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Asya Tsarkova
Exploring Clinicians'
Experience of
Countertransference in Play
Therapy

ABSTRACT

The purpose of this qualitative study was to explore clinicians' experience of countertransference in play therapy. Through semi-structured individual interviews with twelve clinicians, narrative data was collected on the ways in which clinicians experience, process, and utilize countertransference in play therapy. Some of the findings of this study support previous research and theoretical literature on countertransference in the field of child psychotherapy. Additionally, this study's findings introduce the possibility that specific aspects of play therapy have a unique effect on the experience and processing of countertransference in play therapy due to the nature of this therapeutic modality. Implications for social work practice highlight the need for further research, guidelines for play therapy supervision, and approaches to addressing countertransference in play therapy.

Exploring Clinicians' Experience of Countertransference in Play Therapy

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

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CHAPTER I

Introduction

It is estimated that “a total of 13%–20% of children living in the United States experience a mental disorder in a given year, and surveillance during 1994–2011 has shown the prevalence of these conditions to be increasing” (Center for Disease Control and Prevention, 2005-2011). If left untreated, children’s mental health challenges likely will affect their ability to grow and develop in positive ways and live to their fullest potential. Play therapy is an effective, developmentally appropriate, and widely used therapeutic intervention that can meet this growing demand for mental health treatment of children. More research and training in the area of play therapy is essential to advance the understanding and development of this widely used therapeutic modality. Play therapy is a dynamic and complex mental health intervention. It requires therapists to engage and immerse themselves in the symbolic expression of the child’s inner world through play. The task of play therapy is complex in that the therapist must think analytically about what is happening in the child’s play verbally, nonverbally, and symbolically (Allan, 1997). Clinical work with children can evoke powerful reactions in the therapist such as countertransference, a reaction a therapist may experience toward the client or the client’s system. The complexity of play therapy work and the challenges of working with the vulnerability of children present the possibility for powerful countertransferential responses to occur during play therapy. It is the combination of the complexity and depth of both countertransference and play therapy work that lead to the interest to study them in conjunction by asking the following question: *How do clinicians experience, process, and utilize countertransference during play therapy?*

Further understanding of the characteristics of countertransference in play therapy is warranted to support clinicians in navigating their countertransference responses and enhancing their play therapy practice through increased self-awareness and understanding of how best to process and address these responses. There is a rich body of literature on the topic of countertransference. Historically, many leading psychoanalysts and theorists have contributed to the understanding and development of the concept. Early in the development of the concept of countertransference there was a dearth of literature on the topic in child treatment, but a significant amount of theoretical writing on the topic exists. Similarly, there is a body of research that describes the origins, theoretical foundation, and approaches to play therapy. Recently, more theoretical work and limited empirical research has been devoted to the topic of countertransference in play therapy work. Specifically, this literature has suggested that given the unique characteristics of countertransference in play therapy, alternative modalities such as play and art may be helpful in dealing with and addressing the countertransference responses during play therapy (Gill & Rubin, 2005). In general, there is limited research available on the phenomenon of countertransference in play therapy, its defining characteristics, and implications for practice.

This research study will begin to fill the gap in the literature on the phenomenon of countertransference in play therapy by trying to answer the research question: *How do clinicians experience, process, and utilize countertransference reactions in play therapy?* This study explores the phenomenon of countertransference in play therapy through qualitative research methods, which produce narrative data on clinicians' experiences and the way they make meaning of those experiences.

There are some limitations to this study. First, the non-probability convenience and snowball sampling that was used in this study may have led to sample bias. There is racial homogeneity in this sample, as well as other demographics such as theoretical orientation and type of agency practice, which may affect the similarities of participants' experiences and responses. While this study cannot be used to make generalizations about clinicians' experiences of countertransference in play therapy, it does provide considerations for practice and direction of future research in play therapy.

This study is important to the field of social work as its findings may provide useful information for future research and new practice guidelines for training clinicians and providing supervision. Interviewing clinicians on how they experience countertransference in play therapy is an important first step into understanding this phenomenon more closely through the narratives of clinicians and the recognition of its particular characteristics.

The following chapter describes the existing literature on countertransference in child treatment, play therapy, and countertransference in play therapy. The chapters that follow describe the methodology and findings of this study. The concluding chapter discusses the meaning and implications of the study's findings.

CHAPTER II

Literature Review

Introduction

There is an increasing need for mental health services for children in the United States (Center for Disease Control and Prevention, 2005-2011). The need for effective mental health treatment for children is important at the individual, family, and societal level. Play therapy is largely accepted as the preeminent choice for treatment in psychotherapy with children (Homeyer & Morrison, 2008). The interventions that the play therapist chooses are important because they influence the progression and nature of the therapy. Child clinicians' feelings and how they convey those feelings to the child client, whether consciously or unconsciously, is perhaps even more important to the healing process of a child in treatment. The clinicians' feelings may have a powerful impact on the relationship quality between child and therapist. The quality of the therapeutic relationship itself is an essential component of the healing process (Altman, Briggs, Frankel, Gensler, & Pantone, 2002). This makes the study of countertransference during play therapy especially significant. Further understanding of the characteristics of countertransference in play therapy is warranted to support clinicians in navigating this experience.

Due in part to the increased demand for mental health treatment for children, the importance of early intervention in child mental health treatment, and a recent interest in the value of the clinician-client relationship for the healing process, the body of literature on the topic of countertransference in therapy with children is growing. More recently, there have been some developments on the specific factors that make countertransference

in play therapy unique. Researchers and practitioners have recognized the need for trained supervisors and alternative ways of processing and addressing countertransference in play therapy but are still in the beginning stages of introducing active approaches of addressing countertransference in play therapy and operationalizing potential techniques.

This research project will operationalize countertransference using a broader, expanded definition of the concept developed by play therapist Kevin O'Connor. Countertransference will refer to any reaction a therapist experiences toward the client. It will include the clinician's thoughts, feelings, and behaviors that effect treatment, and that occur in reaction to the client, the client's family, or elements of the client's ecosystem (O'Connor, 1991). The philosophy of child-centered play therapy places great emphasis on the value of the quality of the relationship that is formed between the child client and clinician. It is the quality of this relationship that allows for the child to grow and heal. The therapist's awareness of their feelings and the tools and systems for processing these feelings are essential for the development of a strong relationship, and consequently, the child's healing process.

This literature review will begin with a history of the development of the conceptualization of countertransference with a special focus on understanding the characteristics and traits of countertransference in child treatment. Later in the literature review, the focus will shift to play therapy and the scientific and theoretical orientation of this therapeutic modality. The review of the literature will conclude with a discussion of the various unique factors that exist in addressing countertransference with children. It

ultimately will identify a gap in the literature on the specific topic of addressing countertransference in play therapy.

A Brief History of the Development of Countertransference as a Concept

Sigmund Freud, a neurologist by training who is considered to be the father of psychoanalysis, initially developed the concept of countertransference. The conceptualization of countertransference is heavily rooted in psychoanalysis, although it has come to be used in various modern psychotherapy modalities. Although he never provided an explicit definition, Freud (1910) referred to the concept as an awareness that “arises in him as a result of the patient’s influence on his unconscious feelings” (p.144). The growth of the psychoanalytic movement raised awareness of the concept of countertransference. However, until the 1970’s, the study of the phenomenon was still relatively rare (Brandell, 1992). In its beginning the concept was viewed as a manifestation of the therapist’s own inner conflicts and psychopathology. Countertransference was seen as an obstacle that the analyst had to overcome for effective psychoanalytic treatment to take place. Freud emphasized that the analyst must undergo thorough self-analysis and training to avoid any hindrance in treatment that may arise from the therapist’s own unresolved conflicts.

Other notable psychoanalysts, such as Annie Reich, have also subscribed to the classical conceptualization of countertransference (Brandell, 1992). This classical conceptualization focuses on the concept as an unconscious reaction of the analyst. The reaction was conceptualized as inherently problematic, and ultimately an obstacle in therapy. The conceptual development of countertransference has expanded significantly since (the initial) understanding the phenomenon being largely viewed as something that

must be overcome by the clinician. Perhaps one of the first psychoanalysts to further develop the concept of countertransference from its original conceptualization was psychoanalyst Heinrich Racker. Racker was the first to assert that countertransference was not just a possible challenge to effective treatment but also an important tool for understanding the client:

It is precisely this fusion of present and past, the continuous and intimate connection of reality and fantasy, of external and internal, conscious and unconscious, that demands a concept embracing the totality of the analysts' psychological response, and renders it advisable, at the same time, to keep for this totality of response the accustomed term countertransference (Racker, 1957, p.163).

Racker developed the concept of countertransference into a broader, clinically significant phenomenon by differentiating between two kinds of countertransference, direct and indirect (Racker, 1957). Direct countertransference occurs in response to the clients themselves whereas indirect countertransference occurs to any significant third party. Racker further delineated the concept of direct countertransference by discussing two relevant concepts, concordant identification and complementary identification.

Concordant identification refers to the clinician's experience of empathy or their attempt to understand the client's psychic reality (Brandell, 1992). Complementary identification refers to a feeling the therapist experiences when they are treated as an internalized object of the therapist (Brandell, 1992). An internalized object refers to a mental or emotional image of a past or current figure in the client's life.

Other psychoanalysts such as Paula Heimann and Margaret Little described the phenomenon of countertransference to be the sum of the totality of the therapists' feelings toward the patient (Brandell, 1992). Other psychoanalysts such as Heimann and Little expanded upon the concept of countertransference. Perhaps what all these psychoanalysts shared in common in their conceptualization was the identification that in some unique way, using clinicians' experience of broad affective experiences can be a useful clinical tool. The understanding that countertransference can be utilized as a clinical tool is one of the points of interest to this research project in the context of play therapy. This research study will aim to explore how clinicians use their countertransference responses in play therapy in particular.

Although Freud recognized that both the client and clinician bring conflicts, tension, and earlier pathologies based on childhood experiences into the treatment relationship, relational theorists were the first to expand on these concepts (Goldstein, Miehl, & Ringel, 2008). Relational psychotherapists delineate the importance of accepting and using countertransference. Donald Winnicott coined the term objective countertransference which referred to the "...justifiable reactions of the therapist to extreme aspects of the client's behavior, and concordant identification, in which the therapist identifies with the main emotion that the client is feeling at a given time, or with the feeling that the client has put into the therapist by means of projective identification" (Goldstein et al, 2008, p. 142). Another type of countertransference response is named complementary identification. In this kind of response, a therapist may begin to take on a role as a reaction to the client's behavior. An example given by Goldstein et al (2008) is when a therapist begins to feel like a harsh and controlling figure while the client

perceives the therapist as similar to a client's authoritarian parent (p. 142). In understanding the various kinds of countertransference responses, therapists can use countertransference to understand the client's earlier and current patterns of relating as well as to more deeply understand the dynamics of the relationship between therapist and client.

Countertransference in Child Treatment

As previously mentioned, the exploration of transference and countertransference issues in treatment developed in the context of treatment with adults. For many years, limited attention was given to the theoretical understanding of countertransference in child treatment. Berta Bornstein was one of the first theoreticians to write about countertransference in child treatment (Brandell, 1992). Bornstein was particularly interested in the factors that made child treatment challenging. Through her observations of clinicians in the field of child psychotherapy, she noted that many child therapists would quit their therapy work with children after a few years. Although Bornstein rarely used the term countertransference in her writing and did not differentiate the concept from other various responses a therapist may experience in working with a child, she delineated specific factors that make the process of emotional responses of therapists that work with children unique and difficult (Brandell, 1992). Some of the factors that Bornstein described are the general unpredictability of children including their tendency toward narcissism, their difficulty in controlling and modulating affect, and use of primary defenses and processes (Brandell, 1992). In addition, Bornstein emphasized the emotional reaction of child therapists being more complicated than that of therapists who work with adults due to what she described as the difficulties children have with free

association and their limited insight into the need and reasons for treatment (Kohrman, 1971).

The historical lack of literature on countertransference in child treatment may arise from the general challenge clinicians have in acknowledging emotional reactions that occur with child clients (Brandell, 1992). The following issues have been described by Palombo (1985) as some of the factors that may contribute to this difficulty:

1. Children may arouse intense infantile longings in the therapist.
2. Therapists come to be considered by children as substitute parents, which induces in therapists a parenting response rather than a purely therapeutic response.
3. Children's communications are often primitive and action-oriented; these forms of communication may evoke defensive reactions in the therapist, which cloud the perception of the child's transference.
4. Children's regressions may lead the therapist to identify with the child patient and therefore not deal therapeutically with the regression.
5. The fact that contact with parents is often obligatory in work with children adds to the complications of the treatment process. (Palombo, 1985, p. 40 as cited in Brandell, 1992, p. 14).

An additional factor that has been noted to explain the historical lack of literature in the field of countertransference in child treatment is the cultural value placed on "...protecting, helping, and giving love to young children" (Brandell, p. 15). This societal value of the carefulness with which we approach even the exploration of the emotional reaction toward children is an important point to consider for the purposes of this study.

This study will explore how, if at all various values and experiences affect the countertransference responses of clinicians during play therapy.

Three influential figures in understanding child treatment and the countertransference tendencies therapists have in working with child clients were psychoanalysts and theoreticians Anna Freud, Melanie Klein, and Donald Winnicott. Anna Freud and Melanie Klein had vastly different views and approaches on child treatment. Anna Freud's conceptualization of child treatment stemmed closely from her father, Sigmund Freud's theories on the structures of the mind as well as his developmental theories (Schmidt, 2008). Melanie Klein was the first psychoanalyst to develop her theory that the equivalent of free association in therapy for children is their play (Schmidt, 2008). Another major difference between A. Freud and Klein was Freud's concept of the "preparatory period" (A. Freud, 1946 as cited in Altman, Briggs, Frankel, Gensler, & Pantone, 2002). Anna Freud developed the concept of the preparatory period to explain the importance of the phase in which the goal of treatment was to form "affectionate attachment" (A. Freud, 1946). Anna Freud saw this as a necessary step in building rapport with the child patient because she felt that the child patient would only take risks and listen to those who they love and feel love from (Altman et al., 2002). In simple terms, Anna Freud was clear in her opinion that the child must like the therapist in order for successful treatment to occur (Altman et al., 2002). In this way, A. Freud was one of the first therapists to emphasize the significance of the relationship between child and therapist in treatment.

As previously mentioned, Melanie Klein was the first to discover that the play of children in psychotherapy sessions was similar to the free association of adults in

psychoanalysis (Altman et al., 1992). Klein differed from Anna Freud in her theory of directly making interpretations to the child client, as she believed that because their personality is still developing, the connection between the unconscious and conscious material is navigated more easily in children (Altman, et al., 1992). Another major difference of Klein's work with children is that she preferred to have minimal contact with parents (Altman, et al, 1992). This therefore prevented the discussion and recognition of countertransferential issues with parents that some writers, including Anna Freud, have discussed.

Pediatrician and psychoanalyst, Donald Winnicott fused the theories of Melanie Klein and Anna Freud into a new approach in working with children and countertransferential issues that is now widely cited (Altman et, al, 1992). This approach placed value on the relationship between client and therapist as well as the therapist's intentions and reactions. Winnicott (1958) stated that: "What matters to the patient is not the accuracy of the interpretations so much as the willingness of the analyst to help, the analysts' capacity to identify with the patient and so to believe in what is needed and to meet the need as soon as the need is indicated verbally or in nonverbal or preverbal language" (p. 122). Winnicott emphasized the need for open and warm relationship with children clients while respecting the historically based interpretive psychoanalytic approach (Altman, et. al, 1992). The ability to understand what the child patient needs and is expressing in symbolic language such as play and art is an important factor to consider for clinicians who practice play therapy. Winnicott emphasized the value of the relationship between the child and the therapist and the challenge of working with needs that are expressed verbally and non-verbally such as expression of children through play.

The consideration of the feelings that arise in the challenging work of exploring the symbolism of the child's world in their play is one of the areas of interest of this study. The study will aim to explore what effect, if any, children's' expression of their inner worlds through play has on the countertransference of the clinician.

Although the roots of the development of transference and countertransference issues have arisen from psychoanalytic thought, these concepts are now present in various kinds of treatment modalities. A relational conceptualization of countertransference goes beyond the possible representation a therapist may have for the patient of a prior relationship or parental figure. A relationally based conceptualization focuses more on the current and immediate relationship between client and therapist (Altman, et. al, 2002). In working with children, two meaningful points arise from the mandatory communication the therapist has with the child's parents (Altman, et. al, 2002). First, the therapist has to find ways to address information about the client that comes from the parents outside of the session and secondly, countertransference issues may arise from the contacts with the parents as well (Atman et al., 2002). Using an object relations based conceptualization, the therapist is therefore both a new and an old object.

As previously mentioned, this researcher chose to use a broader definition of countertransference as outlined by play therapist Kevin O'Connor. Other similarly universal definitions of countertransference exist, such as a description of the concept as the total response of the child analyst to the patient, the parents, and the therapeutic situation (Kohrman, et al, 1971). This study proposes to use this more expanded concept of countertransference in order to gather information from clinicians with diverse kinds of backgrounds, training, and theoretical orientations. The original, classical

conceptualization of countertransference was formed from a psychoanalytic school of thought. Therapist and clinicians now receive their training from various theoretical orientations. In order to look at the phenomenon of countertransference in play therapy across different types of practitioners, this paper will use a broader definition of the concept in order to allow for participation from clinicians of various backgrounds. In this way, this study will look at countertransference as a phenomenon that includes any thoughts, feelings, and behaviors that arise in the therapist during treatment with a child including the relationship the therapist has with the child's family and the larger system in which the client is embedded.

Play Therapy

Play is the natural way for children to explore and discover themselves and aspects of their world. Play is critical for healthy brain development and there is a growing body of research on the connection between play and neurobiological development (Landreth, 2002). Beyond the importance of normal brain development, play has also been found to be an effective healing tool in treating children who experience severe trauma (Homeyer & Morrison, 2008). Bessen A. Van der Kolk, a clinician, researcher, and teacher who has done extensive work in the area of trauma and mental health writes that because trauma often becomes stuck in the nonverbal parts of the brain such as the amygdala, thalamus, and hippocampus, treatment of trauma needs to incorporate the sensations, feelings, and actions that have become stuck (Van der Kolk, 1994). Landreth (2012) sums up the significance of play for children by underlining its understanding as a global human right: "The universal importance of play to the natural development and wholeness of children has been underscored by the United Nations

proclamation of play as a universal and inalienable right of children” (p. 36). Both the theoretical and scientific literature on play have demonstrated the developmental and therapeutic powers of play.

Play is an effective basis for therapeutic intervention because it is within play that children learn to explore, express, and master their environments. Landreth (2002) describes the following important characteristics of play: it is child directed, contains flexibility and creative expression, and is an intrinsically motivated activity. Using these tenets, he then defines play therapy as:

“...a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child (or person of any age) to fully express and explore self (feeling, thoughts, experiences, and behaviors) through play, the child’s natural medium of communication for optimal growth and development” (Landreth, 2002, p.11).

Toys may take on special meanings to children during their play. In their imagination, different objects can represent everything from a family member, to a memory, a feeling, or a thought (Moustakas, 1953). In play therapy, the internal world of the child is allowed to become external through the support of a trained play therapist. Landreth (2002) notes that children’s feelings are often not accessible at a verbal level as they are not yet cognitively able to verbally express or articulate what they feel.

The developmental psychologist Jean Piaget conducted research that demonstrated that children are not fully able to engage in abstract thought until approximately 11 years old (Piaget,1962). The ability to verbally express thoughts and

feelings require the use of abstract thinking as words are made of symbols and symbols are a form of abstract thought (Piaget, 1962). It is through play that concrete expression of the child's inner world can occur. Piaget (1962) described play as that which can connect concrete experience with abstract thought, and that it is the symbolism in play that holds much importance. The concrete objects of play are symbols, or metaphors of something in the child's life. As Landreth (2002) writes, "sometimes the connection is quite apparent; at other times, the connection may be rather remote... either case, play represents the attempt of children to organize their experiences and may be one of the few times in children's lives when they feel more in control and thus more secure" (p. 16). The idea that the meaning of the symbolism of a child's play may at times be ambiguous is of interest in relation to the effects this phenomenon may have on the clinician's countertransference. This study is interested in exploring the experience a clinician has in attempting to process and address this ambiguity.

There are several different kinds of play therapy. In psychoanalytic play therapy, play is used to build rapport with the child patient; it is used as a vehicle for observation and collection of data, and as a medium, which can assist the therapist in making interpretive communications (Schaefer & O'Connor, 1983). Psychoanalyst, Hermine Hug-Hellmuth was considered one of the world's first practicing child psychoanalysts. She was one of the first practitioners to recognize that play is essential for the expression of children in therapy (Landreth, 2002). As previously discussed, both Melanie Klein and Anna Freud then both used psychoanalytic play, albeit with opposing theoretical understanding and approaches to this work.

A different approach to play therapy was coined relationship therapy and has been mainly recognized as the contribution of child therapists Jesse Taft and Frederick Allen (Landreth, 2002). Unlike psychoanalytic play therapy, relationship play therapy deemphasized the importance of past history and underscored the importance of the “here and now,” the current relationship between the therapist and child. Relationship therapy influenced the development of the client centered or nondirective play therapy approach developed initially by Carl Rogers and later operationalized by child therapist Virginia Axline (Landreth, 2002). Axline stated the following about play therapy: “The child begins to realize the power within himself to be an individual in his own right, to think for himself, to make his own decisions, to become psychologically more mature, and, by doing so, to realize selfhood” (Axline, 1947, p. 16). In this way, the experience of play itself is healing and the relationship between therapist and child client is integral to that healing.

More directive approaches to play therapy are often used specifically when a child may be using the defense of denial or suppression (Gill, 1992). The clinician may be more directive during play therapy when a child is avoiding traumatic memories. They may guide the child through the event so that the child can begin to process it and set a foundation for this experience when their cognitive abilities increase (Gill, 1992). Another play therapy approach that stands on the more directive end of the spectrum of play therapy is family play therapy. Family play therapy uses more goal-oriented and planned activity sessions to connect play therapy work with family therapy. Family play therapy practitioners may involve the parents into their play, recognizing that children exist in a family system. Although this type of therapy tends to be more directive, at

times practitioners will use a non-directive method in this treatment modality by having the child spontaneously chose the activity or toys that they and their families will engage in (Schaeffer & O'Connor, 1985).

Fair Play Therapy is another major approach to play therapy. This approach uses a combination of directive and non-directive techniques to construct the kind of conditions in which a child can learn to solve problems and build upon their interpersonal skills and understanding of interpersonal experiences (Schaeffer & O'Connor, 1985). In this approach, the therapist is emphasizing the values and experiences of equity and fairness rooted in empathic understanding. Although several theoretical approaches exist in the play therapy world, the research of Lambert et al (2007), has demonstrated that play therapists identify the most with a child centered therapy approach. This is also the kind of play therapy that has had the longest history of use and research support (Landreth, 2002). The study examines clinicians' particular play therapy approach and theoretical conceptualization as a way to provide context for their perspectives and experiences regarding the research question.

Another specific approach in non-directive play therapy is the use of the identification of play themes (Ryan & Edge, 2011). As previously stated, many non-directive play therapists emphasize the quality of the relationship between therapist and child client and see the play experience itself as potentially healing and emotionally rewarding. Often, non-directive play therapists are trained to view the content of the children's play and organize the play into thematic categories. An accepted assumption when using this themed-based approach to the understanding of children's play is that when therapy is successful, the thematic tones in the play will shift to more positive and

developmentally appropriate ones (Wilson & Ryan, 2005). When looking at the relationship between the perception of themes in play therapy and clinicians' experience of countertransference, it will be important to understand what, if any, emphasis clinicians give to different theoretical and practice frameworks which can affect the perception of what the child client emphasizes in their play and subsequently, the countertransference experience of the clinician.

Countertransference in Play Therapy

Although the prevalence of theoretical conceptualization of countertransference in child treatment has increased in the past two decades, the literature on the phenomenon of countertransference during play therapy is limited. The traditional method of addressing countertransference has relied on the intellectual and verbal means of addressing the issue (Gill & Rubin, 2005). Therein is the key factor that makes countertransference unique in play therapy. Because play therapy is not dependent on the verbal discourse of traditional therapy such as discussion, interpretation, and exploration through questions, the traditional methods of addressing it may not apply as well to addressing countertransference responses in play therapy (Gill & Rubin, 2005). Rosenberg and Hayes (2002) have found that anxiety management, self-integration, and clarification were the most widely cited means of countertransference resolution (Rosenberg and Hayes, 2005). Other therapists (Robbins and Jolkowski, 1987) have emphasized therapist self-awareness, understanding, and alertness as important factors in addressing countertransference. O'Connor (1991) was one of the first writers to discuss the specific topic of countertransference in play therapy. O'Connor emphasized the use of therapy and supervision as tools to effectively deal with countertransference issues in

play therapy (Gil & Rubin, 2002). In addition, Metcalf (2003) as cited in Gil & Rubin (2002) noted particular ways in which play therapists may address and process countertransference including group supervision, consultation, and peer process groups.

The issue of play therapy supervision is critical in supporting play therapists in all areas of their work including understanding, managing, and addressing countertransference issues. Homeyer & Morrison (2008) describe that although play therapy has been rapidly growing in popularity, literature written specifically on play therapy supervision is limited. They write about supervision in play therapy, “given the nonverbal nature of play therapy, supervisees may benefit from exploring supervision issues through nonverbal means. Perhaps supervision experiences that use symbolism, metaphoric play, and art would be appropriate, if not the standard” (p. 219). This research project will aim to gather narrative data from clinicians on their perception and use of these techniques.

Gil & Rubin (2002, 2005) have suggested a particular approach to address countertransference in play therapy. Similarly to Homeyer & Morrison, they suggest that the modality of play can be a useful tool to address various countertransference reactions in play therapy (Gil & Rubin, 2002). More specifically, they suggest various play techniques and expressive mediums that can be used before or after sessions with a client to process some of the more difficult countertransference reactions. No research to date exists on therapists’ use, application, or perceived usefulness of this technique. This research project will aim to explore how clinicians address and process their countertransference responses in play therapy. The study seeks to gather clinicians’ perspectives on their use of the tools Gil & Rubin (2002) describe.

Play therapy is a complex therapeutic intervention that requires many abilities from the therapist. Landreth (2002) writes about the unique requirements of the play therapist:

The play therapist is a person who hears the hurt in a child's heart; a person who cares enough to listen to the depth of a child's pain; a person who accepts without judgment the person of the child; a person who prizes the uniqueness in the midst of the child's despair; a person who appreciates the desperation of a child's loneliness; a person who understands and is willing to be with a child" (p. 97-98).

This ability to do what Landreth describes, to truly be with a child, requires that the therapist pays close attention to what reactions may arise in them, their countertransference, while they are navigating the complex and intricate work of play therapy with a child. Further research into the intricacies of countertransference in play therapy will be helpful to provide clinicians the support to understand their countertransference experiences while engaging in the complex work of play therapy.

This literature review has explored the development of the conceptualization of countertransference. It has discussed the various ways in which child therapy treatment is unique and what the literature has described to be the distinct factors of countertransference in child treatment. In addition, the theoretical conceptualization of play therapy and its major approaches have been described. A significant amount of literature exists on the topics of countertransference and countertransference in child treatment. Similarly, much research and writing has been devoted to exploring and researching the theoretical basis for play therapy as well as various play therapy

techniques and modalities. The topic of the phenomenon of countertransference during play therapy however is one that has not benefited from narrative data based on clinician experience. This research study aims to fill a gap in the literature on this topic while simultaneously aiming to provide helpful insight to play therapists' practice. The subtle, complex, and at times, unclear expressions of emotional conflicts expressed in children's play in play therapy may evoke strong countertransference responses during play therapy; a further exploration of this experience may help practitioners and educators navigate this complex experience and inform supervision, future research and training.

CHAPTER III

Methodology

Formulation

This study is a qualitative investigation into clinicians' experience of countertransference during play therapy, which aims to answer the following question: *How do clinicians experience, process, and utilize countertransference during play therapy?* In order to better understand the context of clinicians' countertransference experiences, this study also will explore clinicians' theoretical foundation for their practice and conceptualization of their play therapy approach. This chapter describes the rationale for the chosen methodology of this study, including the sampling and recruitment techniques, ethics and safeguards, and data collection and analysis.

Qualitative methods were used in order to collect the full, individual, and unique experiences of the clinicians in the study. The concept of countertransference is full of complexity and depth. Qualitative research allows for an unstructured approach in which "...the possibility of getting at actors' meanings and of concepts emerging out of data collection is enhanced" (Bryman, 2012, p. 408). This study is interested in the deeper meaning and nuances of the phenomenon of countertransference in play therapy. The use of qualitative research methods will allow for the comprehensive perspectives of clinicians who practice play therapy to be collected and analyzed (Rubin & Babbie, 1989).

Sample/Recruitment

Eligibility requirements for this study included the following: clinicians or therapists who work with children ages 3-12, utilize play therapy in their practice, and

have a Master's degree or Doctorate degree in one of the following disciplines: Social Work, Marriage and Family Therapy, Mental Health Counseling, or Psychology. These criteria were chosen to include therapists with different theoretical training and orientation in order to increase the diversity of experiences and responses. Mental health treatment with children and play therapy, in particular, is performed by practitioners with different educational degrees and theoretical foundations. The selected degree qualifications were chosen based on these disciplines being some of the more common mental health providers for children in the United States. The literature point to the 3-12 year age range of children to be most conducive to play therapy (O'Connor, 1991).

The sample size for this study was 12 participants. Recruitment for the study occurred through two main approaches. These approaches were used in consideration of schedule and resource feasibility. The recruitment strategy allowed for the researcher to finish data collection within an allotted time frame by using existing networks to recruit participants. First, an email was sent to former and current colleagues and acquaintances who were known to have worked or are currently working with clinicians who work with children through play therapy. These individuals received an email with a brief description of the study and eligibility criteria. In the email, they were asked for referrals for potential participants as well as for the email to be forwarded to potential participants. The second approach to recruitment took place at the agency where the researcher was interning. Clinicians who had been identified as working with children received an email describing the study and eligibility criteria. They were then asked to forward this information to potential participants.

As described, the sampling for this study began with purposive, convenience sampling. After three participants were identified through professional networks, snowball sampling was then used to reach other eligible participants. Due to the time constraints of this research project, snowball sampling offered a way for identified participants to propose other participants who have had the experience and characteristics relevant to this research project (Bryman, 2012).

Ethics and Safeguards

In the initial contact with a potential participant, the study was described and the procedure was outlined. This initial contact was done through email and phone contact. The procedure of the study was explained using the “Consent to Participate in a Research Study Form” (Appendix B). If participants wished to participate in the study, a time and place was scheduled for the interview. The “Consent to Participate in a Research Study Form” was given to each participant and included information on the study’s potential risks and benefits, right to discontinue participation, and confidentiality. Potential benefits to the study include clinicians having an opportunity to talk about their experience of countertransference in play therapy and possibly gaining insight into that experience. Possible benefits to social work are providing information for future research and supporting social workers and social work educators in navigating the experience of countertransference in play therapy. Finally, a potential benefit to the study is the study’s possible utility for future and current training programs. There are no foreseeable risks that have been identified with the participation of this study.

When participants agreed to partake in the study, they were asked to read and sign the “Consent to Participate in a Research Study Form”. Participants were given a copy of

this form. The interviews took place at the researcher's office, at the offices of clinicians, and at coffee shops that allowed for privacy and convenience for the participant.

All participants agreed to be audiotaped. Recording of the interviews was done with a tablet device using the iTalk application on an iPad device. Participants were not asked to identify themselves on the audio recording. All audio and written data is currently password protected and will stay password protected through the federally mandated storage period. Participants were given code numbers, which appear on each document. No names were used on any of the materials except for the consent form.

Data Collection

This study used a qualitative design to gather narrative data through individual, in-person interviews with twelve participants. An interview guide (Appendix C) with semi-structured questions was used consistently for all study participants. As Bryman (2012) describes, in a semi structured interview, questions do not follow exactly the way they are outlined on the interview guide, "questions that are not included in the guide may be asked as the interviewer picks up on things said by the interviewees, but by and large, all the questions will be asked and a similar wording will be used from interview to interviewee" (p. 471). The semi structured interview along with the interview guide allowed for the flexibility to explore what is important to the interviewee and how they understand and experience particular concepts while still providing the same framework for all participants.

The questions in the interview guide were developed to gain a deeper understanding of the phenomenon of countertransference in play therapy by collecting in depth narratives of clinicians' experience. The initial questions in the interview were

designed to gather the theoretical foundations of the clinicians' play therapy practice. Questions that focused on the research question itself were designed to be open-ended in order to gain deeper meaning and various perspectives. Clinicians were often asked to provide clinical case examples of a specific phenomenon they were describing. These clinical vignettes enabled the interviewer to understand the experience more deeply, while connecting more closely to the clinical work the clinician described.

The questions in the interview guide could be broken down into the following categories:

- Approach/Theoretical Orientation to Play Therapy
- Training in Play Therapy
- Perceived Strengths and Benefits of Play Therapy
- Experience of Countertransference in Play Therapy
- Processing of Countertransference in Play Therapy
- Utilization of Countertransference in Play Therapy

In addition to the semi-structured interview questions, participants were asked to answer five basic demographic questions that included their age, gender, race/ethnicity, degree, and years of play therapy experience.

Data Analysis

The data from the interviews was analyzed using data coding techniques using the *grounded theory model* (Strauss and Corbin, 1998). The data analysis in this study was therefore grounded in the data, rather than in theory. As discussed in the previous chapter, there is limited available research on the specific topic of countertransference in play therapy. As Rubin & Babbie (1989) write, “the openness of the grounded theory approach allows a greater latitude for the discovery of the unexpected” (p. 474). The

grounded theory model was used in order to understand the deeper meaning and specific characteristics of a phenomenon, which has not been studied or written about in depth. The data analysis was set up to look for “patterns, themes, and common categories”, so that general conclusions about this data could be made (Rubin & Babbie, 1989, p.474). The data analysis was organized based on the categories of the questions in the interview guide outlined above. The demographic data was analyzed manually, using basic statistical tests such as the calculation of mean and median scores.

Interviews were first fully transcribed and then analyzed. This analysis consisted of labeling, separating, combining, and organizing the data from the interviews. The transcripts were reviewed multiple times. Bryman (2012), writes about coding process that it “entails reviewing transcripts and/or field notes and giving labels (names) to component parts that seem to be of potential theoretical significance and/or that appear to be particularly salient within the social worlds of those being studied (p. 568). The process described by Bryman was used to analyze the interviews. Concepts were created through the identification of components of interviewee narratives that were relevant to previous literature, emphasized and appeared salient to the participant’s experience, or were of general interest due to its complexity and further potential inquiry. The coding methodology in this study facilitated the analysis of the clinician narrative data.

The expected findings of this study include the general understanding that several characteristics of countertransference in play therapy parallel countertransference experience in child treatment that exists in the theoretical literature. An unexpected finding of this study is the particular kind of countertransference responses that were emphasized by participants in this study as well as the emphasis on the importance of

supervision in various areas of practice. Perhaps the most significant limitation of this study is in its sample and sampling technique. The non-probability convenience and snowball sampling that was used in this study led to sample bias. While this study cannot make any generalization about all clinicians' experience of countertransference in play therapy in the field, the study does provide an exploration of interviewed clinicians experience of this topic.

This study's findings may still have implications for both theory and practice. In considering theory, future research may lead to an understanding of this phenomenon, which either supports or argues against some of the themes found in this study. This study's findings may also support current and future practitioners by enhancing training, practice, and supervision guidelines for play therapy work.

CHAPTER IV

Findings

This chapter presents the findings of a qualitative methods research project that was conducted using semi-structured interview questions. The purpose of this project was to explore how clinicians experience, process, and utilize countertransference reactions in play therapy. This chapter begins with a description of the demographic data of the twelve participants of this study. The findings then briefly present clinicians' narrative data on their approach to play therapy as well as experience of training in play therapy. This information will serve to provide context to clinicians' experience of countertransference in play therapy work. Finally, this chapter presents the gathered clinician data on the research question itself. It presents the major findings on the way that interviewed clinicians shared that they experience countertransference in play therapy.

On the topic of the experience of countertransference in play therapy, the findings identify and illustrate three major themes: *complexity of experience*, *feelings of frustration*, and *feelings of uncertainty*. The findings then identify two major themes that were gathered from clinicians' narratives on the processing of countertransference in play therapy. The two themes illustrated on this topic will be *visual tools* and *importance of supervision*. Lastly, the findings will identify two major themes that were gathered on the topic of the utilization of countertransference in play therapy: the *use of self-disclosure* and *enhancement of self-awareness*. Additionally, some of the data that was not explicitly

pertinent to the research question of this project will be presented in a separate section of this chapter.

The twelve interviews of this study were conducted in person. The interviews were fully transcribed and coded by identifying themes, subthemes and differences between the gathered clinician data. The chosen research methodology allowed for the collection of in-depth narratives from clinicians as well as the identification of relevant and salient segments of data.

Demographics

A total of twelve clinicians were interviewed for this research project. All twelve clinicians reside and work in either Connecticut or Massachusetts. Although clinicians were never explicitly asked to describe the setting in which they work, throughout the interviews, all clinicians shared that they work in outpatient settings ranging from child and adolescent outpatient clinics, to intensive outpatient programs, to private practices. The following demographic information was collected prior to the semi-structured interview questions began: gender, race, age, degree, and number of years of play therapy experience. Out of the twelve participants of the study, 11 identified as female, and one identified as male. The majority of the study participants identified as white (n=8), while two clinicians identified as African-American and one each identified as biracial and as Latina. The biracial participant identified her ethnic heritage to be half Puerto Rican, half white. The average age of interviewed participants was 41 years old and the median age was 39.5 years old. Out of the 12 participants interviewed, 67% (n=7) were Licensed Clinical Social Workers (LCSW), one of whom also held a PhD in social work, 17% (n=2) of the participants held the Licensed Marriage and Family Therapy Degree

(LMFT), and .09% (n=1) participant held the Doctor of Psychology (Psy.D) degree. The number of years that the study participants have been in practice ranged from 2 to 17 years, with both an average and mode of 8 year of experience in therapy practice.

Play Therapy Approach

On the topic of participant's play therapy approach, out of the twelve interviewed participants, 75%, n=8, participants identified their approach to play therapy to be some kind of variation of the broad category of child-centered or non-directive play therapy approach. These eight participants tended to describe this approach in a similar way with some of the key factors of the approach including child's choice, benefit of child feeling in control, flexibility, and empathic observation.

Participant Two shared the following about their play therapy approach:

My approach is most importantly child-centered. I use various techniques of course, and I really feel that in this work we always pull from various orientations, but at the center of my play therapy work is allowing the child to guide their experience. I am there to support them, to offer empathic responses, provide curiosity, and always be present with them. But I really have the child be the one that makes choices about the play. If it is the child that is leading the play then they are the ones showing me what is important to them, what is happening in their world.

Similarly, two other participants, Participants Six and Eleven spoke about an approach in which the child leads the play. They spoke of the therapeutic benefits that this allows to occur in the playroom:

The way I have come to practice, and I have not always practiced this way, is by providing the necessary environment for a child to feel free to express themselves. By that I mean, I will offer the space and tools, like the toys and board games, and safe room, and guidelines, and all of that, but then, at least in the beginning I will sort of step back, will stay curious, open-minded, and engaged. This shows the child you are an ally rather than an authoritative figure. I really try to stay with their experience, be fully present, pay attention with what they may be trying to tell me, or themselves. And sometimes, that is just so perfect because the child is genuinely surprised that you act this way with them. They are sort of not used to an adult acting this way with them. I had a kid just the other day that said “So I can really play with whatever I want”, and I said “yep”, and he just “wow”...

Both Participants Two and Six emphasized the significance of having the child choose the direction of their play as well as the toys of their play. In addition, the importance of providing empathic observation and responses was emphasized by n=7 different participants including the aforementioned quotes. Participant 3 stated the following about making observations:

I don't have to tell you that empathy is key to this work, you know, more than any kind of approach, it is really about empathy. And that concept has a lot of meaning with a child who has struggled. I really try to understand what has happened to a child, how it has

affected them, the best way to understand that in this work is to truly listen and pay attention to their play.

The above quote from Participant Three captures another major theme that several other participants spoke about during their interviews on the topic of their approach to play therapy. These participants described that in their approach, they value that understanding the child's experience, inner world, or the way that they make meaning of their experience and environment can be understood by paying attention to the meaning of their play. Participant One eloquently described the process of listening to the child by immersing oneself in the child's play:

What is truly beautiful about this work is that I get to enter the child's world, but in a really developmentally appropriate and respectful way. When I do that, I learn so much. I learn what is important to the child, and sometimes I miss it, and the amazing thing is that the child will let me know when I did, they will come back to it. So I really get to learn what is important to this child, what they are struggling with, and how they have made meaning of something that has been really tough for them.

Participant Four also described that in her approach, she pays attention to how a child has made meaning of what has happened to them:

...with time, I give a voice to what is happening to the child... um and that is based on both what is happening in that moment in the actual play and how it may be a reflection, or a metaphorical piece of a particular psychosocial difficulty, or as you probably already know, trauma in that

child's life. Often the best way of understanding the impact of trauma on the child is to understand, and really pay attention to how they are communicating that impact in their play.

In describing their approach, n=4 of the interviewed participants spoke about being more deliberate, and at times more directive in their play in the specific instances when children struggle with social difficulties. Participant Four stated that that she will often use specific activities to support the child in learning how to manage social difficulties:

There are so many factors that will determine my approach, although for the most part I still let the child lead the play, there are times when I change my approach if say for instance a child has specific social skill needs. In a case like that, I may chose a particular kind of activity or game that may help that child either express their social difficulties or help them navigate the social relationships in a better, more healthier, age appropriate way.

Similarly, Participant Eleven spoke about changing her approach slightly for children diagnosed with Autism Spectrum Disorder. Instead of looking at the meaning of the play for a child whom she describes to be highly interested in planes, she uses his interest to build a relationship with this boy and teach him about listening, sharing interests, and trust.

My approach is a little different with kids with Autism, and lately I have had a lot coming in, I think a lot of times parents of this community become quite close so word spreads if a clinician has experience with in providing therapy. But yes, so a lot of times when a kid who has been

diagnosed with Autism comes in, or I make the diagnosis I see one of my biggest goals as helping them learn how to form appropriate relationships. So I had one boy who was absolutely obsessed with different kinds of planes. So a lot of times in our sessions, he would play with planes, bring some of his own planes, and books about planes. So with this kind of kid, it's not really about what do these trains mean, you know, its more about I'm going to ask you to teach me about these planes because I want to show you that what you have to share is interesting and in that process we are going to build a relationship and learn about social interaction together, and that builds self esteem for sure.

This section has identified and illustrated some of the salient data on interviewed clinicians' approach to play therapy. The following themes were identified: a child-centered or non-directive therapy approach, the importance of empathy and empathic observations, the values of understanding the child by understanding the meaning of their play, and the modification and flexibility of play therapy for children who experience social difficulties.

Training

This section briefly describes the main themes that emerged from the narrative data on the topic of training in play therapy. The interviewed clinicians described various training background and experiences. As noted in the demographic section, more than half, 67% of the clinicians interviewed were Licensed Clinical Social Workers. Some of the major themes to come out from the clinician narratives include experience in psychodynamic training, training through the support of solid supervision, use of

trainings and conferences, and self training, in which the clinician gains experience from being immersed in the work.

Participant Four here speaks of both her psychodynamic training, attending conferences as well as gaining experience from her immersion in this work:

I went to a psychodynamically trained school, and play therapy was part of that training. I also have a postgraduate certificate from ...Child and Adolescent Psychoanalysis. I have been to multiple conferences over the years on play therapy, but I have never received specific advanced training in it. You know, with this kind of work, you have to do really do it, be immersed in the work in order to advance your understanding, part of the work is about being incredibly present.

Three other participants shared their background in psychodynamic theory, making 33% (n=4) of the interviewed participants identify with this theoretical orientation during their training. Similarly, Participant Eleven describes her training experience as mainly consisting of her education during her Master's degree as well as trainings and conferences she has attended throughout her years as a clinician:

...When I was getting my MSW I took a bunch of classes on child and adolescent treatment and I had one professor who was quite experienced and had so much to share with us. She brought in toys, videos of real sessions, and sand tray slides. It wasn't just theoretical, we really had great play case material. After I graduated, I started working here right away and you know about having to have CEU credits. So I have gone to conferences and trainings on play therapy. In the past couple years I feel

that there have been so many more really on play therapy, play therapy and trauma and so on. I have gained a lot from these.

Participant One and Seven both spoke about the importance of having supervisors who are passionate about the work and competent in its theoretical conceptualization.

Participant One shared:

...I realized after a few years of doing the work that I didn't have the proper training actually. I went to some trainings and was looking into taking more graduate courses. Then I started talking to some peers I went to school with and so many of them had hired supervisors for their private practices. So I did the same thing, and that was really the game changer for me, I finally understood the theory behind what I was doing, because I could actually talk about the kids I was seeing with someone who truly got it.

Here, Participant Seven speaks about the significance of supervision when she looks back on her training:

I really got amazing training from a supervisor who was so passionate about play therapy work. I took classes on it at school, but was so nervous when I was seeing kids in the playroom, thinking am I doing this right, nothing is happening, and that sort of thing. My supervisor was so great in really helping me understand what exactly my role is, when to step in and step back. I think most of what I learned really came in those first couple of years from her.

On the topic of their experience of training in play therapy, three major themes

emerged from the gathered clinicians: experience in psychodynamic training, use of additional conferences and training throughout their work experience, and importance of supervision in their training. This next section will present the findings on the topic of the research question itself, including the ways in which clinicians experience countertransference in play therapy, the way clinicians process countertransference in play therapy and the way clinicians utilize their countertransference in their work with child clients.

Experience of Countertransference in Play Therapy

There were three major themes that developed on the subject of the way clinicians experience countertransference in play therapy. These themes included a general recognition that countertransference reactions tend to be of *increased complexity*, and contain *feelings of frustration, and feelings of uncertainty*. This section of the findings will elaborate on these themes as well as provide direct quotations from clinicians to illustrate these concepts.

Increased complexity

Among the interviewed clinicians, 42% (n=5) identified their experience of countertransference in play therapy to be of a complex nature. In the following quote, participant Four describes that she views her experience of countertransference in play therapy as more complex because of the involvement of the entire system of the child in play therapy:

... Well let's see it's probably similar to any countertransference experience but I would say it is more complex. More complex, because you are never just dealing with a child, you are dealing with the parent, the

family, often the school, or DCF. So if a child says something to me or I should say expresses something to me in their play and as it is often the case in a child who is in treatment they are describing or expressing being hurt by someone or something and expressing sadness or a sense of loss... I will in turn at times feel sadness or anger but not only about their sadness or anger but about feeling that they have been wronged by adults in their lives, wronged by the school system, or DCF or the myriad of other entities involved in their lives.

Participant Two similarly explored the complexity of dealing with countertransference reactions that arise in relation to the child's parents or caregiver:

There is just so much you feel when you are working with a child. I have my feelings of empathy toward the child, in which at times I will feel the sadness they feel, or the loss they feel. But there is also the really intense reactions I have toward the parents and caregivers. The frustration and anger I feel toward them for feeling like they could be doing more, or should be more gentle or understanding. That is really difficult. Especially since I have become a mom, I think it has been tougher. Maybe I am less patient with parents, which is funny because I thought it was going to be the opposite, I don't know. I feel that recently I have had more intense reactions toward parents... and in play therapy, those reactions are even harder because it's happening while you are trying to stay in the play to figure out the meaning. It is just a lot to juggle all at once. It keeps it highly interesting though.

Participant Nine similarly describes the complexity of understanding the child's play and being present with the child in session while experiencing countertransference. The participant presented a clinical vignette of this complexity in the following case example:

So actually, yea I have an example of this from last week. I come into work and I have this confusing message from a frazzled parent that EMPS (*reader, note Emergency Mobile Psychiatric Services*) were in the home over the weekend. Then I have a message from the EMPS worker stating that she feels that this child, my client who I have been seeing for two years now needs to be in a home based program and that the mother feels that therapy has not been enough. This is a 7 year old girl with multiple loses, attachment disruptions, and multiple home placements by the way. An hour after I receive these message and am obviously feeling a lot ranging from frustration at the parents and EMPS worker to extreme worry for this little girl as well as a definite sense of some level of incompetence, I am scheduled to see this child for an individual session. So she comes into the play room and starts, as she usually does building this really elaborate doll house with multiple characters and settings, and she is obviously conveying a lot there, but it's hard for me to focus on it all when I'm also trying to deal with all my feelings from these messages I received an hour ago.

This participant has described a case example in which the experience of countertransference is more complex when balancing navigating the information and reactions that may be coming from parties outside of the session while simultaneously

attempting to focus on the child's play and its meaning in session. Participant One gives a clinical example that also illustrates the complexity of their responses to the child:

You know something that comes to mind right away, and maybe because it tends to come up frequently is when a client, usually a really little one, wants to play some kind of pretend game where I am the parental figure and they are a baby. So this sort of poses the issues of boundaries and limits, but this kind of play has a lot of meaning. Also personally a lot of issues come up with this sort of thing, like for me, my own identity as a mom.

The excerpts above have been used to illustrate the theme of the complexity of the experience of countertransference in play therapy. Clinicians spoke of the complexity of this experience due to the involvement of multiple parties when a child is in therapy. In addition, clinicians described the complexity of simultaneously balancing their attempt to understand the meaning of play, the relationship between the client and themselves, as well as their countertransference.

Feelings of Frustration

Another major theme that was identified among the collected data on the topic of the experience of countertransference in play therapy was clinician's experience of feelings of frustration. Among the interviewed participants, 33% (n=4) identified feelings of frustration to be a significant aspect of their experience of countertransference during play therapy. Participant Five speaks of the frustration she often feels when feeling that the child is "stuck" in the same play:

Often what I feel is pretty frustrated in session. There is all sorts of

frustration to be felt, but I really feel it the most when I feel like my client has been stuck in the same play for awhile. I am making observation, but I feel like they are the same observations. Like, “I see that you are hiding the little zebra under the sand, I really can’t see it, I wonder if you don’t really want me to see it, but I wonder if maybe I can see it just a teensy little bit, and we’ll take it one step at a time?” So, a lot of that session after session, same play, same choice of toys, same themes, and not much movement. This kind of frustration is pretty personal because to me at least, it makes me feel like wow, this child is definitely trying to tell me something, because even repetitive play means something, but either I am not getting it, or I am tuning out, or I’m not being creative enough... so I end up feeling frustrated toward myself but also toward the child...and I know it’s not the child’s fault of course, but feelings aren’t exactly rational, *laughs*.

Participant Twelve described quite a similar experience in her feelings of frustration toward a child who may not be progressing in therapy at the pace at which the clinicians would like:

There is a lot of pressure to see results. But play therapy is a complex tool, and I gotta say I am just beginning to feel comfortable with taking it slow, one of the main things I have often felt is frustrated when nothing is really happening, and I’m like agh, we are just playing, and the parents and school are calling me everyday with the same complaints and I’m just playing Connect Four with this kid for the past month.

When discussing challenges to the work of play therapy, Participant Four also spoke about the difficulty of feeling pressure to see immediate results.

Let's see where do I start, *laughs* I don't know if the challenges I think are necessarily specific to play therapy or just social work in general. So the main one probably is pressure from the agency and insurance companies to see immediate results or practice in a specific way. Play therapy takes time, results are not going to be immediate. Also, sometimes parents just don't understand what it is that I do with the child.

Feelings of frustration was a significant theme identified in the gathered narratives of the clinicians. Clinicians described feeling frustration and related feelings at occasional lack of progression the child is exhibiting in their play. In addition, clinicians recognized that their frustration is related to the pressure they often feel to see more tangible and immediate results. The identified sources of this pressure included the clinicians themselves, parents and caregivers, schools, and the administration in the clinician's work places.

Feelings of Uncertainty

The last major theme that was identified on the topic of the way clinicians experience countertransference in play therapy was feelings of uncertainty. Among the interviewed participants, 50% (n=6) of the clinicians identified this reaction to be of significance. Some of the clinicians had named this experience as hesitation, ambiguity, and doubt. The following excerpt by Participant Four illustrates the experience of uncertainty in connection to understanding the symbolism of the child's play:

Well I would say that the metaphor comes with a certain level of

uncertainty, and that kind of uncertainty is absolutely a type of countertransference I feel. I don't know for sure that the tiger attacking the little baby in the sand tray is a manifestation of the little boy's sense of helplessness or anger or aggression, or if it something else. That uncertainty is the work, staying with it, not letting it scare you, or push the child into telling you something. It doesn't go away by the way, the uncertainty I have just learned to embrace it and be comfortable with it.

Two other participants spoke about uncertainty as a reaction they have felt when not being confident that their interpretation of the symbolism of the child's play is correct. Participant one describes her experience of doubt during play therapy in connection to her recognition that there is bias in her interpretations. She also emphasizes the importance that curiosity and genuine concern has for the building of a therapeutic relationship and the child's healing process:

Oh I always doubt my interpretations. You have to, and you know, we have our own biases in those interpretations too. I remember we used to have these clinical meetings, you know when our clinical director at the time would show us sand tray slides, and everyone would come up with these beautiful, meaningful interpretations, but they would all be different. And I think that's fine, because probably what is more important is that you are showing the child that you are genuinely curious about their experience, you know that you are present with them, and are respecting their way of exploring their experience.

Participant Eight describes her experience of ambiguity when suspecting, due to certain

play themes, that there may have been a history of abuse that was not reported:

There is ambiguity to this work for sure. That's something I feel. I have a client, a 9 year boy who I have had a feeling from the beginning may have had a history of sexual trauma. He has had multiple foster home placements, has a therapeutic case worker at DCF and his current foster parents who he has been with for umm maybe 3 years deny any trauma, he has also denied being touched inappropriately by anyone. But in his play, there are these recurring things that really make me wonder if he was at one point touched inappropriately or if he maybe witnessed something of a sexual nature. He does these drawings of people touching each other in private parts and a lot of times takes clothes of dolls. He also sets up these parties for us where he puts kind of yucky combinations of food together like, and that's one you know from even textbooks, the child is sort of testing you out to see how much yuckiness you can handle as a way to see whether you will accept him. And I don't know there are many other issues with this child, but I have to be okay with that ambiguity, it's really hard when you feel that there may be something there as serious as sexual trauma. The possibilities are always there and you see so much in this field.

As seen in the clinicians' quotes, feelings of uncertainty are yet another complex theme that was identified on the topic of the experience of countertransference in play therapy. This section has summarized the three major themes that developed from the clinician data on the subject of the way clinicians experience countertransference in play

therapy. These themes included a general recognition that countertransference reactions tend to be of *increased complexity and include feelings of frustration and feelings of uncertainty*. Later in the discussion section, the connection between these themes and themes on other topics of the research question will be explored.

The Processing of Countertransference in Play Therapy

The second major part of this project's research question was to explore how clinicians process their countertransference responses in play therapy. This section will discuss two major themes that came out of the gathered clinician data on this topic. The two themes that will be illustrated in this section *the value of special tools to process countertransference* and *the importance of supervision*. Among the interviewed participants, 50% (n=6) spoke about use of specialized tools to process countertransference responses in play therapy and 75% (n=8) spoke about the use of supervision in processing their countertransference responses during play therapy.

Visual Tools

Participant Four described the usefulness of visual tools that she had utilized when she started out in the field. She identified using drawings of play, videotaping sessions, and engaging in play after session as ways clinicians can support themselves in processing countertransference reactions and the meaning of their play they have engaged in:

Well when I first started out, and I was still getting my license and I lucked out with a supervisor who loved play therapy. She would have me draw pictures of the sand trays from the perspective of the child. I'm not an artist, so they would be basic sketches just labeling the miniatures in

the sand tray. I still do that at times, but not as much anymore. I used to videotape sessions at times. That is very helpful because it gives clear context to the feelings I am experiencing whether it's anxiety or sadness or anger....I know of colleagues who will actually play as a way of understanding all that, I had done that a long time ago as well.

In the above quote, Participant Four identified the use of visual tools as well as the importance of supervision. Participant Four also spoke of the processing of countertransference being more complex due to the clinician's reaction being a response to the symbolism in a child's play:

What makes processing it unique, okay. Well I would say unique in that you it really helps to have visuals. Also when you are processing it you are trying to understand why you felt a certain way and what they may mean in terms of what is the client experiencing, but all of that is in the context of play, so in a way it is removed, not as direct, so at times everything is just a bit more muddy.

This participant along with three others participants also identified the limitation of time in being able to utilize these tools. This point will be discussed further in the discussion chapter of this project. Similarly to Participant Four, Participant Eleven describes the value of having a visual recording or reminder of the play, which elicited a countertransference response:

I have taken photos of some of the play set ups. In our agency we have a sign consent form for the parent. You know some of the kids will build really detailed scenarios, I mean you will forget what they actually did,

never mind what you thought the play meant or what you were feeling at the time, like umm what you seem to be interested in.

Participant Nine also describes her use of a play therapy journal in which she keeps a recording of the various play themes present in a child's play to see how the themes may be progressing:

I have kept this journal for a long time. It's small so I bring it into the session with me sometimes. I will record play themes in there so I can go back and see any changes, and what keeps coming up and that sort of thing. It is helpful. I had a supervisor who used to have me write down my reactions to the play too. I stopped doing that, but it was perfect for supervision.

Importance of Supervision

Another major theme that has already been already illustrated in the quotes from the clinicians above has been the importance of supervision in processing the countertransference during play therapy. Participant Seven describes how supervision has supported her in processing countertransference responses as well as supporting her in understanding the deeper meaning of her child clients' play:

... a great supervisor is really key to that. You have to find the right one of course. The right supervisor, I think will focus a lot on your own reactions and your feelings about the client and their parents. If you don't talk about it with someone who will encourage you to think more deeply about it, at least for me, I think I would not think about it as much as I should.

Similarly, Participant Five speaks of the importance of supervision in child treatment:

I process with my supervisor, I don't think I would be able to do this work without great supervision. I lucked out, I speak to old classmates all the time that are really struggling because no one is supporting them with the toughest part of this work. I think working with kids, with kids who have been through so much, there is so much that is uncomfortable to acknowledge, like feeling frustrated with a child, or annoyed, or bored. It's unacceptable in a way to feel that, we are supposed to be empathic constantly, but we are also people with our own pressures and history and supervision is really the place to talk about all that.

This section of the findings has summarized the data on the topic of processing countertransference in play therapy. Two related themes were discussed and illustrated in this section: utilizing special tools to aid in processing countertransference responses in play therapy as well as the importance of supervision in the processing of countertransference in play therapy.

Utilization of Countertransference in Play Therapy

The last part of this research question dealt with exploring the way clinicians utilize their countertransference reactions in play therapy. The two major themes that emerged from this topic were clinician self-disclosure of their countertransference as well as an enhancement of self-awareness. Among the interviewed participants, 25% (n=3) participants spoke about occasionally self-disclosing their countertransference to a child client if it may serve to be therapeutically beneficial. Participant One describes a clinical example in which she shared her own sadness to a young client:

You have some favorites sometimes, have you experienced that? *Laughs*

And you know, with those favorites to me, it makes me want to be as genuine and as real as possible. I was terminating with a little girl because she was moving, so premature termination, with kids these are always really tough for me. So together we planned a special activity, and what was it, we were going to put on a puppet show. I felt very sad to say goodbye to this girl. She was sad as well, she has a parent who passed away, and a grandmother who she was close to that passed away close to that time, so this goodbye was not just about the loss of a therapist, but so much more. So in that session, during that puppet show, I told her how sad I felt, how sad I felt to say goodbye to her but also how sad I felt that she had to say goodbye to so many important people to her.

Similarly to Participant One, participant four describes how she at time utilizes her countertransference as a way to reflect feelings to show interest and build rapport:

At times I use it by pointing out what I am feeling in the moment. So an example I do often is when a child comes in with a history or um even currently a chaotic environment, they often fill the sand tray with many toys and what that conveys to me is that the child is maybe perhaps overwhelmed or anxious, looking at that sand tray I myself start feeling overwhelmed, so sometimes I will just point that out and say something like “wow, there sure is a lot in here, I wonder if together we can help you sort it all out” Its simple but works well because one, you’re labeling and reflecting back the feeling and two, letting the child know you are interested and want to help, but won’t jump in their play right away

without understanding and trying to set it up differently.

Participant Three also described the value of self-disclosure in connection to building a relationship with a client:

I used to work with adults and sometimes I think that kind of genuine relationship is built when the therapist shares their feelings too. So I absolutely do it with kids. Kids who have been abused and show aggression, I will tell them I feel so angry about what has happened to you too. It shows them you are a real person, and that real reciprocal connection is essential to the healing process.

Another significant theme that arose from participants on the topic of the utilization of countertransference in play therapy is a growth in self-awareness. Participant Ten spoke about learning of her own triggers to difficult emotional responses:

Well I utilize it mainly by just knowing what really gets me, especially when it has to do with parents. Spanking for instance, if a child describes that to me, or sometimes displays in in play, I get riled up almost instantly. I know other clinicians, friends even who will not have that reaction. So I learn my own biases, my triggers, and things that are tough for me to handle. That is how I know I need to take it to a clinical meeting, or talk to colleague, a friend in the field.

Participant Eight also spoke of utilizing his countertransference during play therapy to know when he may need to seek further support:

I use it to know when to bring issues into supervision. When something powerful is coming up for me, and especially if it keeps coming up I know

I should go to supervision. So I sort of use it as a tool to know when I need to get some extra help.

This section of the findings has looked at the gathered clinician data on the topic of the way clinicians utilize their countertransference responses in play therapy. Two major themes were identified. First, the theme of self-disclosure through sharing countertransference responses was described. Secondly, the theme of countertransference being used to enhance therapist self-awareness was depicted.

Other Findings

This section will briefly present the findings which resulted from questions generated by the researcher and data analysis, but which were not directly relevant to the research question itself. Two of these findings are *responsiveness to client's race and culture* and *pressure for empirical, evidence-based practice*.

Cultural/Racial Considerations

Twenty five percent of the interviewed participants, n=3, spoke about the need, challenges, and experience of cultural and racial diversity in the field of play therapy. Participant Eight shared his experience of coming into a new agency in which toys and games were not representative of the racial and cultural diversity of the population served in his clinic. He described the “dolls mostly being white, limited play material that showed all the various ways families function, like importance of grandparents in raising kids and that sort of thing”. Participant Eight spoke about the initial hesitance he experienced in speaking to his supervisor, the director of the outpatient clinic, about the need for toys to be more representative of the demographics of the population served. He states, “I was new, so you don't want to complain right away, but those things are very

important to the work”. Participant Nine also shared her thoughts on the need for culturally responsive play therapy. Specifically, she describes that she feels the approach may need to be changed for non-Western cultures. She stated:

I don’t know exactly how this would look, but as a profession, we need to know how to apply these play techniques to other, like non-Western cultures. Sometimes, kids are not that comfortable with everything being about them- their thoughts, their feelings. We need to respect that.

Pressure for Empirical, Evidence Based Practice

Twenty five percent, n=3, of the study participants also spoke about the need, pressure, or discussion of empirical or evidence based practice in play therapy.

Participant Two here speaks of the pressure for all psychotherapy practice to be evidence based:

Everything has to be evidence based now and that’s a very limited way of thinking about this work. Not everything can be measured, the value of relationships for instance is so important to this work and can’t be calculated. I mean there is probably neurobiology studies that can be used to show the importance of that. But the relationship is key in play therapy, and relationships take time to really blossom, you can’t be filling out ratings or scales on client’s symptoms, that’s not what the work is.

Two other participants spoke about the pressure of the need for empirical practice. One participant noted that all the requirements for additional paperwork mandated by the hospital and state in her previous job significantly led to her decision to pursue her private practice career.

Two themes have been identified in this section that were generated from the data analysis in this study, but were not directly relevant to the study's research question. The themes that were identified in this section were culturally responsive play therapy and the pressure for empirical, evidence based practice. These themes will be discussed further in the following chapter.

Summary

This chapter presented the findings of the 12 interviews that were conducted with clinicians who practice play therapy. The chapter began with description of the demographic information of the clinicians. The findings then provided data on the theoretical orientation of the clinicians. This data was derived from questions that served to provide some context to the collected data of the research question itself. The semi-structured interview questions were designed to elicit information on clinician's experience of countertransference in play therapy, the way clinicians process countertransference in play therapy and the way they utilize it. The following chapter will discuss and synthesize the themes in this data in relation to the literature found on this topic. It will also provide the implications for this data including the identification of possible future areas of research.

CHAPTER V

Discussion

The purpose of this qualitative study was to explore the phenomenon of countertransference in play therapy with children. Specifically, this research project posed the following question: *How do clinicians experience, process, and utilize countertransference in play therapy?* Through semi-structured individual interviews with twelve clinicians, narrative data was collected on the ways in which clinicians make meaning of their countertransference in play therapy.

The general findings of this study support previous research and theoretical literature on countertransference in the field of child psychotherapy. Additionally, this study's findings introduce the possibility that specific aspects of play therapy have a unique effect on the experience and processing of countertransference in play therapy. The findings in this study indicate consideration for future research as well as the development of future practice guidelines. In addition to discussing the findings of this study as they relate to theoretical frameworks for understanding countertransference and previous research, this chapter will also consider the study's implications for scholarly work and social work practice.

I. Findings and Literature

The findings of this study will be discussed in context of their meaning and connection to previous literature. The section will begin by discussing the major themes that emerged from clinicians describing the general experience of countertransference in play therapy. It will then discuss the findings on the topics of processing countertransference in play therapy and the utilization of countertransference in play

therapy.

The Experience of Countertransference in Play Therapy

Three major themes emerged from the clinicians' narrative data on the topic of experiencing countertransference in play therapy: complexity of countertransference in play therapy, feelings of frustration as a countertransference response, and feelings of uncertainty as a countertransference response. One of the factors clinicians identified that to contribute to the unique complexity of countertransference responses in play therapy are the reactions they may experience in response to the various parties involved in the child's life. In addition, clinicians identified the complexity of countertransference in play therapy stemming from the simultaneous demands a clinician has in paying attention to the symbolism of the child's play while experiencing countertransference that may be occurring in response to a client's play or an event that occurred outside of the session. Clinicians often identified feeling a sense of frustration in their play therapy work toward themselves, the client, agencies, and progression of the therapy. Lastly, clinicians identified a sense of uncertainty as a prominent component of their countertransference in play therapy.

Complexity of Countertransference in Play Therapy

One of the findings of this study is the general recognition that the interviewed clinicians experience countertransference in play therapy in a uniquely complex way. One of the factors that contributes to this complexity is the mandatory work a clinician must do with the parents/guardians and family of the child in treatment. This finding supports previous literature on the experience of countertransference in child therapy (Bernstein & Glenn 2008; Christogiorgos & Giannakopoulos 2015; Metcalf 2003).

Christogiorgos & Giannakopoulos (2015) describe that due to the consent and cooperation that is needed from parents in order for the therapy to continue, parental influences are present from the very beginning of treatment and impact clinician countertransference in an important way. They write, “in child psychotherapy, parental presence makes the existence of the external world constantly present for the therapist, increasing the risk of bias in interpreting and understanding the psychic world” (p. 4).

A number of the clinicians interviewed in the study spoke about their countertransference experience in play therapy being complicated by the experience of their reactions toward both the client and the various parties involved in the client’s life. This finding is not necessarily specific to countertransference in play therapy. For example, this kind of countertransference response may be present in case management works, a social skills group, psychopharmacology work, and other forms of therapy. The identification, empathic understanding, or negative countertransferential responses toward parents can and will be present when working with a child, as the presence of parents in this work is mandatory.

Bernstein & Glenn (1988), detailing a more psychoanalytic understanding of the phenomenon, describe the two different ways that clinicians can experience countertransference in child treatment. “Sometimes the analyst, identifying with the parents, attempts to control rather than interpret. Other analysts find they are unable to apply realistic restraints in conjunction with interpretations because they feel identification with grown-ups is taboo” (p. 230). One of the participants of the study spoke about wanting to control the course of therapy in the actual, physical presence of a parent:

The other day, I had a parent join an individual play session. It was sort of random, it kind of just happened. It was maybe the first time I had a parent do that. So the kid goes in and is pretty excited to show his mom all the stuff he plays with. And I'm like uhh, what is this mom think we do in here, she pays me to babysit. *Laughs*. So because of my insecurity, I jump to play like a therapeutic game with him, stuff about his feelings, and can you think of a time when you felt this and what did it feel like, and what did it look like and blah blah... And the kid like engaged in it, but I could tell he was like wait a minute, this isn't what we do.

Just as Bernstein & Glenn (1998) note, the clinician describes attempting to control the course of the therapy rather than interpret the meaning that the parent's presence may have had on the client, the parent, and the clinician herself.

The second way Bernstein & Glenn (1988) describe that family or parental involvement can affect countertransference is in the therapist's strong identification with the child. They explain that the therapists' involvement with the family may arouse Oedipal feelings. "He (the therapist) may identify with his patient, accept the child's view of his parents, and become excessively attached to them or angry with them" (p.230).

Illustrating the theory of Bernstein & Glenn, a participant describes the "frustration and anger" they at times feel toward a parent in their practice:

...But there are also the really intense reactions I have toward the parents and caregivers. The frustration and anger I feel toward them for feeling like they could be doing more, or should be more gentle or understanding. That is really difficult. Especially since I have become a mom, I think it has

been tougher. Maybe I am less patient with parents, which is funny because I thought it was going to be the opposite, I don't know. I feel that recently I have had more intense reactions toward parents... and in play therapy, those reactions are even harder because it's happening while you are trying to stay in the play to figure out the meaning. It is just a lot to juggle all at once.

The quote above demonstrates three relevant concepts into the discussion of the experience of complexity of countertransference in play therapy. First, clinicians described the experience of feeling identification with a child client that ranged from feeling protective of the child to defensive. This kind of reaction, in which a therapist feels a certain attachment to their client and experiences subsequent feelings toward the caregiver of the child, has been noted in the previous literature (Bernstein & Glenn, 1988). Using a psychoanalytic understanding, Bernstein & Glenn refer to this kind of reaction as an over identification with a child client, in which the therapist accepts the child's view of his parents. The interviewed clinicians tended to speak of this kind of reaction as an experience of intense empathy toward the child and congruent identification with the emotions of their child client.

The second concept that the quote above illustrates that is also supported in the theoretical literature is the connection between certain life events and personal identities and the experience of countertransference in child treatment. Previous literature has explored the meaning of this connection. "Countertransference may be influenced by important life events in the therapists' life, such as divorce, death and loss, marriage, and financial issues including utilization review and interfacing with managed care agencies

(Sarles, 1994 as cited in Metcalf, 2003, p. 32). Other writers, such as Bernstein & Glenn, 1988 and Waksman, 1986, Similarly, the literature has also explored the countertransference reaction of adopting a nurturing parenting role. (Waksman, 1986; Bernstein & Glenn 1988). Congruent with this concept, one aspect of the complexity of the countertransference experience in play therapy that a clinician touched upon was the reaction she had when the role of a parent is assigned to them in play. Another participant described her reaction when a young child asks her to role-play as a mother in pretend play. She described that on a personal level, many issues came up for her during this session in the context of her own identity as a mother.

Both the concepts of the experience of identification with the child client and the effect that identity and life experience has on countertransference have been previously explored in the theoretical literature. In addition, although clinicians spoke of these concepts as phenomena that occurred in play therapy, these experiences are ones that could be present in any kind of therapy with children. This implies that in these specific aspects, countertransference in play therapy may present similar kind of complexities as countertransference responses in other modalities of working with children. It is possible that the concepts of identification with a child client and the relationship of identity and countertransference are broadly experienced reactions in the field of child psychotherapy.

The third and final point that can be illustrated from the clinicians' excerpt above and other narrative data is a concept that has not been developed as clearly in the previous literature and research. This concept is the idea that various countertransference reactions are more difficult to recognize and deal with while the clinician is engaging in the simultaneous task of thinking about the meaning of the child's play. The intervention

of play therapy requires that clinicians be very present and mindful of the child's play. They have to be engaged in the play while simultaneously thinking of its meaning and how that meaning should affect their next step or intervention. The additional layer of experiencing strong countertransference responses complicates the play therapy work. In a reciprocal way, countertransference responses may be experienced in a more difficult or ambiguous way while the clinician is attempting to focus on exploring the meaning of a child's play. One clinician in the study illustrates this concept by giving an example of a complex process in which multiple, simultaneous demands are occurring during a play therapy session. She describes attempting to navigate the countertransference she feels toward various parties in her client's life as well as the client herself, while also attempting to stay present in the session and try to understand what is being conveyed in a complex play scene the client is setting up. This identified concept of the complexity of the specific, simultaneous demands countertransference in play therapy poses is a concept specific to play therapy countertransference.

Feelings of Uncertainty and Frustration

Another theme that emerged from clinician narratives on the topic of the experience of countertransference in play therapy is the recognition of feelings of uncertainty. A number of study participants spoke about the uncertainty they often feel in their play therapy work. More specifically, the clinicians spoke about the uncertainty of their interpretations of the symbolism of the child's play. In addition, clinicians also recognized that ambiguity is an important aspect of the play therapy work that can enhance practice once a clinician feels more comfortable with it. A number of clinicians identified a sense of ambiguity to be a type of countertransference response.

These findings are supported in the theoretical literature on play therapy. Landreth (2003) writes that embracing ambiguity is essential when working in a child-directed approach, in which the therapist truly believes in the creative, inner-directional, and self-healing qualities of play therapy. Landreth (2003) writes that a part of ambiguity involves not knowing what a child's behavior means. He describes that play therapists must be comfortable living in the child's world of uncertainty. The findings of this study support this literature. The narrative data identified that clinicians often question and explore the meaning of a child's play and its connection to both the child's inner and outer world. In addition, these findings are congruent with literature on child directed play therapy work with which a significant number of participants identified (Axline, 1947; Schaeffer & O'Connor, 1985; Landreth 2003).

Another theme that was prominent in the collected data on the topic of clinicians' experience of countertransference in play therapy was the identification of the feeling of frustration. Clinicians in this study spoke of feeling frustration toward themselves, the client, agencies, and progression of the therapy. Sarles (1994) writes that countertransference is a phenomenon that can take on many various responses including anger, frustration, envy, joy, love, and hate. When exploring the implications that countertransference can have in child treatment, Schowalter (1985) as cited in Gill & Rubin, (2003) noted that countertransference can have various effects including premature diagnoses and discharge, under or over inclusion of parents, and excessively positive or negative feelings toward the parent. It is important to note that study participants described that frustration was a significant emotional response. Previous literature such as Schowalter (1985) has explored the possibility that such strong

countertransference responses can have various detrimental effects on treatment, and further research into how clinicians can address this kind of response may be helpful for clinicians.

A number of clinicians in this study spoke about their experience of frustration as a countertransference response due to the pressures they often feel for their play therapy work to progress more quickly or in a specific, possibly agency or insurance company mandated way. To this day, there is no research that specifically explores the various internal or external pressures that may lead to a clinician's sense of frustration in play therapy. However, some theoretical literature has explored the nature of these pressures and the subsequent reactions from clinicians. Metcalf (2003) for instance, spoke about the possibility that a clinician's feelings toward their agency can be a type of countertransference. In addition, Landreth (2003), although not speaking directly about the feeling of frustration, spoke about the importance of patience as a way to prevent or counteract feelings of frustration. He describes the importance of the quality of patience stating that the play therapist should be "...patient with child in the moment, patient with child's expression, and waits with eager expectancy for the child to come forth at the child's own pace. Patience allows the play therapist to take in, see, and experience what the child sees in her world" (p. 99). The writing of Landreth (2003) supports the narrative data themes of patience as well as the ability to be fully present in play therapy work.

Processing of Countertransference in Play Therapy

Two major themes that emerged from the study data on the topic of the ways in which clinicians process countertransference responses in play therapy are the use of visual tools and supervision. These two themes are very likely related as supervision may

enhance the use of tools, which enable the clinicians to process their reaction in a more meaningful way. This section will discuss these two themes in conjunction with one another.

Clinicians noted that they have used the videotaping of sessions, photos of the play, journal recordings of play themes, and play itself to help themselves in addressing and making meaning of their countertransference reactions. This finding supports past literature that has explored the possible usefulness of such techniques. Homeyer & Morrison (2008) describe that although play therapy has been growing rapidly in popularity, literature written specifically on play therapy supervision is limited. They write about supervision in play therapy: “given the nonverbal nature of play therapy, supervisees may benefit from exploring supervision issues through nonverbal means. Perhaps supervision experiences that use symbolism, metaphoric play, and art would be appropriate, if not the standard” (p. 219). Gil & Rubin have suggested that the modality of play, the same modality that is used in the actual treatment with children in play therapy be used to address the various reactions embedded in countertransference (Gil & Rubin, 2002). More specifically, they suggest various play techniques and expressive media that can be used before or after play therapy sessions to process some of the more difficult countertransference reactions. A clinician speaks of the technique of play in addressing countertransference:

I used to videotape sessions. That is very helpful because it gives clear context to the feelings I am experiencing whether it's anxiety or sadness or anger... I know of colleagues who will actually play as a way of understanding all that, I had done that a long time ago as well.

Although there is limited literature on the alternative and creative modalities that can be used to process countertransference responses in play therapy, study data supported the use of these aforementioned modalities. Further research and development of guidelines for the use of these modalities may provide the additional support for these tools to become more widely used and researched.

A number of therapists spoke about the importance of supervision in addressing and making meaning of countertransference responses in play therapy. “Countertransference management involves the recognition and examination of countertransference reactions, and utilizing them in a positive way in the therapeutic relationship without allowing them to diminish the effectiveness of treatment” (Robbins & Jolkovski as cited in Metcalf, 2003). Both previous literature and clinicians in this study note the importance that supervision can have on the processing and addressing of countertransference in child therapy.

The Utilization of Countertransference in Play Therapy

The two main utilizations of countertransference in play therapy that were identified from the collected data were the use of self-disclosure and the general enhancement of self-awareness. Self-disclosure of countertransference refers to a therapist’s disclosure to the child client of what they may be feeling in the moment or in reaction to a child’s past or current difficulties. Self-awareness includes a clinician’s growing understanding of themselves as clinicians and individuals. This section will describe these themes in relation to existing literature and research.

Self-disclosure of countertransference

The finding that therapists utilize self-disclosure of countertransference is

supported by previous literature and findings. However, most literature addresses the general phenomenon of self-disclosure to refer to various kinds of information therapists may disclose, with countertransference being one type of information. Traditional psychoanalysts believe that self-disclosure of the therapist is an impediment to treatment as it takes the focus away from the client's therapy onto the therapist. None of the clinicians of this study explicitly identified with a psychoanalytic approach, though it should be noted that three of the clinicians all shared that they received advanced training in psychoanalytic institutes. Nevertheless, clinicians in this study spoke about their self-disclosure as one way they utilize countertransference in play therapy.

Most of the theoretical literature that exists on both self-disclosure and countertransference self-disclosure pertains to psychotherapy with adults and cannot be applied directly to psychotherapy work with children. However, there is some research that has provided valuable information on the experience of self-disclosure with children in therapy. A study by Vondracek & Vondracek (1997) found that 6th grade children “revealed more to adult interviewers who disclosed information than to ones who did not, and that the content of the children's' disclosure mirrored those of interviewers” (Capobianco & Farber, 2005, p.37). Similarly, clinicians in this study spoke about using their disclosure of countertransference to their child clients as a way to build rapport and establish connection. One of the participants noted:

I used to work with adults and sometimes I think that kind of genuine relationship is built when the therapist shares their feelings too. So I absolutely do it with kids. Kids who have been abused and show aggression, I will let them know “I feel so angry about what has happened

to you too”. It shows them you are a real person, and that real reciprocal connection is essential to the healing process.

Theorists have written about several reasons why self-disclosure in therapy may be beneficial. As previously noted, writers explored this phenomenon in context of working with adults, however, the interviewed clinicians in this study generally supported some of these points. Gorking (1997) as cited in Fowley and Sills (2011) note the following arguments:

- Self-disclosure may confirm the patient’s sense of reality.
- They may help to establish the therapist’s honesty and genuineness.
- They show that the therapist is not so different from the patient, that the therapist too is human.
- Self-disclosure may help to break through treatment impasses and deeply entrenched resistance (p. 50).

In addition, therapists in this study spoke about their tendency for self-disclosure in direct relation to the play. This is an area that has not received as much attention in that kind of specificity in the literature. Further research into how the self-disclosure of countertransference is relayed through the medium of play may be helpful for more understanding of this phenomenon as well as the broader concept of the utilization of countertransference.

Enhancement of self-awareness

The second theme that was identified in this study as a way that clinicians use their countertransference responses is through the increase of self-awareness. This finding is generally supported in the theoretical research. Landreth (2003) describes that therapist

self-understanding is vital to the effective practice of play therapy and the development of a healing relationship. He notes that the recognition of clinicians' motivations, needs, blind spots, biases, and areas of emotional difficulties and personal strengths are very important for effective treatment. Clinicians in the study spoke of their experiences of feeling that an awareness of their countertransference in play therapy allows them to be aware of certain biases. One participant shared:

Well I utilize it mainly by just knowing what really gets me, especially when it has to do with parents. Spanking for instance, if a child describes that to me, or sometimes displays in in play, I get riled up almost instantly. I know other clinicians, friends even who will not have that reaction. So I learn my own biases, my triggers, and things that are tough for me to handle. That is how I know I need to take it to a clinical meeting, or talk to colleague, a friend in the field.

Landreth (2003) notes that although the therapist will inevitably bring aspects of their personality into their work, an awareness of this process is important for effective play therapy work for both clinician and child. The concept of utilizing countertransference as a way to enhance self awareness may be closely tied to the previously explored themes of the use of various tools and supervision to process countertransference in play therapy. The tools for processing and supervision may support clinicians in increasing their self-awareness in play therapy work.

II. Implications for Social Work Practice and Future Research

This study has illustrated that clinicians experience, process, and utilize countertransference in play therapy in complex ways. Further research into this

phenomenon can support play therapy practitioners and the field of social work education. Providing more tools, training, and processing space to discuss and navigate these experiences may be helpful for social work students, internship settings, and general agency practice. In addition, students and clinicians may benefit from understanding how they can use supervision to navigate this complex phenomenon. One of the important findings to come out of the study data is the importance of solid supervision. Creating research-based guidelines on the requirements and demands of play therapy supervision may be helpful for supervisors and supervisees alike. Furthermore, creating recommendations on the ways that various tools and media can be used in play therapy supervision may be helpful for students and practitioners to navigate the complex phenomenon of countertransference in play therapy.

It may be beneficial to attempt this study with a sample that is more diverse to see how issues of reliability and validity stand in relation to a more representative sample in terms of various demographics such as race, gender, theoretical orientation, and type of practice and level of care. Similarly, it may be beneficial to interview clinicians about the various themes found in this study to see whether they resonate or have meaning for other clinicians in the field. In the future, it may be helpful to develop a research and theoretically based framework that supports clinicians in recognizing, addressing, and when appropriate, utilizing their countertransference responses while simultaneously working to understand the meaning of a child's play and its possible connection to the clinician's countertransference and child's world.

III. Study Strengths, Limitations and Biases

The research question of this study was explored by collecting clinicians' narratives

on the complex ways in which they experience countertransference in play therapy. This study explored participant experiences and the way they make meaning of these experiences, which was an important part of its design. Additionally, clinical case examples from the clinicians supported and further illustrated the gathered data of a complex phenomenon, which at times may appear abstract without the context of clinical vignettes.

Perhaps the most significant limitations of this study lie in its sample and sampling technique. The non-probability convenience and snowball sampling that was used in this study lead to sample bias. First, there is racial and gender homogeneity in this sample. In addition, the study was conducted in mainly cities and towns in the Northeast, which may have also lead to similar responses and conclusions. A number of the participants of this study knew each other, came from similar educational backgrounds and theoretical foundations. In addition, although the interview did not specifically ask for this piece of information, almost all of the participants in this study work in an outpatient setting. This kind of longer-term work with clients in an outpatient setting may have important implications for this research question. For instance, a similarity in the acuity level of the clients' clinical presentations may affect the way clinicians' experience and view particular countertransference responses. This study cannot make any generalization about all clinicians' experience of countertransference in play therapy in the field. Instead, the study provides an exploration of interviewed clinicians' experience of this topic with various possible implications based on the gathered narratives and identified themes.

An additional important limitation to consider in this study is researcher bias.

Norris (1997) describes:

A consideration of self as a researcher and self in relation to the topic of research is a precondition for coping with bias. How this can be realized varies from individual to individual. For some, it involves a deliberate effort at voicing their prejudices and assumptions so that they can be considered openly and challenged. For others, it happens through introspection and analysis. The task, if you like, is seeing what frames our interpretations of the world (p. 174).

This researcher, the writer, chose to study this topic with some rudimentary, yet meaningful play therapy experience. The researcher strongly believes in the importance of understanding and addressing countertransference responses. These experiences and beliefs may have certainly led the researcher to choose to focus on aspects of the clinicians' narratives which resonated to her own experience in this work and with this phenomenon. It is also possible that the researcher's bias with her experience of this subject matter may have enhanced the study by facilitating rapport development with participants as well as leading to increased understanding of some of the nuances present in the clinicians' narratives on the topic.

This study gathered and analyzed the narratives of clinicians describing the ways that they experience, process, and utilize countertransference in play therapy. The clinicians who have participated in this study offered rich perspectives with clinical case examples full of meaning and depth. It is to be hoped that the data and discussion presented in this paper will be of use to practitioners and to future research for the further development and understanding of a complex phenomenon.

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Appendix A:
HSR Approval Letter



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

February 10, 2015

Asya Tsarkova

Dear Asya,

You did a very nice job on your revisions. Your project is now approved by 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,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

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

CC: Alison Hopkins, Research Advisor

Appendix B:

Informed Consent Form

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

.....

Title of Study: Exploring Play Therapists' Experience of Countertransference

Investigator(s): Asya Tsarkova

Phone number: (XXX) XXX-XXXX Email: atsarkova@Smith.edu

.....

Introduction

- You are being asked to be in a research study investigating clinician experience of countertransference during play therapy.
- You were selected as a possible participant because you work with children ages 3-12, utilize play therapy in your practice, and have a Master's degree or Doctorate degree in one of the following disciplines: Social Work, Marriage and Family Therapy, Mental Health Counseling, or Psychology.
- 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 learn about the experience of countertransference in play 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 do the following things: participate in an individual interview that will last approximately 45 minutes-hour. The interview will be audio recorded.

*If you do not feel comfortable being audio recorded, you may participate in an interview that will only be recorded on paper by the researcher.

Risks/Discomforts of Being in this Study

- There are no reasonable foreseeable (or expected) risks.

Benefits of Being in the Study

- The benefits of participation are having an opportunity to talk about your experience of countertransference in play therapy and possibly gaining insight into that experience.
- The benefits to social work/society are to possibly provide information for future research, support social workers and social work educators in navigating the experience of countertransference, and provide possible support for training programs.

Confidentiality

- Your participation will be kept confidential. The interview will take place at the researcher's office, your office, or at a quiet local coffee shop or another public space that is convenient for you and provides privacy. The records of this study will be kept strictly confidential. I will be the only one who will have access to the audio recording and know of your participation in the study. Recordings will be destroyed after the mandated three years. They will be permanently deleted from the recording device.
- 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. I will not include any information in any report I may publish that would make it possible to identify you.

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 April 1, 2015 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. 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 1, 2015. After that date, your information will be part of the thesis.

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, Asya Tsarkova at atsarkova@smith.edu or by telephone at (XXX)XXX-XXXX. 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 decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

.....

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: _____

2. I agree to be interviewed, but I do not want the interview to be audio taped:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

Form updated 9/25/13

Updated 8-6-14

Appendix C:
Interview Guide

INTERVIEW GUIDE

Demographics of Clinician

Age: _____

Gender: _____

Race: _____

Degree: _____

Number of years of play therapy experience: _____

Interview Questions Regarding Practice, Play Therapy, and Countertransference in Play Therapy

1. Can you describe your play therapy approach?
Does your play therapy approach change depending on the clinical presentation of the child? If so, how?
Can you give an example of two different approaches to play therapy you have used and explain why you chose the two different approaches?
2. What, if any kind of formal training have you had in play therapy?
3. What do you find to be some of the challenges of play therapy?
4. What do you find to be some of the benefits/strengths of play therapy?
5. How does play therapy affect the relationship between yourself and the client?
6. Can you describe and give examples of some of the countertransference responses that you have experienced during play therapy?
7. How, if at all, does staying in metaphor affect your countertransference experience during play therapy?
8. Do you find that your countertransference responses in play therapy are different than other countertransference responses you have experienced?
If so, can you discuss some of the factors that you feel make the countertransference responses in play therapy different or unique?
9. How do you process countertransference responses in play therapy? Can you give an example?
10. Are there any factors you feel make processing countertransference responses in play therapy unique? If so, can you give an example?

11. How, if at all, have you utilized supervision in processing the countertransference responses in play therapy?
12. How, if at all, do you utilize your countertransference responses during play therapy? Can you give an example?
13. How does play therapy affect the relationship between you and the child?
14. Is there anything you would like to share about this topic that I did not ask you?