents getting clients to attend would be a problem, was based off of their experiences that adolescents do not attend group therapy. This experience is supported by the literature, which found that clients in community mental health settings only attend 58% of sessions (Misurell et al., 2014). However, games have been shown to increase engagement by as much as 24% in the case of GB-CBT, showing that client engagement is increased with gaming. This corresponds with participant's assertion that games would increase engagement. They even reported that this increased engagement could be another limitation of RPGs, as many believed that clients could get lost in the game or use it in a maladaptive way. However, the literature surrounding the use of RPGs only focuses on its benefits and thus does not address this possibility. Furthermore, these internal contradictions lead

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

me to believe that pre-clinicians are concerned about therapeutic engagement in general, regardless of treatment modality.

Pre clinicians continue to present their concerns about more general therapy modalities; with two participants explicitly saying that play therapy has very similar limitations. The limitation that play therapy and RPG therapy share is that both are different from traditional talk therapy, and therefore may lead clients and parents to believe that it is ineffectual. Therefore, though this is a possible limitation of RPG therapy, it is a limitation of many therapies that use play as an effective method to connect to children and adults alike.

While participants were supposing client barriers, they were very clearly able to explain the barriers and limitations of RPGs from a clinician's perspective. The primary barrier to using RPGs in adolescent group therapy was pre-clinicians' significant lack of knowledge. Because participants do not know about RPGs, they do not know how to implement a RPG therapy group. RPGs are not disseminated in the typical ways pre-clinicians find out about treatment modalities, through school, and use in clinical placements. However, some participants mentioned that they had heard about RPGs through me, or had clinical or personal experience with RPGs, when asked about their knowledge of RPGs. This, yet again, demonstrates that peer influence, and clinical experiences play a large role in clinical decisions. For RPGs to be used by pre-clinicians, and the larger clinical field, there needs to be a dissemination of knowledge through schools and clinical placements.

The lack of use in clinical placements is also mediated by possible institutional barriers, which participants addressed. Participants are new pre-clinicians, and thus are only just learning the Medicaid requirement for billing, which requires the use of evidence based practice, and was belabored in these participant's agency training about how to bill for services. Participants only

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

brought up the idea that RPGs were not evidence based practice when they were concerned about an organization getting paid. However, the idea that RPGs are not evidence based and would thus not be paid for is not supported by literature or personal experience. The literature shows that RPGs are effective to move adolescent clients towards adaptive behaviors (Enfield, 2007) and is further supported by developmental theories (Erikson, 1968) and other similar evidence based practices such as GB-CBT (Springer & Misurell, 2013). Moreover, I have personally led an adolescent therapy group using RPGs and, but implementing CBT and DBT techniques, gotten approval from supervisors, and gotten reimbursed by Medicaid. This shows that pre-clinicians are unclear on what evidence-based practice is, or how it can be implemented. Furthermore, it shows that the primary time that pre-clinicians look for a research base is when getting paid for services.

Strength, Limitations, Implications, and Recommendations for Future Research

In this study, the same aspects that are identified as strengths are also limitations, which often lead to recommendation for future research. I will first discuss the research design, including the approach and sample, followed by my own relationship with participants, and finally the implications for social work practice and additional recommendations for future research.

To begin the discussion of strengths and limitations I will examine the qualitative approach used in this study. Because there is very limited research on RPGs, and none specifically asking what clinicians think of RPGs, a qualitative approach was needed to gain insight into the nuances of pre-clinician's experiences (Steinberg, 2004), In fact, this qualitative study may be helpful to outline the questions that could be used in further quantitative studies. I

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

recommend further quantitative investigation into pre-clinicians' views of RPG adolescent group therapy.

The fact that this was an exploratory qualitative study made the sample less of concern (Steinberg, 2004), but the limited demographics of the sample still created limitations. The participants' level of experience, school, and current place of residence make this study not applicable to all pre-clinicians, but the ethnic demographics, though limited, mimics that of the general population of clinicians (Duffy et al., 2004). This analysis of the general population of social workers, counselors, and psychologists, the fields covered in this study, found that 87.2% of these clinicians are white, non-Hispanic. The current study has a similar demographic of 91.7% white non-Hispanic, with one participant identifying as white Hispanic. Therefore, though the sample is limited, it represents the racial demographics of the field at large. However, the age of participants is differs significantly from the general population of clinicians, likely due to the fact that this was a survey of pre-clinicians early in their careers (Duffy et al., 2004).

All participants were my colleagues, attended weekly trainings with me during internships, and many worked closely with me, or were my friends, which was both a strength, and limitation. The dual relationship I had with participants was a strength in that it likely made participants feel more comfortable when speaking with me, which is essential when conducting interviews. However, the dual relationship is also a limitation because participants knew that I was interested in this topic and may have felt pressured to say that RPGs are an effective mode of treatment. Furthermore, many participants knew that I was leading a RPG group with young adolescents, at the time of this interview and this may have further influenced their answers throughout the interview.

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

The implications of this study are qualified by the listed limitations of this study, but still contribute to the existing literature around RPGs and how pre-clinicians make clinical decisions. The first implication is that clinical training needs to emphasize evidence-based practices and help pre-clinicians understand that, though clinical and personal experience may influence clinical decisions, research aids in providing effective interventions. Pre-clinicians clearly continue to use personal and clinical experience to make clinical decisions, even though they are currently being taught evidence-based practices. This shows that, though pre-clinicians know that they are supposed to use evidence based practices, something is making them believe that their own clinical or personal experience will be more of an indicator of effective practice than research. One possible reason for this is that pre-clinicians do not really understand what evidence-based practices are, and how to use them. Another recommendation for further research is therefore to further examine what clinicians believe defines an evidence-based practice, and how clinicians use them especially in group therapy. Furthermore, it seems important to research how these practices are taught, or not taught, in group therapy classes for master's students.

RPGs are one form of group treatment that is supported by evidence, but is not considered evidence-based practice. This is because there is not a clear form of how to use RPGs in adolescent group therapy, as shown by this study and previous research. However, pre-clinicians believe it could be effective, leading me to believe that there needs to be further research to solidify RPGs' evidence base. This could be done by large controlled study looking at of the effects of an adolescent RPG group with various diagnoses and adventures.

Though this study would further the evidence base, for clinicians to adopt the practice, this study shows, that it must either be taught in schools, or widely practiced in clinical settings. Because pre-clinicians, and clinicians alike do not seem to use research, to make clinical

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

decisions, the research must be disseminated through schools, clinical practice, or other in person training mechanism or even a manual.

This research demonstrated that, though an evidence base is important, clinicians need to experience RPGs to gain knowledge and decide to use them with adolescent clients. This experience is essential because pre-clinicians appear to learn through experience. This study added to the research showing the importance of experience in clinical practice and formal education, i.e. group classes. Pre-clinicians heavily rely on their experiences to make decisions around group therapy, and this is the same for RPGs, However, when pre-clinicians have little to no experience, they rely on their knowledge of evidence based practices, to guide their clinical decisions. This shows that there needs to be further research regarding the utility of adolescent RPG therapy, and a wide dissemination of this research through schools and clinical settings.

Conclusion

There are not many studies that have looked at the use of RPGs, and even fewer that look at RPG use in adolescent group therapy. The current study contributes to this literature by providing a clinician perspective, which has not previously been done. Two aspects of RPG group therapy are addressed in this study: the mode of delivery, and the content. First, the mode delivery is examined by examining pre-clinicians' experience with group therapy as a whole to understand if the modality of delivery is problematic. Next, it investigates pre-clinicians' current knowledge and views of RPGs fill the gaps in the literature regarding what clinicians know of RPGs.

The mode of delivery is addressed by the first research question and found that pre-clinicians' experiences with group therapy in education and in-vivo exposure led to overall positive feelings towards group therapy, with some negative personal experiences leading to

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

hesitation and uncertainly. It was also discovered that pre-clinicians do not use research to guide their understanding and experience with group therapy. This leads to the conclusion that the mode of delivery may be a barrier to using RPGs in adolescent group therapy, as pre-clinicians have mixed feelings about group therapy and do not base their concerns in research, but rather rely on personal experience.

The content of the group, i.e. RPGs, was addressed by the second research question. The present study found that pre-clinicians do believe that RPGs could be an effective treatment, and even base this belief in research. However, their significant lack of knowledge, and experience with RPGs makes them uncertain if it will be effective and possible in community mental health settings. Therefore, this study clearly shows that the primary barrier to using RPGs in adolescent group treatment is that pre-clinicians do not know enough about the modality to be able to use it in clinical settings.

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

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EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES
IN GROUP THERAPY WITH ADOLESCENTS

Appendix A

Smith HSR Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

February 13, 2015

Sarah Flashman

Dear Sarah,

You did a very nice job on your revisions. Your project is now approved conditionally on receiving the agency approval letter/email, and sending it to the Human Subjects Review Committee. You may begin collecting data only after this approval letter is received and a copy sent to us for the file. Once you receive it, you may begin collecting data immediately and you do not need to wait for further follow up from the Human Subjects Review Committee.

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.

Congratulations and our best wishes on your interesting study.

Sincerely,

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES
IN GROUP THERAPY WITH ADOLESCENTS

A handwritten signature in black ink, appearing to read "Elaine Kersten". The signature is written in a cursive, flowing style.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Shannon Audley-Piotrowski, Research Advisor

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES
IN GROUP THERAPY WITH ADOLESCENTS

Appendix B

Mental Health Partners Approval Letter



March 24, 2015

To Smith College HSR committee,

Sarah Flashman has received approval from Mental Health Partners'

Chief Compliance Officer – Elisabeth Strammiello;

Chief Strategic Officer - Matt Meyers, Ph.D

Chief Clinical Officer - Beth Lonergan, Psy.D

to interview current Mental Health Partners' interns for participation in Ms. Flashman's research study. Inclusion in the research study is purely voluntary and not a requirement of Mental Health Partner's field placement.

Amy Jenkins LCSW

Manager of Intern and Volunteer Programs.

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES
IN GROUP THERAPY WITH ADOLESCENTS

Appendix C

Consent Form



**Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA**

.....

Title of Study: Use of Role Play Games as Group Therapy For Adolescents

Investigator: Sarah Flashman.....

Introduction

- You are being asked to be in a research study about your experience and knowledge about of the use of role-play games in group therapy with adolescents.
- You were selected as a possible participant because you are currently seeking a degree in a mental health field and are a current intern at Mental Health Partners who has complete the group therapy training.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to explore pre-clinicians' views of group therapy with adolescents and the use of role play games in therapy.
- This study is being conducted as a research requirement for my Master's in Social Work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to: engage in a 30-45 minute interview in person at a convenient location regarding your views of group therapy with adolescents and your experiences with role play games.

Risks/Discomforts of Being in this Study

- There are some risks to talking about your experiences. If you at any time would like to not answer a question or stop the interview feel free to let the researcher know and she will respect your decisions.

Benefits of Being in the Study

- The benefits of participation are having an informal space to discuss and further thoughts on group therapy.
- The benefits to social work/society are: *this study will contribute to the literature around role-play games and clinicians views on different modalities for group therapy treatments.*

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

Confidentiality

- Your participation or decision to not participate will be kept confidential in as much as is possible. There are risks that your decision to participate or not to participate will be discovered because consents are filled out in a group. Additionally, the records of the study will be kept strictly confidential. I will be the only one who will have access to the audio recording.
- All signed informed consents will be kept separate from the interview materials. All tapes and transcripts will be assigned numerical codes.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you, however because there are a small number of participants that are pulled from this agency, it may be possible if staff read the thesis then they may be able to guess which interns participated and what they said.

Payments/gift

- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up to the date noted below) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. Your decision to refuse will not be disclosed to any agency, or individual. Your decision to refuse will not affect your current or future relationship with Mental Health Partners, colleagues, or supervisors. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by April 1st, 2015. After that date, your information will be part of the thesis, dissertation or final report.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Sarah Flashman by email [REDACTED] by telephone at [REDACTED]. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have read and understood the information provided above. Checking the "I would like to participate" line indicates that you have decided to volunteer as a research participant for this study. If you would like to decline participation please check the line indicating that you would not like to participate. You will be given a signed and dated copy of this form to keep through email. If you have chosen to participate you will be contacted at the email address listed below to schedule an interview time.

I would like to participate in this study please contact me to schedule an interview time.

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES
IN GROUP THERAPY WITH ADOLESCENTS

I would NOT like to participate

Email address not associated with current agency: _____
.....

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

.....

1. I agree to be audio taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

EXPLORATION INTO PRE-CLINICIANS' VIEWS OF THE USE OF ROLE-PLAY GAMES IN GROUP THERAPY WITH ADOLESCENTS

Appendix D

Interview Outline

- What is your age, sex, gender, ethnicity, race, religion, city/town of origin, religion,
- Describe your previous experience with group therapy, including what you have heard other clinicians say and your own personal experience either attending or running a group therapy session.
- Who do you think group therapy is effective for? What, do you see, are the major benefits and limitations of group therapy? Can you illustrate with specific examples?
- What types of group therapy have you heard about or experienced (e.g., CBT within group therapy). What is your current knowledge or experience with role-play games as part of group therapy?
- Role-play games are defined as *a* game in which players take on the role of a character other than themselves. Table top role play games will be the type of role play game asked about specifically. Table top role play games are one form of role play game that consists of players creating a character using pen (or pencil) and paper while working with a game master and other players to create an adventure. Knowing this definition, does it change your previous answer about your knowledge or experience with role-play games?
- When you think about role play games as I have described above, what types of people do you think would enjoy or benefit from role-play games?
- Do you think role play games could be used as a therapeutic tool used with adolescents? If so, how? If not, why?
- When, if ever, do you think you would use role-play games in a group treatment setting with adolescents? What benefits do you see from using these types of games? What limitations do you see?
- What would stand in the way of your using role play games as a therapeutic intervention?
- Do you see impediments to using role play games in group therapy (e.g., parents don't approve, other clinicians may look down upon the practice, etc).
- Is there anything else you wish to tell me?