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Carolyn Andrews
Who directs the play and
why? An exploratory study
of directive versus
nondirective play therapy

ABSTRACT

The purpose of this qualitative study was to explore how play therapists determine when to use a directive versus nondirective treatment approach with children.

Eleven therapists who engage in play therapy with children participated in individual interviews designed to collect their perspectives about their preferred play therapy treatment approach. Participants were selected through a non-random convenience snowball sampling technique from across New England.

The findings of this study reflect for this sample, there does not appear to be a uniform method of determining when a directive versus nondirective play therapy treatment approach is utilized. Participants tend to determine treatment method based on their personalities and educational backgrounds, suggesting that the needs of the client may be less important than the comfort level of the therapist when determining treatment approach. These findings suggest that a more thorough educational structure is needed for effective clinical social work practice with children and families.

WHO DIRECTS THE PLAY AND WHY? AN EXPLORATORY STUDY OF
DIRECTIVE VERSUS NONDIRECTIVE 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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CHAPTER I

INTRODUCTION

You can discover more about a person in an hour of play than in a year of conversation. Plato, Greek Philosopher

Children do not communicate, nor have they developed adequate skills, to convey mental health related concerns or problems in the same way that adults have learned to do. As a result, assessing children's innermost problems is a challenge to mental health professionals. Fortunately, over time, specialized techniques have been developed to overcome communication barriers to augment assessment and treatment issues in the field of children's mental health care. Among these specialized techniques, play therapy has evolved as a key approach for assessing and treating children. The play therapy technique approach is useful because oftentimes children do not have the verbal ability to express their thoughts and feelings. In play therapy, toys are a child's words and play is the child's language (Hall, 2002; Landreth, 2002; McMahon; 1992). Thus, play therapy is to children what talk therapy is to adults.

Over the course of its evolution, play therapy approaches have also evolved in various specific play therapy techniques. The purpose of this research is to explore the commonalities in the rationale that child therapists who engage in play therapy use when determining use of a directive or nondirective treatment approach. This study seeks to illustrate the benefits, expectations, and limitations of directive versus nondirective play therapy treatment methods. The research question is as follows:

What are the commonalities in the rationale used by child therapists to self-identify their play therapy treatment approach as directive versus nondirective?

In order to examine this question, the design of this study is exploratory, based on the use of structured interviews with a non-random convenience sample.

This study is important to social work because determination of when to use a directive or nondirective treatment approach is an understudied topic concerning play therapy with children. Since research states that in terms of directive versus nondirective methods, similar to the findings on adult therapy, there is little evidence to suggest that some forms of treatment are superior to others (LeBlanc, et al., 2001), a better understanding of the rationale used by play therapists to determine when to use a directive versus nondirective treatment approach is essential. Although there is quite a bit of research on the efficacy of directive and nondirective approaches, there is limited research on integration of directive and nondirective methods. Furthermore, research shows that neophyte therapists engaged in play therapy often enter the workforce with doubts about their ability to practice (Jones, 2006). Since neophyte therapists have doubts about their ability to practice, studies that examine how experienced play therapists approach the determination of treatment approach are crucial. This study will provide neophyte therapists with a comparison of the benefits, expectations, and barriers to directive and nondirective treatment approaches.

Finally, it is relevant to social work practice because so little research focuses on the effectiveness of directive versus nondirective treatment methods. Therefore, clinicians who work with children and families are likely to be faced with the choice and they

must be aware and educated in the benefits, expectations, and barriers to each of these treatment approaches. Once the rationale for when to use a directive, nondirective, or integrated approach is better understood, we will have more helpful methods or assessment tools for determining which approach to use and for further education and training.

Definitions

It is important to conceptually define play therapy, directive play therapy and nondirective play therapy. According to the literature, play therapy is defined as a research supported approach to helping children cope with and overcome the problems they experience in the process of living their lives (Landreth, 2002). For the purpose of this study, play therapy was defined as an opportunity for a child to express his feelings and problems through play just as adults do in talk therapy. Directive play therapy was clearly defined as a treatment approach in which the therapist determines the choice of activity and issues in treatment. Nondirective play therapy was clearly defined as a treatment approach in which the child determines the choice of activity and issues in treatment.

How this Thesis is Organized

Chapter I presented the purpose, research question, and definitions. Chapter II provides a review of the related literature including research and theoretical models of play therapy. Chapter III explains methods for selecting participants and describes how data were collected and analyzed. Chapter IV gives a description of the participants and presents the results. Finally, Chapter V discusses the results of the study, presents implications for practice, outlines the strengths and limitations of the study, offers suggestions for further research on the topic, and concludes the document.

CHAPTER II

LITERATURE REVIEW

Introduction

The literature review will focus on the literature that explores the theory, history, and outcomes of play therapy interventions with children in order to provide a framework for exploring the rationale child therapists use when determining when to use a directive versus nondirective play therapy treatment approach. A review of the theoretical literature will focus on psychodynamic theories and cognitive behavioral theories as related to play therapy. Strengths and limitations of research questions and design will also be addressed throughout.

Play

In order to understand play therapy, it is important to conceptually understand play. The idea that children's games form an important part in juvenile development can be traced back 2,500 years where at Athens, Plato and Aristotle were advancing such theories (Beaumont, 1994). Over the past two centuries, theories of play have contained differing explanations of play. According to Mellou (1994), play theories are divided into two categories, classic theories of play and modern theories of play. Classical theories of play originated in the late nineteenth and early twentieth centuries and tried to explain the existence and purpose of play. Modern theories were developed after 1920 and attempted to explain the role of play in child development (Mellou, 1994).

Classical theories of play were developed based more on philosophical reflections than experimental research and suggest that play is a biological process. Early classical theories such as surplus energy theory and recreation theory posit that play occurs because children have excess energy. Another classical theory, recapitulation theory, suggests that play development follows the evolutionary development of the human race and that through play, primitive instincts are weakened (Stagnitti, 2004). One of the most well known and valued classical theories is self-development theory that states play serves an adaptive purpose in that through play children construct the adaptive skills they will require throughout life. Self-development theory paved the way for modern theory by admitting play into the ranks of the activities that are most essential to overall development in children (Elkonian, 2005).

Modern theories of play include arousal modulation theories, cognitive behavioral theories, and psychodynamic theories. Arousal modulation theories of play viewed play as a stimulus seeking behavior and eventually led to the distinction between exploration, where a child asked “What can this object do?” and play, where a child asked “What can I do with this object?” Cognitive behavioral theories suggest that play contributes to cognitive development, problem solving, and creative thought. According to cognitive behavioral theories, play develops innovation, flexibility, enhanced problem solving and adaptation. Psychodynamic theories of play suggest that through play, children can play out wish fulfillment and master traumatic events in their lives (Stagnitti, 2004).

Defining play

An important step in documenting the value of play should be defining play. Play is a generic term applied to a wide range of activities that are satisfying to the child. One

of the most commonly agreed upon definitional criteria for play is that it does not seem to serve any apparent immediate purpose (Pellegrini & Smith, 1998). Observers (reliably) recognize play when they see it, but have a difficult time presenting an operational definition (Pellegrini & Smith, 1998). Children appear to have similar difficulties in defining play. Children identify an activity as play when they choose it, but they define the same activity as work when an adult chooses it for them (Pellegrini & Smith, 1998). Despite the difficulty in defining play, a common theme among definitions of play is that play is a voluntary activity that is enjoyable to the child.

Benefits of play

Although play often refers to a fun, enjoyable activity that elevates our spirits and brightens our outlook on life, play is more than just fun and games. It expands self-expression, self-knowledge, self-actualization, and self-efficacy (Association for Play Therapy, 2008). Play is the key way in which children learn about the world around them as they attempt to organize and understand their experiences (Landreth, 2002). Through play, children learn to interact with others, develop language skills, recognize and solve problems, and discover their human potential (The Alliance for Childhood, 2004). Research on the neurobiological aspects of play shows that play stimulates both verbal, mainly left hemispheric brain activity and non-verbal, primarily right hemispheric activity. Play thus performs an important bridging function to permit a better integration of experience (Levy, 2008).

Given that play has been shown to be beneficial to children, it appears logical to use the curative powers of play to help children work through their problems in therapy. Play treatment enables children to enact their difficulties with an adult who understands

the benefits of play. Play treatment can also provide children with a means to explore old patterns and to develop new patterns of relating and experiencing self and others (Levy, 2008).

Play Therapy

In order to understand directive and nondirective play therapy approaches, it is important to conceptually understand play therapy. Play therapy is a well-thought-out, philosophically conceived, developmentally based, and research supported approach to helping children cope with and overcome difficulties in their lives (Landreth, 2002). Through play therapy, children learn to communicate with others, express feelings, modify behavior, develop problem-solving skills, and learn a variety of ways of relating to others (Association for Play Therapy, 2008). Research has shown that play therapy techniques are effective tools in treating a multitude of childhood issues including behavioral and emotional problems, physical challenges, and learning difficulties (Fall, Navelski, & Welch, 2002; Ray, Blanco, Sullivan, & Holliman, 2009; Post, 1999; Wright, 2006; Knell, 1998; Bratton, Ray, Rhine, & Jones, 2005).

Meta-analytic research

Much of the research on play therapy, like psychotherapy research in general, is limited to small sample sizes, case studies, and anecdotal reports (White & Allers, 2001; LeBlanc & Ritchie, 2001; Bratton, et al., 2005). Meta-analytic research combines the effects of small individual studies to create generalizability, thus increasing research reliability and validity. Research shows that prior to 2001, play therapy studies were largely ignored in meta-analytic studies on the effects of child psychotherapy (Bratton, et al., 2005). Bratton, et al. (2005), attributes the scarcity of play therapy studies in the histori-

cal literature to a lack of respect for play therapy among the scientific community. Recent meta-analytic studies that focus exclusively on the efficacy of play therapy have significantly increased the number of play therapy studies included in the research (LeBlanc & Ritchie, 2001; White & Allers, 2001; Bratton, et al., 2005). Thus, if there is a correlation between respect and number of play therapy studies included in the literature, play therapy appears to be gaining widespread respect in the scientific community.

Meta-analytic research found that play therapy appears to be as effective as non-play therapies in treating children experiencing emotional difficulties (LeBlanc & Ritchie, 2001). Play therapy appears to be equally effective across gender, age, and presenting issues, regardless of whether children were treated for internalizing or externalizing problems (LeBlanc & Ritchie, 2001; Bratton, et al., 2005). Behavioral outcomes are overwhelmingly the most used type of outcome measure included in the play therapy research (Bratton, et al., 2005). Research has shown that children exposed to play therapy perform higher on outcome measures when compared to children not exposed to play therapy (LeBlanc & Ritchie, 2001). According to Bratton, et al. (2005), who performed the most comprehensive meta-analysis of controlled outcome play therapy studies to date, doubts about the efficacy of play therapy as a viable intervention can be laid to rest.

Finally, meta-analytic research has identified two factors that appear to significantly impact play therapy treatment outcomes. The first factor, parental involvement in the child's therapy, predicted the largest effects (LeBlanc & Ritchie, 2001; Bratton, et al., 2005), suggesting that play therapists include parents in the therapy process whenever possible. The second factor, duration of treatment, also predicted significant effects. Research shows that optimal treatment effects were obtained in 35-40 sessions, with a dimi-

nishing effect size as session number increased or decreased from that range (LeBlanc & Ritchie, 2001). Interestingly enough, many studies with fewer than 14 sessions, primarily in crisis settings, also produced medium and large effect sizes (Bratton, et al., 2005). LeBlanc & Ritchie (2001) recommended that play therapy treatment include at least 20 sessions. Despite these findings, managed care guidelines often place limits on the number of play therapy sessions allowed (LeBlanc & Ritchie, 2001; Jones, K.M., Casado, M. & Robinson, E.H., 2003; Bratton, et al., 2005; Joiner, K.D. & Landreth, G.L., 2005; Reddy, Files-Hall, & Schaefer, 2005). This suggests that managed care guidelines may impact the ability for children to receive the length of treatment necessary to resolve their issues.

Defining play therapy

An important step in documenting the value of play therapy should be defining play therapy. Play therapy is defined as the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychological difficulties and achieve optimal growth and development (Association for Play Therapy, 2008).

As mentioned earlier, there are two basic play therapy treatment approaches, directive or structured play therapy and nondirective or child centered play therapy. Techniques such as storytelling, puppets, art, drama, games, and play are incorporated in both treatment approaches. The major distinction between directive and nondirective treatment approaches lies in the role of the therapist (Rasmussen & Cunningham, 1995; LeBlanc & Ritchie, 2001; Bratton, et al., 2005). In directive play therapy the therapist designs the activity, selects the play medium, and creates the rules, whereas in nondirective play

therapy, the therapist allows the child to select the play medium, set the rules, and use play items as he chooses (White & Allers, 2001, Guzzi-DelPo & Frick, 1988; Jones, et al., 2003). Hence, the play therapist using a directive approach reads a story with purpose and meaning related to the child's presenting issue, whereas the play therapist using a nondirective approach allows the child to tell his own stories through the play.

Regardless of whether a directive or nondirective treatment approach is used, the establishment of an empathic therapeutic relationship in which the child feels known and understood cannot be overemphasized (Phillips & Landreth, 1998; Hall, et al., 2002; Jones, et al., 2003; Barish, 2004). It is by genuinely connecting with children through play that therapists can help them shift their organizations of self and relationships and thereby permit new possibilities to arise (Levy, 2008).

Directive versus nondirective treatment approaches

In terms of directive versus nondirective play therapy treatment approaches, meta-analytic research has found that play therapy can be considered effective regardless of which approach is used (Bratton, et al., 2005). Although recent research suggests that treatment effects appear more positive for nondirective versus directive play therapy, researchers urge caution when interpreting this finding. Analysis revealed that several factors, including a large disparity in the number of studies coded as directive versus nondirective, lack of consistency in treatment protocols, and lack of specificity in the description of interventions used in many of the studies, may have influenced this outcome measure (Bratton, et al., 2005). It is interesting to note that if, as suggested earlier, there is a correlation between number of studies and scientific respect, directive play therapy appears to be more respected by the scientific community than nondirective play therapy.

Directive Play Therapy

Directive play therapy is a research supported approach that centers primarily on symptom relief and the underlying themes of the child's presenting issues. Specific evidence based directive play techniques have been developed for a multitude of childhood issues, yet it would be naive to assume that all techniques will work for all children. Directive play therapy uses various play medium to teach children skills and model behavior or attitudes (Guzzi-DelPo & Frick, 1988; Hall, et al., 2002; Bratton, et al., 2005). A plethora of play therapy techniques exist that specify how to utilize the therapeutic powers of play (Hall, et al., 2002). In fact, Hall, et al. (2002) suggests that the number of play therapy techniques available is limited only by the therapist's imagination and creativity.

Directive play therapy techniques

In order to understand directive play therapy, it is important to conceptually understand play therapy techniques. Children have difficulty verbalizing their feelings when directly questioned because they are either guarded or they do not connect with the feelings they find most threatening (Hall, et al., 2002). According to Hall, et al. (2002), when children are involved in playing a game, their defenses are reduced and they are more likely to talk about their feelings. Therapeutic games such as The Feeling Word Game by Heidi Kaduson (Kaduson & Schaefer, 1997) provide therapist with a nonthreatening way to discuss and question issues that are generally too intimidating for children to communicate about directly.

In the Feeling Word Game (Kaduson & Schaefer, 1997b), the child identifies the names of eight "feeling words" common to a child his age, which the therapist then writes on separate pieces of paper and places in a row. The therapist starts the game by

devising a story about herself, being mindful to include both positive and negative feeling words. When she finishes the story, the therapist places a differing amount of “feelings” (poker chips) on each appropriate feeling word, thereby demonstrating that not only is it possible to have more than one feeling at the same time, it is also possible to have different amounts of each feeling. Next, the therapist tells a nonthreatening story about the child and asks him to place the feelings he might feel under those circumstances on the appropriate feeling words. The child tells the next story and the therapist places the appropriate feelings on the feeling words. The game continues until the major issues of the presenting problem are discussed.

Another nonintrusive play therapy technique, *The Rosebush* by Violet Oaklander (Kaduson & Schaefer, 1997), uses guided imagery to help children express themselves. The therapist asks the child to close his eyes, take a few deep breaths, and imagine he is a rosebush. The therapist gives many suggestions and possibilities and asks questions like “Are you in full bloom, or do you have only buds? Do you have thorns? What do they look like? Are you growing in a pot or in the ground or through a crack in the sidewalk? Are there any other rosebushes, or are you alone? What is the weather like for you?” The therapist then asks the child to open his eyes and draw his rosebush and the scene around it without worrying about the quality of the drawing. The therapist addresses the child as the rosebush and asks him questions like “Who takes care of you? Are you lonely? Who lives in your house?” and makes note of the child's answers. After the child describes himself as a rosebush, the therapist reads the notes aloud and asks if there is anything he said as the rosebush that fits for him and his life or reminds him of anything. According

to Oaklander (Kaduson & Schaefer, 1997), adolescents respond particularly well to this self-defining exercise.

Following the needs of the child

The directive play therapist develops a plan for each session and designs specific structured activities with play materials appropriate to the goals of therapy and the child's issues and developmental level (LeBlanc & Ritchie, 2001; Jones, et al., 2003; Bratton, et al., 2005). Directive play therapists have a rationale for every activity chosen for a particular child. In terms of child victims of trauma, directive approaches posit that effective treatment requires adult direction to lead the child through the trauma and discuss the trauma itself (Ryan & Needham, 2001). Thus, therapist must be cognizant and respectful of the child's readiness to approach certain topics and activities. One of the primary concerns about directive play therapy is the therapist forcing the child to work on issues he is not ready to face. Models for incorporating play therapy into practice such as the Structured Play Therapy (SPT) model by Jones, et al. (2003) address this concern by providing therapists with a framework for the timing and sequencing of directive play therapy interventions.

Structured Play Therapy Model

The SPT (Jones, et al., 2003) model of choosing topics and activities is a five-step approach wherein intensity of topics and activities is increased as therapy progresses from the introduction stage through the middle, or working stage, then decreases as the therapy progresses to the end, or termination stage. Moreover, the model provides a flexible framework that allows therapist to increase or decrease intensity of topics and activities according to the child's readiness to progress through the stages. Finally, the SPT

model posits that the importance of the termination stage cannot be overemphasized and stresses that, if at all possible, therapy should not be terminated during the working stage when intensity level is high. To that end, the SPT model suggests the last session be devoted, at least in part, to reviewing and summarizing the child's experience in therapy and processing his feelings around ending therapy and saying goodbye (Jones, et al., 2003).

In order to conceptually understand the model, the five steps mentioned above are summarized below:

Step 1: Brainstorm topics and activities appropriate to the child.

Step 2: Assess the extent to which these activities will focus on feelings, evoke anxiety, challenge the child to self disclose, increase self awareness, evoke anxiety, concentrate on the here and now, and focus on threatening issues.

Step 3: Choose beginning stage activities that focus on getting to know the child, orient him to therapy, allow him to feel safe, and build the therapeutic relationship.

Step 4: Choose working stage activities that will focus on the goal of therapy, allow the child to recognize and express a wide range of feelings, and kindle a willingness in the child to risk exposure to and disclosure of threatening material.

Step 5: Choose termination stage activities that prepare the child to end therapy and include future orientation and coping skills.

Cognitive behavioral play therapy

Cognitive Behavioral Therapy (CBT) is another useful framework in which to view directive play therapy. CBT emphasizes techniques designed to challenge the client's cognitive distortions, such as false attributions about himself, others, or the world, that undermine positive coping or problem solving skills (Albano & Kendall, 2002). CBT is one of the most widely practiced forms of psychotherapy (Wright, et al., 2006). Although CBT was developed for use with adults, theoretical literature supports its adapta-

tion for use with children and adolescents (Knell, 1998; Albano & Kendall, 2002; Munoz-Solomando, et. al, 2008). According to Knell (1998), Cognitive Behavioral Play Therapy (CBPT) can facilitate cognitive change as well as the acquisition of new behavior skills on a developmentally appropriate level.

CBPT is a solution based, goal-oriented method that focuses on the effects of maladaptive or dysfunctional beliefs and attitudes on behavior and how the child's reactions to his experiences are influenced by the meanings he attaches to them (Knell, 1998; Nims, 2007). Typically CBPT uses play medium such as a puppet, stuffed animal, or character in a story to model solutions to problems similar to the child's problems (Knell, 1998), thus helping him investigate and discover new ways of thinking and behaving. Specific CBPT frameworks are available for virtually all childhood problems from bullying to psychopathology and everything in between. CBPT typically requires the therapist to assign and check homework and provide feedback (Wright, et al., 2006).

Nondirective Play Therapy

Many people interested in play therapy are familiar with the play therapy classic, *Dibs in Search of Self* by Virginia Axeline (1967), which demonstrates application of nondirective play therapy through verbatim session notes, or process recordings. Axeline (1947) is also credited with developing nondirective play therapy, a strength based approach based on eight principles designed to assist therapist in establishing a safe, therapeutic relationship and entering the child's inner world. Thus, psychodynamic theory is a useful framework in which to view nondirective play therapy. Although Axeline originally created the principles more than six decades ago, they are still in use today with only minor revisions and extensions (Axeline, 1947; Landreth, et al., 1999; Paone & Douma,

2009). According to Axeline (1967), the principles of nondirective play therapy are designed to teach the child to understand himself and others a little better, thereby causing him to extend emotional hospitality to all people more generously.

Nondirective play therapy posits that children are always communicating through their bodies, their play, and their total selves; hence there is less need for verbalization than with more directive approaches (Axeline, 1947; Landreth, et al., 1999, Ryan & Needham, 2001). A defining feature of nondirective play therapy is its mimicking of children's spontaneous play in important respects along with other aspects of their social interactions with carers (Ryan & Needham, 2001).

Principles of nondirective play therapy

In order to conceptually understand nondirective play therapy, it is important to understand the principles upon which it is based. In nondirective therapy, the role of the therapist is to create the kind of relationship that enables the child to discover how he can function independently (Landreth, et al., 1999). Nondirective play therapy prescribes the complete acceptance of the child by the therapist, which allows him to accept all parts of himself, including those that are problematic (Ray, et al., 2009). The nondirective therapist is genuinely interested in the child and develops a warm, caring relationship with him, hence she resists any urge to direct the play (Landreth, et al., 1999).

According to Landreth, et al. (1999), when the child feels safe in a relationship, he extends the person he is, the self, into the creative expression of play. Thus, the nondirective therapist can enjoy and fully experience the child as the unique person he is, thereby teaching him how to enjoy, experience, and like himself (McCalla, 1994). Through skilled use of empathy and a nonjudgmental attitude, the therapist assists the child to dis-

cover his inner strengths and become more self-accepting, self-reliant, and self-directing (McCalla, 1994).

As mentioned previously, in nondirective therapy, the child is allowed to lead the play, thus he may also opt to play or not to play. The therapist is an observer participant whose actions are responsive to and guided by the child (Guzzi-DelPo & Frick, 1988). The child is not expected or required to verbalize stories, descriptions, thoughts, feelings, guesses, insights, issues, problems, or concerns (Landreth, et al., 1999). He is allowed to play out what is most important to him as opposed to what the therapist believes the issues are (Axeline, 1947; McCalla, 1994; Barish, 2004; Joiner & Landreth, 2005; Ray, et al., 2009). According to Ryan & Needham (2001), nondirective therapy may enable therapists to understand processes and events unique to each child's life more readily than directive therapies.

Nondirective play therapy posits that children have the ability to solve their problems satisfactorily through spontaneous play with an accepting, empathic, and responsive adult (Axeline, 1947; Landreth, et al., 1999; Paone & Douma, 2009). The nondirective therapist follows the child's lead through reflection of content and feeling. She is sensitive to what the child is feeling and expressing through his verbal and nonverbal play and responds accordingly (Axeline, 1947; McCalla, 1994; Paone & Douma, 2009). Feedback from the therapist and corrective learning opportunities inherent in play interactions between the child and therapist promote development of insight, resolution of internal conflicts, and mastery of difficult life experiences (DelPo-Guzzi & Frick, 1988). The therapist aids the child in developing self awareness and beginning to assume responsibility and

become resourceful in problem solving, thereby facilitating self-actualizing growth (McCalla, 1994; Josefi & Ryan, 2004; Paone & Douma, 2009).

Nondirective play therapy allows the child to act according to his actual developmental stage and choose play activities accordingly (Josefi & Ryan, 2004). Nondirective therapists concentrate on accepting each child's current functioning, with the belief that children have an instinctual drive towards better functioning. The therapist views maladaptive behavior as resulting from the drive for complete self realization, hence there is no attempt to change or control the child (Axeline, 1947; Ray, et al., 2009). Liberated from the constraints of appraisal or injunction, the child will naturally resume innate striving toward self actualization and congruence (Landreth, 2002).

Additionally, nondirective play therapists appreciate the gradual nature of the therapeutic process and do not attempt to hurry it along (Axeline, 1947; Landreth, et al., 1999; Ray, et al., 2009), a principle that appears contradictory to managed care guidelines. Although nondirective play therapy is not necessarily a lengthy, open-ended treatment for children, the amount of time allocated to therapy may limit in depth changes (Ryan & Needham, 2001), hence therapists are urged to challenge managed care guidelines when they appear contraindicated.

Finally, although nondirective play therapy encourages children to express themselves with very few limits on their behavior, the therapeutic relationship is not completely permissive. Children do not feel safe, valued, or accepted in a relationship where there are no boundaries hence the nondirective therapist establishes only those limits that help the child accept personal and appropriate relationship responsibility (LeBlanc, et al., 2001; Bratton, et al., 2005). Paone and Douma (2009) stress the importance of nondirec-

tive therapists informing caregivers of what to expect in regards to their child's behavior. Specifically, that the child's behavior may initially improve before getting worse for a while, then as he regulates through therapy, his behaviors are expected to again improve and represent a more permanent change (Paone & Douma, 2009). According to Paone and Douma (2009), caregivers are more likely to be supportive of nondirective therapy when they understand how it works and what to expect.

Setting limits in nondirective play therapy

According to Landreth (2002), limit setting is perhaps the most difficult for play therapists to learn and is one of the least researched areas in the literature, hence it may be helpful to conceptually understand how limits are applied. Landreth developed the ACT method of limit setting: Acknowledge the feeling, Communicate the limit, and Target two alternatives. Thus, a nondirective play therapist using the ACT method might say “You would like to snap the doll's head off, but dolls are not for destroying. Play-Doh and Popsicle sticks are for destroying.” According to Landreth (2002), the objective of ACT is not to stop the behavior but rather to provide an acceptable arena in which the child can act out or express the motivating feeling, want, or need. ACT posits that self control can only be learned when an opportunity to exercise it occurs, thus limits should not be set until they are needed (Landreth, 2002).

Nondirective play therapy and trauma

Nondirective play therapy permits children to re-experience unpleasant situations and gradually assimilate those experiences in a way that allows them to master difficult experiences (DePo-Guzzi & Frick, 1988). In terms of child victims of trauma, one of the primary concerns with nondirective play therapy is that these children are at risk of re-

traumatization if allowed to reenact the trauma in repetitive play (Rasmussen & Cunningham, 1995). According to Ryan and Needham (2001), the extent to which traumatized children are able to help themselves through spontaneous play re-enactments without direct adult help remains under researched. Therefore, nondirective play therapists must remain mindful and respectful of indications of the play becoming stuck and be willing to intervene as required to prevent retraumatization.

Integration of directive and nondirective play therapy

Although research supports the efficacy of both directive and nondirective play therapy, there is an ongoing debate in the field over which approach is better. According to Rasmussen and Cunningham (1995), polarization of directive and nondirective philosophies is counter-therapeutic to the needs of children. An integrated strategy of play therapy blends the strengths of both techniques. The therapist may use nondirective principles to build therapeutic rapport and then direct the therapy towards specified goals through focused intervention (McMahon, 1992; White & Allers, 1994; Rasmussen & Cunningham, 1995; Nims, 2007).

In terms of trauma, research has found that abuse-reactive children are unlikely to deal with the issues underlying sexually inappropriate behavior unless therapists confront these issues (Rasmussen & Cunningham, 1995). According to Rasmussen and Cunningham (1995), behavioral interventions appear more effective in handling sexually inappropriate behaviors of victimized children than nondirective interventions. Furthermore, a nondirective approach that does not begin to address the abuse issues may be colluding in the secrecy surrounding the abuse or placing the child at risk for further victimization.

On the other hand, having a safe, therapeutic relationship is essential for abused children, who have suffered betrayal in their relationships. A prerequisite to helping abuse-reactive children begin to be accountable for inappropriate behaviors and acknowledge the harmful impact of their actions on others is a trusting therapeutic relationship (Rasmussen & Cunningham, 1995). Children with PTSD and their parents may avoid treatment when an intervention proceeds too quickly and does not adapt itself to the child's level of distress (Ryan & Needham, 2001), suggesting a nondirective approach may be required to build rapport with this population. Thus, an integration of directive and nondirective approaches may be required to facilitate communication with child victims of sexual assault (Rasmussen & Cunningham, 1995).

Summary

This literature review has examined the literature on play from historical, theoretical, and treatment approach perspectives. Specifically, research on directive versus nondirective play therapy suggests both methods are equally effective. While not every play therapy treatment method has been described, this literature review provides a basic understanding of play, play therapy, and directive and nondirective play therapy treatment approaches. The current study used existing meta-analytic and theoretical literature on play therapy to inform research methodology on therapist use of directive versus nondirective treatment methods.

Given the findings of studies on play therapy, I have chosen methodology that strives to capture a detailed picture of how clinicians determine when to use a directive versus nondirective treatment approach. This study hopes to be able to clearly identify significant factors that clinicians used in determining when to use a directive versus non-

directive treatment approach through first-hand experiences of clinicians who engage in play therapy with children.

CHAPTER III

METHODOLOGY

This chapter presents the research methods used in this study, including sample selection, data collection, and data analysis. The purpose of this qualitative study is to explore the rationale child therapists use when determining when to use a directive or nondirective play therapy treatment approach. This study investigated the specific factors that influence the therapist when engaging in play therapy. The research examined the therapist perspective related to their experience working with children using definitions of directive and nondirective play therapy with the goal of exploring the differences in therapist beliefs about treatment approaches.

The research design for this study was a fixed method of collecting demographic information and narrative method of collecting data. The fixed narrative approach allowed for the experiences of a sample group of child therapists to be explored to examine the differences in their beliefs about why and how directive versus nondirective play therapy works. The narrative survey questions focused on how therapists determine when to use directive or nondirective play therapy and their rationale for doing so. Variables were collected through demographic information to provide data toward possible future research.

Sample

Participants were limited to eleven participants who identified as therapist with at least one year of experience engaging in play therapy with children between the ages of five and twelve. The participants were required to have at least a master's level education or beyond or to have had engaged in play therapy research or publishing or had attended at least two continuing education workshops specific to play therapy that provide continuing education credits. The survey intended to be as diverse in regards to gender, professional designation, number of children treated, and years of experience working with children as the population of child therapist. The survey was limited to participants who were fluent in English.

Participants were recruited through direct contact with the researcher's personal contacts including former classmates, colleagues, and professors. The convenience portion of the sample was completed through advertising for interested participants using an email request and a recruitment flier. The recruitment materials provided contact information and requested that interested recipients contact the researcher via telephone or email. Recipients were asked to forward the recruitment materials to other therapists who fit the criteria and might be interested in participating in the study, creating a snowball effect. Potential participants were screened for eligibility and informed about the nature of the study during the initial contact.

Ethics and Safeguards

The details of this study were presented to the Smith College Human Subjects Review Board (HSRB) before advertising. The proposal approval letter from the HSRB (Appendix A) documents that this study is in compliance with Federal regulations. Elements presented in the proposal included the informed consent letter (Appendix B), example advertisements used for recruitment (Appendix C), the interview guide (Appendix D), and the demographic and open-ended interview questions (Appendix E).

Participant contact information was obtained during the initial contact and two copies of the informed consent form were mailed to each participant prior to the interview. Participants were asked to review the informed consent form and to sign one copy and return it to the researcher and to keep the second copy for their records. The informed consent form was reviewed with each participant at the beginning of the interview. The researcher and participant each received a copy of the signed informed consent form.

The informed consent form outlined the purpose of the study and the rights of the study participants, including their right to refuse to answer any question and/or to withdraw from the study at any time within two days of the interview for any reason, without being questioned regarding their reason. Since the analysis and writing of the research findings were being written two days after the interviews, withdrawal from the study was no longer allowed after that time.

Confidentiality was maintained throughout the study by meeting in discreet locations that included offices and homes and provided necessary security. The interviews were audio recorded and transcribed by the researcher. All personal identifying information was removed and kept confidential during the data analysis and reporting of data. All

interviews were numerically coded to protect confidentiality and the researcher's advisor was only allowed access to the data after all identifying information had been removed. Participants were asked not to use any names or other personal identifying information during the interviews. The research documents were kept in a secure area and will be maintained for three years, at which time they will be destroyed.

Data Collection

Data collection consisted of a structured qualitative interview (see Appendix E) carried out at a mutually convenient time and location. The interviews were conducted between January 30, 2009 and April 23, 2009 and lasted between 30 minutes and one hour each. Each interview included six demographic questions related to professional designation, modality of treatment, setting of treatment, preferred play therapy approach (directive or nondirective), years working with children and number of children treated.

The interviews also included four open-ended questions related to the factors that influence each therapist decision to use a particular play therapy approach, their expectations of and perceived benefits of their approach, and barriers that limit the use of their approach. Demographic information was reported in aggregate aimed at describing the sample cohort in general.

This study used descriptive statistics to analyze the demographic data. Narrative data was collected through four open-ended questions and was coded based on themes that were identified as common themes and idiosyncratic themes pertinent to the research topic. Themes were chosen for their commonality and uniqueness and any responses that contained more than one theme were recorded in multiple themes. Both positive and neg-

ative responses within a theme category were included in that category to clearly represent the full spectrum of participants' experiences.

Data Analysis

After the interviews were transcribed, content analysis and descriptive statistics were used to organize the characteristics of the sample cohort. Thematic analysis regarding similarities, differences, and variations among particular participants and the sample as a whole was used to organize and present the narrative portion.

CHAPTER IV

FINDINGS

Introduction

The purpose of this qualitative study was to explore the rationale child therapist use when determining when to use a directive or nondirective play therapy treatment approach. This study investigated the specific factors that influence the therapist when engaging in play therapy. Although there is quite a bit of research on play therapy, there is a lack of research on when a directive or nondirective play therapy treatment approach is indicated.

Participants

Eleven clinicians participated in this study: 10 females and one male. Ten of the participants are Caucasian and one is African American. All the participants are employed in New England: eight at an outpatient child guidance clinic, two at a family stabilization clinic, and one in private practice. The participant employed in private practice is the only participant who does not work exclusively with children and families.

All participants have at least a master's level degree in social work or mental health counseling. Two of the participants have an MSW degree, one has an MHC degree, three have LCSW licensure, four have LICSW licensure, and one has dual LMHC and LMFT licensure. All eleven of the participants are clinicians; two are also supervisors. Participants' length of time engaging in play therapy with children at the time of the

study ranged from eighteen months to thirty years with an average of eleven years and a median of 6 years. Participants worked with a varied number of children between the ages of five and twelve that ranged from 15 to more than 500.

Nine participants engage in play therapy with children individually and two work with children and families. Eight participants practice in an outpatient office setting and three divide their time between a school-based program and an outpatient office setting. Three participants identified their preferred treatment approach as directive, three as non-directive, and five as an integration of directive and nondirective.

The findings presented below are organized according to themes that emerged from content analysis. In the course of data collection, several additional topic areas related to play therapy were generated by the participants that had not been explicitly identified in the instrument. They were integrated into the discussion below.

Rationale

The major findings are as follows: there does not appear to be a uniform method of determining when to use a directive or nondirective treatment approach among this sample. Participants have many different rationale they use in determining the treatment approach, although there is a striking belief that the treatment should start out as nondirective. It is important to note that each participant had a case or client on whom they drew for illustrative material. Thus, there were no hypothetical situations used in describing their approach. Details are discussed below. Pseudonyms are used to maintain confidentiality of sample members.

Regarding the information gathered, a primary finding is that although participants report many different factors that influence their treatment approach, all partici-

pants believe that it is important to be flexible regardless of whether a directive or nondirective approach is practiced. As Robert put it “the people I respect and come into contact with are flexible - they don’t think there is one way to do everything.”

Beginning with a nondirective approach is also a common theme regardless of preferred treatment method. Rebecca said “the first one to three sessions are spent rapport building, very nondirective” then she uses a more directive approach as the treatment continues. Annie said:

In the assessment phase, I want to try to understand the child - what they can verbalize, what they play out, what comfort zone they have with the play materials, what they may be trying to tell me.

As Robert put it “If I work with a child, certainly at the beginning I’m more nondirective because I’m still learning who this person is and I don’t want to influence that.”

Following the needs of the child

A very powerful finding is that participants believe it is important to follow the needs of the child in determining the treatment approach. When discussing following the needs of the child, several participants spoke about integrating directive and nondirective treatment methods. As Robert put it, “I follow the needs of the client and their needs of that session. I might be different in the same session depending on the child’s needs.” He went on to say,

As far as the play itself, let’s say a child is playing with figures. The figures are hiding from each other - there’s a lot of sense of fear and anxiety - depending on what the child needs, they’re the one scaring me or I’m scaring them, and it almost becomes like a dance and you can change. I never assume to know if I’m assigned a certain role that that is what the child needs - he may be looking for me to model courage rather than to hold the fear and verbalize it to him.

Laura stated that some children need a nondirective approach that provides “an avenue in which to express themselves, play out their stuff ... to rehash and rehash until they know they’ve worked it through their own processing system” while others need a directive approach. She went on to say,

If I find that the parent wasn’t providing enough guidance and boundaries, those are the kids who are seeking out a more directive approach. They want the boundaries put on the therapy.

Diagnosis

Many participants reported that diagnosis may influence their decision to use a treatment method other than their preferred treatment approach. Robert said “diagnosis is the key. In terms of music - what key you’re playing in.” Laura spoke about using a directive approach with a multi-handicapped population who did not have the language skills to “prevent people from taking advantage of them” to teach them skills to reduce their risk of victimization. Several participants reported preferring a directive approach with children diagnosed with developmental delays, while others reported a preference for a nondirective approach. Here are a few ways in which this was reported:

Rebecca: There are some autistic children or pervasive developmental disabilities who will do better with directive therapy. They look for the routine, structure and consistency.

Sarah: With more limited kids I’m usually more nondirective - I have a MR kid that I’ve been working with for 3 years. If you try to do directive work with him, he doesn’t respond as well.

Charlotte: When there are developmental delays then using a nondirective approach is helpful because you can learn more and explore more with the child.

Heather: I’m more directive with the kids who are either MR or are on the autism spectrum. I want to set up a behavioral baseline with them to support the school and family about what to expect and where the baseline is.

Grief issues are another common theme. There is a striking belief among participants who discussed grief that grief cannot be rushed regardless of the whether a directive or nondirective treatment method is practiced. Sylvia said “I want to let the kid know it’s okay to talk about here, but at the same time, I don’t want to push him if he’s not ready.”

She went on to say,

With one girl I worked with last year I think I was too nondirective ... toward the end it got better, but I almost think it was too late. I could have been more directive in helping her do activities or a project like let’s talk about grandma, let’s draw a picture, anything that helps kids with loss. She needed more of that.

Robert integrates directive and nondirective treatment methods when working with children experiencing grief. As he put it,

I might look for themes in the play, in her language, in the place space, even in the weather, that might allow me to bring in the words or the colors of grief. Things like, it’s a really gray day today.

Trauma

Participants identified trauma history as a major influence on their choice of treatment method. Several participants reported a preference for nondirective treatment with children with trauma histories. Robert said “in terms of a child who has been traumatized, I am more nondirective all the time.” Laura said “There are some children with trauma histories you can do better with nondirective therapy and the themes.”

On the other hand, several other participants reported preferring a directive approach to trauma work. As Alexis put it, “sometimes a child either doesn’t know how to or doesn’t want to play and I’m forced to be more directive as a way to engage the child and build the relationship.” Charlotte spoke of parentified children who are unable to

play:

I have had children who have been so neglected or experienced life in such a way that they have been exposed to so many adult things that they haven't had that time to play.

When discussing trauma, many participants expressed concern that a nondirective treatment method may allow the play to become stuck and thereby retraumatize the child.

Annie said "I think post traumatic play, that's where nondirective work can get stuck in terms of safety and allowing things to go on that are not in the child's best interest." She went on to say,

I think you have to know the difference between post traumatic and regular play. They're very different and very distinct. In the best world, play is a refuge, a respite, a fun place to be. In the post traumatic world, it's not - they're not set up to play, to be creative. The play is literal.

When discussing this risk, Robert said,

The nature of trauma is that it's like bamboo - it grows along the ground and shoots up over here. If you put a barrier around it you can contain it. Maybe the work with trauma revolves around putting the barrier around it and keeping it from creeping out in other ways. As far as trauma getting stuck, you see repetitive play and you can bring in different characters, puppets, to bring in a different emotion - if they're coloring, bring in a different color - ask a question that is meant to get out of the loop.

As stated above, trauma history plays a major part in play therapist choice of treatment method. A common theme among clinicians who prefer a directive treatment approach when engaging in trauma focused work is the use of trauma focused cognitive behavioral therapy (TFCBT). When discussing the benefits of using TFCBT, Charlotte said,

The TFCBT model is unique in that I feel it does allow for the immediate intervention and looks at what are the thoughts, feelings, behaviors and body sensations that are brought up by this specific trauma and what are some coping skills that I can teach you that will help with symptom reduction and other experiences

in life other than this one experience? I think it's a pretty comprehensive approach even though it is seen as a pretty quick approach.

As Annie put it,

A good thing with this model is that it is a way for kids to talk about things they don't want to talk about. You're trying to teach them how to react when they have those thoughts and feelings. Taking the fear out of the thoughts as you go. That's a very useful thing about this model - strategies so that they are okay. So the narrative isn't overwhelming. You don't do it until the kid is ready - the narrative doesn't come until much later in the model.

Therapist Personality

Interestingly enough, a primary finding among clinicians who self identify as nondirective is that therapist personality is a determining factor in their treatment approach. As Sarah put it "I'm a laid-back, take it easy type of person and my personality comes into it in terms of not being directive." Sylvia went on to say:

I know a lot of clinicians who use directive and it works for them and I know people who do both depending on the situation, but I think it definitely has a lot to do with my personality. I'm definitely more laid back and I don't want to feel like I'm forcing the child to do something they don't want to do.

Kendra stated "I am a laid-back person and it just feels right to let the child direct the play. I'm very comfortable letting the child tell me what to do and how to do it." Another respondent, Alexis, said "being nondirective is my comfort level – it feels right – it's how I feel – what feels right to me."

Therapist Training

Another common theme is that several participants report their early training was a factor in their preference for a nondirective treatment approach. Participants believe that training and clinical supervision influences their preferred treatment approach. As Alexis stated "I was taught nondirective and I know a lot more about it." Rebecca spoke

about the influence her first supervisor had on her:

She was very laid back and chill, relaxed, nondirective. She would give me directive statements to make or questions to ask or even directive activities. I still look at her as a genius in the field, but it just makes sense that I am like her.

Kendra stated that she received her degree from a psychoanalytic school that focused on nondirective play therapy. She went on to say “I was trained nondirective and that’s what I feel most comfortable doing.”

On the other hand, Annie spoke in her role as supervisor when she said that “new therapists who I’ve seen coming up get attached to anything that tells you what to do.”

She gave this example:

One of my supervisees was talking about a kid that was constantly testing the limits, turning the light on and off, and she was moving to setting the limits like this is my office. I suggested that before she shut it down, she try to understand what it might be about that she does this every time she comes in. It’s not a big idea, but its understanding what is being said non-verbally.

Parent/Family Work

Finally, participants reported preferring a more directive treatment approach when working with parents and families versus using a nondirective approach with individual clients. As Alexis put it:

I’m more directive when I’m in a family session or a meeting or something because I think that’s maybe what people can understand more, that’s what they’re looking for and that’s what the family should be doing more.

Heather said “a lot of my work with parents is teaching them skills to help their child.”

Sylvia said her work with parents is more directive than the work with the kids. She tells parents “the ways you’re interacting with your child are so much more important than

what happens here.” She went on to say “I want them to learn the skills that I’m modeling.”

Benefits and Expectations

Benefits of Directive Approach

Interestingly enough, although there are many different directive play therapy treatment approaches, when discussing benefits of using a directive approach, TFCBT was the only directive approach mentioned by respondents. TFCBT is viewed as an evidence based treatment modality for children. Participants believe that the major benefit of the TFCBT model is that it teaches children coping skills to enable them to talk about the trauma. When talking about coping skills, one participant, Annie said, “people want to avoid talking about bad things. That’s a coping skill that works until it doesn’t.” She went on to say that TFCBT has specific strategies for teaching children coping skills and offered this example:

We have bubbles - blowing bubbles is a whole strategy for deep breathing and relaxation and deep belly breathing where bubbles become thoughts that you want to get out. You visually watch them float away.

Charlotte had this to say about TFCBT,

It is an approach where in general you might see more success more quickly, more efficiently. It’s a theoretical, evidence based approach that says that talking about the trauma, exploring the narrative, exploring the cognitive distortions that have come out of that experience is really the key to helping the child experience symptom reduction.

Barriers to Directive Approaches

Interestingly, participants did not identify many possible barriers to engaging in a directive treatment approach. The most common response was that being too directive may cause children to shut down. Alexis stated:

If you're too directive and make them uncomfortable, they're not going to bring as much of themselves as they would have or may not feel comfortable sharing themselves or opening up.

Sarah said "sometimes they think they're being grilled if you come at them too directive, but they see nondirective as we're just playing." Sylvia said "You could ruin that whole relationship building process if you're not careful in terms of how much you're going to push them."

Finally, participants believe they risk creating a chronic cycle of treatment with a directive treatment approach. As Laura put it "Unfortunately, with directive approaches, one problem kind of evolves into another one and it's this chronic cycle." Kendra said,

With directive approaches that target behaviors without addressing the underlying issue, you get a chronic cycle where mom reports that he has stopped bed-wetting but he is now acting out in school. You work on the acting out behavior and next thing you know he's now having headaches or he's fighting with his siblings more.

Benefits of Nondirective Approach

A major finding is that almost all participants identified the relationship between the child and the therapist as both an expectation and a benefit of nondirective play therapy. As was stated by a few participants:

Heather: Children who I work with using a nondirective treatment method value that interaction in having an adult to interact with and have attention with.

Kendra: I think it's really important that the child feel accepted and understood without feeling any pressure from me to change or conform to some expectation that I or anyone else has of him. This relationship he develops with me is probably unlike any relationship he's had with an adult, which allows him the safety to explore without fear of consequences. My hope is that he'll use this relationship to develop new understanding and acceptance of himself.

Alexis: I think my primary goal is for them to connect with me so that they can practice attachment and have an accepting relationship with someone so they can be themselves, which results in the therapeutic process. Having them be able to

express themselves safely – whether it’s in more eye contact or whatever areas of their lives – for them to feel better.

Sylvia: When they feel connected to you they play it out in a way that’s different from how they would before. I don’t care if it takes me a year or more to build a relationship with a client. I’m willing to be able to do that because I know that without that, they’re never going to be able to share what they want to share in this place.

In addition to the relationship with the therapist, allowing the child to be in control of the therapy is believed to be another primary benefit to using a nondirective treatment approach. As Sylvia said:

I feel like children don’t get enough choices - they’re always getting told all day long what to do, when to do it, how to do it, and I want them to feel like they can come in here and have a good time and not feel like, oh no I have to go to therapy and she’s going to make me do this. I want them to feel like this is a safe space and be able to do whatever they feel they need to do. I honestly truly believe that when a child feels safe and when they are ready, it will all come out.

Alexis stated,

A lot of these kids feel like they have no control over anything, even though they might. They lack any real confidence – they’re not able to trust themselves – allowing them to make decisions themselves and its ok.

Finally, participants feel that allowing the child to proceed at his own pace is a significant benefit of using a nondirective treatment approach. As Charlotte put it,

In allowing the child to explore and not necessarily leading the treatment you’ll find the child will get to a lot of those symptoms, issues, and concerns in their own way and in their own time.

Alexis said nondirective work “allows for things to come into the room at a comfortable pace if they’re not emotionally ready.”

Barriers to Nondirective Approach

A major finding is that almost all participants reported therapist comfort level as a barrier to using a nondirective treatment approach for neophyte therapist. Ellen said

“many therapists feel stuck and you have to be one way or another way.” Annie spoke in her role as supervisor when she said,

New therapists feel phony or not real, like they’re doing something wrong or they’re not doing something valuable when they’re doing nondirective play therapy. I try to validate that it is a modality and play therapy isn’t just playing.

Clinicians believe that comfort level increases with experience. As it was stated by a few clinicians:

Charlotte: I think I sometimes feel less successful at certain times in there when I’m nondirective because I’m not always sure what’s happening or where things are going ... You may feel on the other hand, more like you’ve done a concrete piece of work when you’ve been more directive.

Alexis: The longer you’ve been doing play therapy, the more comfortable you get stepping outside of your personal comfort zone.

Rebecca: Its part of the process of learning to and wanting to let go as a new clinician. The more experience I've gained, the more easily I've come to move between a directive and nondirective approach.

Parents

Clinicians believe that parental involvement is required when working with children. As Ellen put it “if you’re doing any work with a child and you don’t include the parent, you’re setting yourself up for a failure situation.” Yet interestingly enough, a major finding is that participants believe that parents present a primary barrier to using a nondirective treatment approach. Robert stated “parents can be harder to work with than the kids.”

Participants reported that oftentimes parents do not understand nondirective play therapy and expect a “quick fix.” Ellen said these parents are “desperate.” Alexis said,

They oftentimes feel threatened by not having complete control over the situation and not knowing what’s going on in the room and having to trust the therapist that they are going to have the child’s best interests in mind, be helpful, etc.

Another respondent, Sarah said, “parents think all we did is play and that’s not therapy.” Laura spoke of helping the family “get some reality testing and understanding nondirective play therapy is going to take some time.”

Managed Care

A primary finding is that participants believe managed care is a major barrier to using a nondirective treatment approach. As it was stated by a few respondents:

Laura: With commercialized insurance, we’re looking at shorter types of therapy, which has sometimes dictated the way in which we do our therapy. Sometimes I feel as though I have to take a more directive approach because I have a limited amount of time to get things done.

Sylvia: The huge barrier is that the insurance companies are not willing to pay for it. We are all going to be going to brief treatment pretty soon. Then when that happens, I don’t know what I’m going to do because it is going to have to be directive. That scares me - what about the relationship building? What about the child feeling safe?

Robert: We live in an economic pressured time with insurance companies so that right away makes me think "how can I provide my services as quickly and as efficiently as possible?" So I usually don’t feel like I have the luxury of doing nondirective work - I think most therapists feel the same way. That influences me a lot.

Alexis: Health insurance companies are a barrier because they require behavioral plans, behavioral interventions, and measurable goals and outcomes. They want clear, researched documented data about directive interventions to help these kids.

Heather: I feel like so much of the insurance stuff is all in behavioral terms. We focus more on behavioral stuff. It’s really easy to write those notes in a behavioral way if you’re doing directive work.

Lack of Respect

Finally, lack of respect was identified as a barrier to nondirective play therapy. Several participants believe parents, educators, and other caregivers do not respect nondirective play therapy because they do not understand it. As Sarah said, “I think getting other people to understand and respect nondirective play therapy – parents, teachers, pro-

viders, DSS is difficult.” Another participant, Robert stated “nondirective is sometimes seen as not as good as or less than because people don’t understand it.” Interestingly enough, he went on to say “I think there’s a bias in clinical circles that nondirective is the way to be - you’re the crème de la crème if you are nondirective.”

Summary

This chapter presented the findings from the semi-structured interviews with eleven play therapists. The major finding is that there does not appear to be a uniform method of determining when to use a directive versus nondirective treatment approach among this sample. Participants have many different approaches to determining their treatment approach.

Several topic areas were generated by the participants that had not been explicitly asked about in the Interview Guide (see Appendix E). These topics include factors such as managed care, therapist personality, and therapist comfort level that influence participants use of a directive versus nondirective approach. Participants reported fewer barriers to directive treatment approaches than to nondirective treatment approaches. Participants also tended to reflect on their practice and how their personal experiences have affected their preference of a directive versus nondirective treatment approach.

The following chapter will compare this study’s finding with current literature and discuss the significant implications to clinical social work practice and education that arise from the findings. Chapter V will also outline the limitations and strengths of the study, offer suggestions for future research on the topic, and conclude the document.

CHAPTER V

DISCUSSION

Introduction

The objective of this research was to understand more clearly the commonalities in the rationale that child therapists who engage in play therapy use when determining use of a directive versus nondirective treatment approach. The research question was as follows:

What are the commonalities in the rationale used by child therapists to self-identify their play therapy treatment approach as directive versus nondirective?

The design of the study was exploratory with methods that consisted of semi-structured qualitative interviews with a non-random sample of convenience.

This chapter compares the major findings of this study to current literature and presents implications for social work practice and education. This chapter will also outline the limitations and strengths of the study, offer suggestions for future research on the topic, and conclude the document.

Key Findings

The rationale child therapists use to determine when to use a directive versus nondirective play therapy treatment approach was explored through the narratives of seasoned professionals in the field. One of the major findings is that there does not appear to

be a uniform method of determining when to use a directive or nondirective treatment approach among this sample. An unexpected finding is that, for this sample at least, factors such as therapist personality, comfort level, clinical supervision and educational background influence therapist preference of play therapy treatment approach. The data collected was surprising since these factors were not readily noted in the literature. Another surprising finding is that although specific cognitive behavioral play therapy frameworks exist for virtually all childhood issues, the only model identified by this sample was a trauma focused model.

Consistent with the research, all self-identified directive therapists in this sample begin with a nondirective approach in the relationship building phase and become increasingly directive as the therapy progresses (LeBlanc & Ritchie, 2001; Jones, et al., 2003; Bratton, et al., 2005). Also consistent with the literature, participants overwhelmingly stress flexibility regardless of whether a directive or nondirective treatment approach is used. In fact, the most striking finding is that, at least for this sample, therapists take flexibility one step further and integrate directive and nondirective approaches, oftentimes even within the same session. Thus, although the philosophies of directive and nondirective play therapy may appear contradictory, participants believe both treatment approaches share many similarities that support their integration. This finding seems to support Rasmussen and Cunningham's (1995) view that polarization of directive and nondirective philosophies is counter-therapeutic to the needs of children.

Throughout this study, it became apparent that there is a consensus among this sample that managed care guidelines may negatively impact therapist ability to provide children with the most effective treatment. Many participants equate nondirective play

therapy with longer treatment durations than directive approaches, a belief that is not supported by the literature (LeBlanc & Ritchie, 2001; Bratton, et al., 2005). Interestingly enough, this sample expressed concern that managed care guidelines may preclude them from using a nondirective approach because of this erroneous belief.

All participants emphasized the importance of building a trusting therapeutic relationship, thus substantiating the literature (Phillips & Landreth, 1998; LeBlanc & Ritchie, 2001; Hall, et al., 2002; Jones, et al., 2003; Bratton, et al., 2005). However, some self-identified nondirective therapists expressed concerns that directive treatment approaches dismiss the importance of building a trusting relationship and may force children to confront issues they are not ready to face. This concern, although legitimate, has been addressed in the literature review conducted for this study.

Finally, this sample substantiated the literature regarding the importance of parental involvement in the child's therapy regardless of treatment approach used. Yet, many therapists in this sample described difficulties in gaining parental support when nondirective play therapy is used, thereby necessitating their use of directive play therapy. Participants attribute these difficulties to parental lack of respect and understanding of nondirective play therapy. This finding substantiates Paone and Douma (2009), position that caregivers are more likely to be supportive of nondirective therapy when they understand how it works and what to expect. Thus, findings strongly resonated with the idea that nondirective play therapy may not be well respected despite meta-analytic research that shows play therapy can be considered effective regardless of whether a directive or nondirective approach is utilized (Bratton, et al., 2005).

Implications for Practice

There are three major implications for clinical practice, which are discussed below in order of importance.

Mandatory focus on directive and nondirective treatment approaches

Just as it may be naive to assume that all play therapy techniques will work for all children, the same may be true for directive versus nondirective treatment approaches. Integration of directive and nondirective treatment approaches should be taken seriously and looked at in research and practice as a possibility when working with children and families. Attention and focus on use of directive versus nondirective treatment approaches should be mandatory instead of optimal in clinical social work practice and education. All play therapy treatment approaches should be addressed more formally and equally in social work education in order to increase therapist comfort level with various approaches.

Managed care guidelines

Social workers have a duty to advocate for their clients, thus it appears logical to challenge managed care guidelines when they interfere with efficacy of treatment. Findings suggest that proving the efficacy of play therapy, especially nondirective play therapy, to third party payers, mental health professionals, school administrators, and parents is necessary for its acceptance as a viable intervention with children. Thus, quantitative research with controlled outcome studies measuring the effects of time limits and other managed care guidelines on play therapy outcomes with children may be beneficial to therapist advocacy efforts.

Therapist personality

The third implication of this study is that findings suggest that, for this sample theoretical models are not as important as therapist personality when determining treatment approach. It appears beneficial for additional research studies to explore the effects of therapist personality on preferred treatment approach, since this may present a treatment bias that has the potential to limit therapist ability to provide the most effective treatment to children and families.

Limitations and Strengths

There are several inherent limitations in this study. First, the size of the sample limited the generalizability to other populations. Future research should utilize a larger, more varied sample in order to obtain a clearer picture of how other settings and treatment modalities approach the determination of when to use a directive versus nondirective treatment approach to play therapy. A larger sample will also strengthen reliability and validity of results.

In addition, all participants work in outpatient and school settings versus residential and hospital settings, thus the lack of diversity in treatment settings may further limit generalizability. Due to limited time and access to therapists outside of New England, the sample lacked sufficient diversity and variation of geographic location, which may have also led to limited reliability and generalizability. The study did yield several implications for practice that are very applicable to clinicians who work in similar contexts.

The lack of detail in the interview guide limited the depth and detail of the responses. The semi-structured instrument only captured a broad picture of how clinicians determine when to use a directive versus nondirective treatment approach and limited the

data gathered on specific areas of this topic. The qualitative nature of responses also limited the data collected. There are no observations of participants conducting play therapy, which would have expanded the range of data gathered.

There were also many strengths in this study, including the methods of data collection and sample selection. The semi-structured interview was a strength of the study because it allowed participants to openly discuss their ideas and experiences without placing many limits on their responses. Participants could discuss case examples, which put the responses into context and allowed dialogue to be created instead of a monologue. Since all participants spoke about the same areas of the topic, the study shows reliability and strength in data-collection method.

The sample was also a strength of this study because it allowed for a diverse group of practitioners to respond to the topic with real-world examples and not hypothetical examples. Thus, the demographic diversity of the sample in regards to participants' gender, race, play therapy experience, educational background, and focus of work, increase its generalizability to other populations.

Conclusion

The purpose of this thesis was to better understand the commonalities in the rationale that child therapists who engage in play therapy use when determining when to use a directive versus nondirective treatment approach. This research is important to social work because determining when to use a directive versus nondirective play therapy treatment approach is a real and present issue faced by therapists. Since research states that directive and nondirective play therapy are both effective modalities (LeBlanc, et al., 2001; Bratton, et al., 2005), a better understanding of how to determine when one ap-

proach is indicated over another is imperative. Research that examines how clinicians approach determining when to use a directive versus nondirective treatment approach is crucial so that therapists are equipped to provide each child with the method best suited to their individual needs.

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Appendix A
HSRB Approval Letter



Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

January 24, 2009

Carolyn Andrews

Dear Carolyn,

Your amended materials have been reviewed and all is now in order. We are glad to give final approval to your study. We see that you have added more requirements for your participants to be eligible and hope that does not make it difficult for you to attain a sample.

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.

Good luck with your project.

Sincerely,

A handwritten signature in blue ink that reads 'Ann Hartman' followed by a flourish.

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

CC: Elaine Kersten, Research Advisor

Appendix B

Informed Consent Letter

Dear Participant:

My name is Carolyn Andrews and I am conducting a brief and confidential survey to assist with research for my Masters Thesis at Smith College School for Social Work and possible future presentation and publication on this topic. My research will explore the rationale therapist use when determining whether to use a directive or nondirective play therapy treatment approach in their work with children. Your participation in this study will contribute to the research and knowledge about the rationale used to determine whether to engage in directive or nondirective play therapy.

To be eligible for participation you need to have at least one year of experience in which you engaged in play therapy with children between the ages of five and twelve years. **Potential participants must have a masters level education or beyond or have engaged in play therapy research or publishing or have attended at least two continuing education workshops specific to play therapy that provide continuing education credits to be eligible for the study.** All professional disciplines are encouraged to apply. The interview will consist of ten questions that include six demographic questions and four open ended research questions regarding your experiences using play therapy. The interview is estimated to take approximately 45 minutes to one hour of your time.

There will be minimal risk to participants who complete this study. Participants will be providing the researcher with their strong professional opinions and trusting the researcher to protect confidentiality.

There will be no financial compensation for participating in this study. There will be a benefit for many participants in being able to share their experience with others and to have their experience be a part of research that will increase the knowledge of play therapy. Additionally, some individuals may benefit by reflecting on their use of play therapy with children.

I will protect your confidentiality regarding any identifying information of your participation by coding interviews without any personal identifiers. The code sheets and Informed Consent Forms will be kept separate from the data. All materials will be kept in a secure place as required by Federal guidelines and will be destroyed after three years. If the research data is used in presentations or publications, it will be presented as a whole. When brief illustrative quotes or vignettes are used, they will be carefully disguised. The research advisor will only have access to the data after the interviews have been

numerically coded. I will audio record and transcribe the interview without any of your personal identifying information to allow your confidentiality to be protected. Information that you provide will not be used in any way that can identify you.

Your participation in this study is voluntary. If at any time you wish to stop the interview, please tell me and we will discontinue the interview without any questions as to your reasons for discontinuing. If you would rather not answer a question, please let me know and we will move on to another question, no questions asked. If you decide that you do not want your interview to be included in the study, you may withdraw by contacting me **within two days of the interview**. If you have any concerns about your rights or about any aspect of this study, you may contact me via email or phone at:

Email: candrews@email.smith.edu

If you have any concerns about your rights or about any aspect of this study, you may contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

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

If you choose to participate in this study I would like to extend my thanks and appreciation of your time and contribution. **You should keep a copy of this Informed Consent Form for your records.**

Thank you,

Carolyn Andrews
Smith College School for Social Work

Signature of Participant: _____

Date: _____

Signature of Researcher: _____

Date: _____

Appendix C

Sample Recruitment Materials

Recruitment Email

Hello. My name is Carolyn Andrews and I am conducting research for my graduate thesis as part of my Master of Social Work program at Smith College School for Social Work. My thesis is exploring the commonalities in the rationale used by therapists to self-identify their treatment approach as directive or nondirective.

My goal is to complete all interviews by *March 1, 2009*, so please help me by considering participating in my research study. To be eligible, you must have at least one year of experience engaging in play therapy with children between the ages of 5 and 12. You must either have a masters level education or beyond *or* have engaged in play therapy research or publishing or attended at least two continuing education workshops specific to play therapy that provide continuing education credits to be eligible for the study. All disciplines are encouraged to apply.

I have enclosed a flyer that includes information about the study. Please contact me via telephone or email if you would be kind enough to participate or if you have any questions. If you are unable to participate in the study, but know someone who may be able to, I would appreciate it if you would forward the flyer on.

Thank you.

Carolyn Andrews
Candrews@email.smith.edu

Recruitment Flyer

***Do you engage in play therapy with children or
know someone who does?***

**If so, I need your help in a study of directive and nondirective
play therapy!** I am a Masters in Social Work student working on my graduate thesis

exploring the rationale play therapists use in their preference of a directive or nondirective treatment approach. My hope is that you will assist me in my research by sharing your knowledge and experience as a provider of play therapy. All professional disciplines are welcome to apply. To be eligible, you must meet these two requirements:

1. At least one year of experience working with children between the ages of 5 and 12
2. Masters level education or beyond or have engaged in play therapy research or publishing or attended at least two continuing education workshops specific to play therapy that provide continuing education credits

If you meet these requirements, please be kind enough to take part in a brief and confidential interview that will take approximately 45 minutes to one hour to complete. To participate, please contact me via telephone or email.

Thank you.

Carolyn Andrews, Smith College School for Social Work MSW student

Appendix D

Interview Guide

Directive play therapy will be defined for the purposes of this study as a treatment approach in which the therapist determines the choice of activity and issues in treatment. Examples participants may want to reflect on include, but are not limited to the following examples:

Bobby is a 10 year-old Hispanic boy who was referred for treatment because he is verbally and physically aggressive to his siblings and peers. Bobby engages in play therapy with violent themes that include torture of a baby and writing a story about domestic violence. The therapist draws a triangle on a piece of paper and explains that each behavior has an action and a feeling associated with it. At the top of the triangle, she identifies the problem behavior, for example, "hitting my sister". She then asks Bobby to identify each decision point involved in the behavior, the options available, and choices he made at each of those points. Finally, she asks Bobby to identify what he was feeling at the time. Bobby and the therapist discuss the relationship between his emotions and his actions.

Sarah is a 5 year-old Caucasian girl who was referred for treatment due to difficulty adjusting to her parents' divorce. The therapist introduces the Feeling Word Game and asks Sarah to identify some feelings that 5 year-old girls have. She writes each word and draws a face representing the feeling on a separate piece of paper, then lines them up in front of Sarah. The therapist then tells a story about herself and places a poker chip on each appropriate feeling to show that it is poss-

ible to have more than one feeling at the same time and different amounts of each feeling. Next, she tells a story about Sarah and asks her to put poker chips down. Sarah is then asked to tell the story while the therapist puts down the poker chips.

Nondirective therapy will be defined for the purposes of this study as a treatment approach in which the child determines the choice of activity and issues in treatment. Examples participants may want to reflect on include, but are not limited to the following examples:

Suzie is an 8 year-old Asian girl referred for treatment of selective mutism at school and in strange situations, although she is verbal during sessions. Suzie introduces a mute dog and its friend hummingbird that speaks for him into the play that mirrors Suzie and her friend Jenny at school. The therapist's character is a squirrel that wants to be the dog's friend but does not know how. Suzie is able to identify and verbalize the dog's desire to speak and its fear of using the wrong work that prevents it from doing so. The squirrel character tells the hummingbird that when that happens to her, she says a silly work like *whatchamacallit* or *thin-gamajig*, words Suzie has never heard before.

Herman is a 5 year-old Caucasian boy referred for treatment of PTSD. During the first play therapy session, Herman introduces a house that catches on fire, a character who downs, and a "real" mommy and a "bad" mommy. Herman's trauma history includes being rescued from a house fire, the accidental drowning of a brother, and allegations of child abuse. Herman instructs the therapist throughout the play on exactly what to say and do. After several sessions in which Herman

replays the house fire without appearing able to move on, the therapist asks Herman if everyone got out safely.

Appendix E

Research Questions

Demographics and Experience:

What is your professional discipline?

What type of play therapy do you engage in most frequently? (Type includes individual, group, or family)

What setting do you provide play therapy in most frequently? (Setting includes home, school, inpatient, outpatient, or other. Specify if other)

What is your preferred play therapy treatment approach? (Directive or Nondirective)

How many years have you worked with children? (Include internships and paid positions in which you provided therapy to children between the ages of five and twelve)

How many children between the ages of five and twelve have you engaged in play therapy with?

Research Questions:

Please share stories, brief examples, or comments to answer these questions from your perspective relating to your experience working with children.

What factors influence your decision to use your play therapy approach?

What are your expectations of your preferred play therapy approach?

What do you believe are the benefits of your preferred play therapy approach?

What barriers do you see that limit the use of your preferred play therapy treatment approach?