Child and Parent Perceptions of Play Therapy

by

Michelle Hoover

A thesis submitted in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

in

Counselling Psychology

Department of Educational Psychology

University of Alberta

Abstract

Play therapy is an effective form of psychotherapy typically used with children under the age of 12. Numerous meta-analyses amalgamating the results of hundreds of play therapy research studies have shown that children who engage in play therapy are better off than nearly 80% of those who do not engage in play therapy. This result is nearly identical to studies examining the effectiveness of therapy in adults who participate in psychotherapy. Within the field of adult psychotherapy there has been significant research examining what makes therapy effective and what the mechanisms of change might be within the therapeutic process. However, a gap has been identified within the field of play therapy regarding this topic. While there has been some initial research exploring what it is within the process of play therapy that helps create change, the vast majority of this research comes from the perspective of the therapist. In psychotherapy, there is often a difference of perspective between what a therapist and a client names as impactful and important within therapy. In play therapy an additional complexity must also be considered. While it is the child typically receiving the clinical services, research has shown that parents also have the ability to impact clinical outcomes achieved. This study focused on child and parent experiences of play therapy and explored each of their perceptions of the therapeutic process. Eight parent/child dyads were interviewed and semi-structured interview questions were used to help explore their various experiences of play therapy. Three shared themes between parent and child groups emerged: support received, the role of the therapist, and the role of play. Results from this study exploring the differences and similarities that emerged between parent and child perceptions of play therapy may help provide insight for play therapists into the expectations that children and parents hold about play therapy, and provide guidance on navigating these multiple impactful participants within the process of play therapy.

Preface

This thesis is an original work by Michelle Hoover. The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Research Ethics Board, Project Name “Child and Parent Perceptions of Play Therapy”, No. Pro00080805, 4/23/2018.

Acknowledgments

I would like to sincerely thank all the parents and children who participated in this study. Your openness and enthusiasm in sharing your experiences made this dissertation possible, and I am truly grateful.

Thank you to the many academics who participated in my candidacy and dissertation committees. To Drs. George Buck, Carol Leroy, Mike Carbonaro, Phillip Sevigny, and Nancy Riedel-Bowers, thank you all for being a part of this process and for the support and feedback provided. To my supervisory committee, Drs. William Hanson and Kevin Wallace, you have both provided tremendous guidance and encouragement throughout this process, thank you so much. Finally, I would like to thank my supervisor, Dr. Derek Truscott, for his unending enthusiasm, incredible knowledge, and commitment to seeing me through my PhD. What a journey this has been, and I am so fortunate that you were my supervisor.

Thank you to my parents, David and Lorraine, and brothers Fabian and Jordan, for their support. Each of you in your own unique way has modeled incredible resilience and helped instill in me the value of tenacity and an appreciation of life-long learning.

To my children Owen and Grace, you are both truly the inspiration and motivation behind me completing this PhD. I hope that my journey may help you both continue working towards your life goals, regardless of how long it may take you to get there.

And to Stu, thank you for being my rock. You are always there providing unending support and making me laugh even on the hardest of days. Thank you for being such an amazing partner throughout this entire journey.

Table of Contents

List of Figures

Chapter 1: Introduction

Psychotherapy is an interpersonal helping encounter based upon psychological principles that involves a trained therapist who offers remedial help, and a client who receives help for a disorder, complaint, or problem (Wampold & Imel, 2015). Thousands of research studies, as well as numerous meta-analyses, demonstrate that therapy is an effective treatment for a variety of mental disorders, complaints, and problems (Chambless et al., 1998; Lipsey & Wilson, 1993; Smith, Glass & Miller, 1980; Wampold, 2011; Wampold & Imel, 2015).

Play therapy is a form of psychotherapy that uses elements of play instead of talk to communicate and engage with children (typically under the age of 12) in a developmentally appropriate manner (Kottman, 2011). Numerous studies examining the efficacy of play therapy have shown that play therapy is as efficacious as adult therapy, with the majority of clients showing positive outcomes (Bratton, Ray, Rhine & Jones, 2005). However, research specifically examining the effective ingredients of play therapy is limited. We know that adult psychotherapy works by way of establishing a healing relationship, creating positive expectations by explaining the problem and its solution in a hopeful way, and encouraging health promoting activities (Wampold & Imel, 2015), but we don't know if play therapy works by similar means or some others. This specific gap—how play therapy works and how client change is created—has been identified as an area worthy of further study (Drewes, Bratton & Schaefer, 2011; Drewes & Schaefer, 2016; Kazdin & Nock, 2003).

Outlining the Problem

Researchers studying different theoretical orientations to psychotherapy have provided evidence that all types of therapy are equally helpful and promote client change. The common factor explanation proposes that general factors independent of the specific factors offered by the

various different therapeutic orientations are the influential change agents in therapy. Some of these common factor elements include hope, expectation, the therapeutic relationship, belief, and a corrective experience (Wampold & Imel, 2015). Drewes and Schaefer (2016) have proposed four common factors that may help enact change in play therapy: 1) facilitating communication (including self-expression and self-understanding), 2) fostering emotional wellness (including stress inoculation and abreaction), 3) enhancement of social relationships (via the therapeutic relationship, empathy, and social competence), and 4) increasing personal strengths (including problem solving, self-regulation, and self-esteem). Drewes and Schaefer's proposed elements are an excellent beginning. However, little research has been undertaken to determine if these are impactful or if other factors are involved.

Purpose and Research Question

This study seeks to understand the lived experience of both child and parent participation in play therapy. Much of the research undertaken in play therapy has been from the point of view of the therapist or the researcher (Hurlburt, Garland, Nguyen & Bookman-Frazee, 2010; Schottelkorb, Swan, Garcia, Gale & Bradley, 2014). One of the limitations of only considering these views is that there is often a difference in perception between the client and the therapist regarding what created change in therapy (Maione & Chenail, 1999), highlighting the critical need to consider the view of the client. Play therapy is also unique in that the role of the parent significantly impacts child outcomes (Bratton et al., 2005). Considering this, one may hypothesize that while there is one therapeutic recipient, there are two clients involved in child outcomes: the child and the parent.

Exploring the lived experience of play therapy from the perspective of both child and parent, and examining their differing perspectives, can provide insight into individual

experiences of play therapy and also allow for a triangulation of data that has been identified as missing in previous play therapy studies (Bach 2017; Carroll, 2002). In addition, this method allows for a greater exploration of factors that help to promote change in play therapy. It is through examining the perspective of both the child and parent that a deeper understanding of which specific elements occurring within the play therapy process help contribute to client change. The research question explored is thus: "What is the lived experience of play therapy from the perspective of both child and parent?"

Significance and Relevance to Counselling Psychology

Counselling psychologists are expected to use psychological knowledge and skills to enhance and promote the positive growth, well-being, and mental health of individuals through a process of collaboration between client and psychologist (CPA, 2017). As identified by Bedi and colleagues (2011), the therapeutic relationship is considered to be a key component of successful therapy in the field of counselling psychology. In counselling research with adult clients, qualitative process research has explored the experience of the client and has also suggested the importance of the therapeutic relationship as a critical component of successful therapy (Binder, Holgersen & Nielsen, 2009; Carey et al., 2007; Higginson & Mansell, 2008). Play therapy is an intervention that counselling psychologists can utilize to create a strong collaborative and therapeutic relationship and engage in counselling through the developmentally appropriate medium of play. My research also embraces the principles of counselling psychology research set out by the CPA, specifically exploring the "counselling relationship and other psychotherapeutic processes" using "culturally appropriate methods suitable for investigating...human behaviour" (Bedi et al., 2011).

This study fills a current void in the field of counselling psychology regarding the client's experience of play therapy and their perception of change. Within the broader field of adult therapy, research exploring the views of the client has provided useful understandings (Binder et al., 2009; Carey et al., 2007; Higginson & Mansell, 2008). However, in the field of play therapy studies exploring the views of the child client or the parent are only just emerging (Bach, 2017; Carroll, 2002). It is hoped that this study will provide rich data regarding what the child and the parent perceive to be helpful mechanisms of change and may be a contribution to the field of counselling psychology and provide insight in both play therapy clinical practice and play therapist training.

Overview of Dissertation

This dissertation is divided into five separate chapters. Chapter two provides a review of the existing literature on therapy, play therapy, mechanisms of change, and process research; all of which inform the basis for creating this current study. Chapter three outlines the process undertaken and rationale for completing a qualitative research study for this topic, as well as the methodology and methods used to complete the study. The fourth chapter presents the results of the study through eight biographical vignettes of the eight parent child dyads. Two exemplar cases are also presented, one highlighting a best-case exemplar and the other highlighting a worst-case exemplar. The biographical parent child dyad vignettes are used to situate the reader to the lived experiences of the individual dyads, and the exemplar cases provide an opportunity to compare and contrast both positive and negative aspects of therapy. The fifth chapter concludes this study with an exploration of its findings considered within the broader context of previous research and literature. Implications for clinical practice and potential future research are explored, and limitations of the current study are also addressed.

Chapter 2: Child and Parent Experiences of Play Therapy: A Literature Review

There is an abundance of research supporting the view that play therapy is helpful to the majority of individuals who undertake it. While contemporary play therapy is typically divided between directive and non-directive therapeutic orientations that each understand the process of change in therapy somewhat differently, there is a call within the field for the common factors of play therapy to also be examined. Common factors have been proposed for explaining the effectiveness of adult psychotherapy and youth family therapy, yet to date there has not been an exploration of common factors in play therapy. Therefore, it is unclear what play therapy common factors may be, and if they are similar or varied compared to other modalities. The lived experience of play therapy experienced by the client promises to help us better understand what creates client change in play therapy. These client perceptions of what is helpful and what creates change in play therapy can help inform clinicians regarding important elements that may then be included in their clinical work.

Psychotherapy is widely practised in numerous countries across the world and is considered to be an effective treatment for mental health issues (Wampold, 2011). Individuals who participate in psychotherapy have mental health outcomes that are significantly better than those who do not (Lambert 2013; Lambert & Ogles, 2004; Wampold & Imel, 2015). Results of numerous meta-analysis studies—a process of amalgamating individual research results and synthesizing effect sizes—conclude that people who participate in psychotherapy will experience better outcomes than 79% of individuals who do not participate in therapy (Smith, Glass & Miller,1980; Wampold & Imel, 2015).

Therapy has been shown to be effective in treating a variety of mental health issues including depression, anxiety, marital unhappiness, addiction, feeding/eating disorders, health

problems (including smoking, physical pain), and sexual dysfunction (Chambless et al., 1998; Wampold, 2011). Therapy has also been shown to be effective among individuals of all ages, including children, adolescents, adults, and the elderly (Chambless et al., 1998). Psychotherapy has been shown to be equally effective or more effective than medication for the treatment of issues such as depression and anxiety, and has lower rates of relapse than medication (Hollon, Stewart, & Strunk, 2006; Imel, Malterer, McKay & Wampold, 2008).

Play Therapy

Mental illness has been identified as the most common source of disability experienced by individuals five years of age and older, with 10-25% of all youth experiencing mental health challenges (Health Canada, 2002; United States Public Health Service, 2000). The consequence of not treating psychological disorders in childhood has significant long-term implications not only to the individual and their family, but also to society (Bratton, Ray, Rhine & Jones, 2005; Health Canada, 2002). The United States Surgeon General and Health Canada have both identified a lack of access to child mental health services as a concern, highlighting that only 1 out of 5 children in need of mental health services, actually receives treatment (Health Canada, 2002; U.S. Public Health Service, 2000). Play therapy is widely recognized as an effective mental health intervention for children that can be responsive to both a child's unique developmental stage and their specific mental health needs (Bratton et al., 2005).

In the late 1990's the newly created Association for Play Therapy (APT) provided a definition of play therapy to help guide the developing field:

> the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients

> prevent or resolve psychosocial difficulties and achieve optimal growth and development (Association for Play Therapy, 1997).

Building upon this initial definition of play therapy, O'Connor (2000) provides an oft repeated definition that further incorporates a practical goal of play therapy:

> Play therapy consists of a cluster of treatment modalities that involve the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development and the re-establishment of the child's ability to engage in play behaviour as it is classically defined (p.7).

Play therapy is an approach to psychotherapy that is typically utilized with child clients under the age of twelve. Children in this age group may have a more limited ability to verbalize their thoughts and feelings, or to use abstract reasoning required in talk therapy (Piaget, 1962). It is through the medium of play that a therapist seeks to access the child's subjective world using toys, art, games, and other play that help the child to explore and express thoughts and feelings without words (Kottman, 2011). Landreth (2012) describes how the action of play is a developmentally appropriate form of reasoning and communication with a child where "toys are used like words by children, and play is their language" (Landreth, 2012, p.12).

Similar to the process of becoming a skilled adult therapist, in order to become a skilled play therapist, it is considered necessary to understand the theoretical framework of play therapy, develop the therapeutic skills and techniques specific to play therapy, and then refine this skill set under the supervision of a trained play therapy professional (Kottman, 2011). Play therapy is different than adult therapy, requiring skills not typically found in other therapeutic mediums

(Landreth, 2012; Van Velsor, 2004). Landreth (2012) highlights these skill differences and argues that even the most experienced and effective adult therapists will often have great difficulty transferring their therapeutic skills to play therapy with children.

In play therapy it is necessary for the therapist to engage with the child through play, while also making conscious decisions throughout the session that integrate theoretical knowledge and the needs of the child into all client interactions (O'Connor, 2000). The overarching process goal for the therapist is to develop a strong therapeutic relationship with the child while engaging with the child in activities that are satisfying, flexible, and respect the child's natural way of being in the world (O'Connor, 2000). By allowing the child to play in a way that is natural for them, the child's challenges may be represented and addressed through play (O'Connor, 2000).

History and Development of Play Therapy

The origins of play therapy have largely been attributed to Sigmund Freud because of the case study he published highlighting how he helped his patient 'Little Hans' overcome a debilitating fear of horses (Freud, 1909). Prior to Little Hans, Freud had only treated adult patients, although he had become interested in the phenomena of children repeatedly enacting difficult experiences through play activities (Johnson, 2016). He felt it was through this repetition that the child was able to regain a sense of control in their world (Johnson, 2016). While Freud is considered a theoretical influence on play therapy, having brought elements of observation and analysis to the field, he did not directly work with Little Hans, and instead all instruction and direct interactions were undertaken by the boy's father (Johnson, 2016).

Play therapy thereafter emerged as a psychoanalytic variant. Hermine Hug-Hellmuth (1921) was one of the first to use the name "play therapy" in the published literature. She also

provided an early description of how play could be used to more fully explore and understand the various symptoms that a child may present with in therapy, arguing that play was a natural mechanism for developing a relationship with the child (Johnson, 2016). Sigmund Freud's daughter, Anna Freud, began incorporating elements of play into child therapy sessions in the 1920's (Kottman, 2011). After rapport was established through play, Anna Freud would shift the focus of the sessions to engage with the child more verbally and introduce analysis, with the goal of promoting insight through their dialogue (Kottman, 2011). Melanie Klein (1932) also significantly helped develop the field of play therapy, and it was through her work that play was understood to be the preferred symbolic language of a child (Johnson, 2016). It was Klein who highlighted the importance in selecting various toys and materials for the playroom to help engage in dialogue with children (Johnson, 2016).

Throughout the 1930's and 1940's a variety of more relational therapeutic orientations were created, including Carl Rogers developing person-centered therapy for adult clients. Virginia Axline, a student of Rogers, collaborated with him in describing the use of non-directive techniques with a child client (Axline & Rogers, 1945). Axline (1947; 1964) continued to apply the principles of person-centered therapy with her child clients and subsequently became known as the “mother of play therapy” (Johnson, 2016). Her non-directive approach built upon the person-centered therapeutic relationship and has strongly influenced contemporary play therapy such that today, regardless of the orientation of the play therapist, the relationship between therapist and child client is considered a necessary requirement for successful therapy (Kottman, 2011). It is from these diverse beginnings that play therapy has now been established as an effective treatment for children struggling with a variety of behavioural and emotional challenges

(Bratton & Ray, 2000; Bratton et al., 2005; Ray, Schottelkorb & Tsai, 2007; Tyndall-Lind, Landreth & Giodano, 2001).

Contemporary Play Therapy

Similar to adult therapy, play therapy is a psychotherapy medium that can be conceptualized in various ways depending on the theoretical orientation the play therapist follows. Broadly speaking, all orientations to play therapy can be grouped into one of two categories: non-directive and directive (Kottman, 2011). Non-directive approaches generally follow the lead of the child; allowing the child to decide what toys to engage with and what topics to address (Kottman, 2011). Non-directive approaches consider the child to be the leader in the session while the therapist follows (Kottman, 2011). Some of the therapeutic orientations that fall under this category are child-centered play therapy (CCPT), also called humanistic play therapy, psychoanalytic play therapy, and Jungian play therapy (Kottman, 2011).

In directive play therapy the therapist takes the lead of the sessions and makes decisions regarding what tasks might be undertaken (Kottman, 2011). Based on the therapist's judgment of what topics the child may need to work on, the therapist decides what toys will be played with, how the toys will be utilized, and topics of conversation to be broached in the play therapy session (Kottman, 2011). Therapeutic play orientations that typically fall into this category are cognitive-behavioural play therapy (CBPT), Adlerian play therapy, gestalt play therapy, and theraplay (Kottman, 2011).

Schaefer and Drewes (2011) define three necessary stages that occur within the contemporary play therapy process, regardless of the orientation that a therapist brings to play therapy. The first is rapport building, where the therapist and child co-create an environment of safety and trust. The second is the working-through stage where the therapist uses various

interventions depending on the needs of the child that address themes and topics being enacted within the play therapy session (e.g., aggressive behaviours, fear, or a need for control). The final stage of play therapy is termination, which allows the child and family to take ownership of changes that have occurred, and prepare for life after therapy (Schaefer & Drewes, 2011).

The Play Therapist

Virgina Axline developed a theory of non-directive play therapy using her own experience as a play therapist as a guide. She identified successful play therapists as having the qualities of (1) an attitude of respect and acceptance toward the child, and (2) a highly developed ability to remain fully alert to feelings the child is expressing through their words or play (Axline, 1947).

Garry Landreth (2012), one of today's leaders in play therapy and play therapist training, argues that key elements of successful outcomes in play therapy are tied to therapist characteristics such as liking children, having respect for children, having a sense of humour and a sense of playfulness, self-confidence, self-awareness, flexibility, acceptance and sensitivity to the child, an ability to set boundaries, and openness to feedback. As intuitively obvious as these elements appear to be, they are based upon his own personal experiences working with children in play therapy and teaching play therapy to student clinicians; little research data is currently available to support his views.

In a further step exploring the necessary qualities of play therapists, Nalavany and colleagues (2005) undertook an exploratory study where they concept-mapped the qualities and competencies that make up a "good" play therapist. Collecting qualitative and quantitative data from 28 experienced play therapists, they identified seven therapist qualities, competencies, and skills that these professionals felt are required for effective play therapy outcomes (Nalavany,

Ryan, Gomory & Lacasse, 2005). Ranked from most to least important these are: being sensitive to the child, having a professional attunement to the child, use of a structured approach to treatment, use of foundational skills, therapist knowledge development, theoretical understanding of child therapy, and skills with the family (Nalavany et al., 2005).

Play Therapy Effectiveness

Similar to adult therapy, the overall effectiveness of play therapy has been solidly established through numerous research studies. Play therapy research dates back to the 1940s, and provides substantial empirical support for the effectiveness of play therapy as an intervention with children through both qualitative and quantitative research studies (Ray & Bratton, 2010). A comprehensive review by Bratton and Ray (2000) examined specifics of the individual play therapy studies completed during the previous decades, and found that play therapy research peaked in the 1970s, and has subsequently tapered off from that point forward (Bratton & Ray, 2000). The review highlighted that over 100 of the research studies were case studies typically conducted by the therapist, and 82 involved an individual or group exposed to a play therapy intervention whose outcomes were compared to a control individual or group (Bratton & Ray, 2000). The median number of therapy sessions individuals participated in was 12, and participant ages ranged from 3-17 years (Bratton & Ray, 2000). For the review, Bratton and Ray (2000) focused on the inclusion of studies that were specifically labeled play therapy, and noted that many of the interventions used were designated as nondirective treatment protocols. The majority of the studies included assessments measuring social maladjustment, with those conducted earlier than the 1970s also typically including measures assessing intelligence and school achievement, while studies after the 1970s focused more on measuring maladaptive school behavior, self concept, and anxiety (Bratton & Ray, 2000). The review included nearly

200 individual play therapy research studies and highlighted that positive outcomes related to play therapy were reported across a vast array of areas of functioning, including: social and emotional maladjustment, withdrawn behavior, aggression, maladaptive school behavior, anxiety and fear, sexual abuse domestic violence, depression, post-traumatic stress, divorce, and alcohol or drug abuse (Bratton & Ray, 2000). In their review, Bratton and Ray (2000) did note some limiting factors of the body of existing research including small sample sizes, and studies not clearly identifying the treatment protocol used. While the review was an extensive examination of the state of play therapy research, it is important to note that hundreds of additional play therapy studies utilizing any other type of treatment providers or including any parental involvement were not included within the review (Bratton & Ray, 2000).

Meta-analysis is a procedure that helps statistically synthesize individual research study results and provides additional clarity when considering outcomes of large bodies of research. This process of meta-analysis has found that play therapy has an effect size of 0.80 (Bratton et al., 2005; LeBlanc & Ritchie, 2001). This is considered to be a large effect size, and indicates that the average child who receives play therapy is better off than 79% of individuals who do not receive play therapy (Bratton et al., 2005; LeBlanc & Ritchie, 2001), a result identical to adult therapy effectiveness (Wampold & Imel, 2015). These various meta-analytic studies included and amalgamated the decades of results from hundreds of play therapy research studies, and further refined our understanding that play therapy is effective in treating a variety of specific challenges faced by children including depression, anxiety, social maladjustment, externalizing behaviour, aggression, and difficulties in self-esteem (Bratton & Ray, 2000; Garza & Bratton, 2005; Ray et al., 2007; Shen, 2002; Tyndall-Lind et al., 2001). Bratton and colleagues (2005) also highlighted an interesting finding in their meta-analysis that has not been found in meta-

analyses of adult psychotherapy: Nondirective play therapy is associated with slightly larger effect sizes than directive play therapy. Bratton and colleagues (2005) specifically identified and categorized 85 research studies, 73 of which were coded as "Humanistic-nondirective" and 12 that were coded "Nonhumanistic-directive". Effect size for the humanistic-nondirective studies was 0.92, while the effect size for the nonhumanistic-directive research studies was 0.71 (Bratton et al., 2005). Bratton and colleagues (2005) conclude that these outcomes exhibit that both nondirective and directive play therapies are effective, with nondirective interventions having a notably larger effect size. Bratton and colleagues (2005) additionally note that while they can comfortably state that play therapy is in fact effective, due to the significant mis-match in the number of studies included in the humanistic and nonhumanistic groups (73 versus 12), that some caution should be applied when parsing the differences in results between these two groups.

Play Therapy Effectiveness for Specific Presenting Issues

The use of meta-analysis as a tool to help conceptualize research within a field of study such as play therapy, has been infinitely helpful. One of the challenges that has been identified within the meta-analysis process is the practice of collapsing different outcome measure effect sizes into one single study effect size (Jensen et al., 2017). This calculation of one over-arching effect size per research study can mask significant variability that may be occurring in different outcome measures within the study. For example, a research study exploring the effects of play therapy on a child's aggressive behaviours may also collect additional outcome data, perhaps a measure assessing anxiety levels. While both measures may be represented within the collapsed study effect size, specifics of each of these outcomes may become lost. For clinicians, having a greater understanding of these detailed outcomes of play therapy that are specific to different

child challenges, may be critically helpful in treatment planning and client care. The following section consists of an up to date review of literature highlighting and identifying various high quality play therapy research studies and their identified treatment benefit effects. An additional review highlighting some current trends observed within the broader field of play therapy research is also provided and briefly discussed.

A systematic review completed by Drisko and colleagues (2020) specifically explored the effectiveness of play therapy and examined play therapy outcome studies that used the highest standard of research design: randomized control trials (RCT). The systematic review was completed to specifically evaluate whether the body of existing play therapy research literature from 1980 to 2018 meets the criteria for play therapy to be considered a research supported treatment (Drisko et al., 2020). While their initial pool included 5,485 individual studies, after utilizing the rigorous standards regarding treatment outcome research set by The Cochrane Collaboration (Higgins & Green, 2011), 17 studies were found to have met the standards of inclusion (Drisko et al., 2020). The results of the systematic review presented treatment outcome effect sizes for six distinct categories of often seen challenges in child clients: aggression, attention/ADHD, anxiety, externalizing behaviours, internalizing behaviours, and trauma symptoms (Drisko et al., 2020).

Aggression

Five studies that reported seven measures of aggression were included in the systematic review of aggression outcomes (Drisko et al., 2020). The range of individual child aggression outcome measure effect sizes ranged from 0.22-2.27, and the date range for these five studies was from 2004 to 2017 (Drisko et al., 2020). The study that reported a small effect size of 0.22, was a study that included a once a week 30 minute play therapy session, that continued for a

maximum of 15 sessions with children aged 5-9 (Schumann, 2004). This study looked specifically at aggressive and other disruptive behaviours within the classroom among children who had previously been identified in their schools as being aggressive, and included a sample size of 37 ethnically diverse children (Schumann, 2004).

The largest effect size within this category was 2.27 and was found in a research study that provided twice weekly 30 minute games-based play therapy sessions over the period of 4 weeks with children aged 4-5 (Sezici et al., 2017). This study consisted of preschool aged children in the largest kindergarten school in Kutahya, Turkey, and parents volunteered their child's participation in the study (Sezici et al., 2017). The children included a range of low, medium, and high income families and the children were not identified prior to the study as having any specific social, emotional or behavioural challenges (Sezici et al., 2017).

The overall average of effect size for the seven individual measures reporting aggressive outcomes was 0.79, which nearly meets the 0.80 criteria to be considered a large effect size. Every one of these included studies did meet rigorous validity and reliability criteria standards to be included in this systematic review however, it should be noted that the five studies included samples from many different countries including the United States, Australia, and Turkey. Additionally, diverse settings where counselling was provided (school setting, private practice clinic) as well as the timing of treatment varied considerably, and may help provide some explanation for the large range of effect sizes seen within the aggressive outcome subgroup.

Attention/ADHD

A total of five studies that reported six attention/ADHD outcome measures were included in the systematic review with individual attention/ADHD outcome measure ratings effect sizes ranging from 0.33 to 1.94 (Drisko et al., 2020). The five research studies included were

published between 2007 and 2016. The study that showed the smallest effect size, 0.33, was from a study using 30 minute play therapy sessions for a total of 16 sessions with 60 children aged 5-11 who teachers identified as struggling with ADHD symptoms (Ray et al., 2007). This study had a play therapy experimental group as well as a reading mentor group but did not contain a no-treatment control group which was identified as a limitation of this particular research study (Ray et al., 2007).

The largest effect size within the attention/ADHD category was 1.94, which meets the criteria to be considered a large effect size (Naderi et al., 2010). This research study provided one hour play therapy sessions for a total of 10 sessions that occurred over a period of 4 months (Naderi et al., 2010). The children who participated in this research lived in Ahwaz, Iran, had been clinically diagnosed with either anxiety or ADHD, and were between the ages of 8-10 (Naderi et al., 2010).

The overall average of effect size for the six measures reporting attention/ADHD outcomes was 0.85, which meets the 0.80 criteria to be considered a large effect size. Every one of the studies met the rigorous criteria to be included in this systematic review, with only one study reporting a statistically significant small effect size, three studies reporting medium effect sizes, and two studies reporting large effect sizes in attention/ADHD outcomes. There was large variability in population used in these research studies, as well as the settings where counselling was provided (school setting, private practice clinic) and may help provide some explanation for the large range of effect sizes seen in this subgroup of research studies.

Anxiety

A total of seven studies that reported nine anxiety outcome measures were included in the systematic review of anxiety outcomes (Drisko et al., 2020). The nine individual anxiety measure

effect sizes ranged from 0.18 to 2.73 and the dates for the seven studies included studies dating back to 1997 up to 2017 (Drisko et al., 2020). The study that showed the smallest effect size 0.18 was a 30 minute, twice a week play therapy session in which 12-16 sessions occurred over an 8 week period (Stulmaker & Ray, 2015). The participants were children aged 6-8 who were identified by school personnel as having heightened anxiety symptoms prior to participation in the research study (Stulmaker & Ray, 2015). This study reported the smallest effect size, 0.18, that was included within the entire systematic review, however it should be noted that this result came from a measure specifically assessing for social anxiety symptoms, not anxiety more generally (Stulmaker & Ray, 2015).

The largest effect size of 2.73 was not only the largest effect size found in the anxiety subgroup, but was also the overall largest effect size reported in any of the 17 studies included in the entire systematic review (Drisko et al., 2020). This was reported in a research study that provided one hour play therapy sessions for a total of 10 sessions that occurred over a period of 4 months (Naderi et al., 2010). The children who participated in this research were between the ages of 8-10, lived in Ahwaz, Iran and had been clinically diagnosed with either anxiety or ADHD prior to the study (Naderi et al., 2010).

The overall average effect size for the nine measures reporting anxiety outcomes was 0.794, which almost meets the 0.80 criteria to be considered large. All of the included studies met the criteria to be included in the systematic review. Culturally diverse samples (North America, Iran, Turkey) and diverse settings where counselling was provided (school setting, private practice clinic), occurred amongst the seven research studies. Additionally, there was also a tremendous diversity between the studies regarding the origins of the anxiety children were

experiencing (school anxiety, parents divorcing, medical anxiety) which may help to explain this extreme range of effect sizes that was found within the anxiety outcomes subgroup.

Externalizing Behaviours

Externalizing behaviors are those that interfere with the rights and boundaries of other individuals and can be a symptom of more significant underlying problems (Abidin & Robinson, 2002). They are characterized by a difficulty in controlling emotions, which is often reflected in challenges with interpersonal relationships, and behaviours may include: aggression, rule-breaking, destruction of property, disruptive off-task behaviours, or verbal insults (Meany-Walen et al., 2014). A total of four studies reporting six measures examining externalizing behaviour outcomes were included in the systematic review with externalizing behaviours outcome measure effect sizes ranging from 0.26 to 0.98 (Drisko et al., 2020). The dates for the four studies included ranged from 2004 to 2017.

The study that showed the smallest effect size of 0.26 was a twice weekly, 30 minute play therapy session occurring in the school for a total of 14-17 sessions (Meany-Walen et al., 2014). The study included 58 participants aged 5-9, and utilized an Adlerian play therapy experimental group and compared results to a reading mentoring control group (Meany-Walen et al., 2014). The study found that there was a statistically significant, albeit small effect size reduction of child disruptive behaviors for those children assigned to the play therapy experimental group while the reading mentoring control group actually showed an increase in externalizing behaviours (Meany-Walen et al., 2014).

The largest effect size of 0.98 within the externalizing behaviour category was found in a research study that provided intensive child centered play therapy (CCPT) for 30 minute sessions twice daily, for a total of 20 completed sessions (Ritzi et al., 2017). The children who

participated in the study were aged 6-9, located in Darwin, Australia, and were identified as having problematic externalizing behaviours (Ritzi et al., 2017). This study reported statistically significant improvement in children who participated in the CCPT compared with children in the waitlist control group from the perspective of both parent and teacher reports (Ritzi et al., 2017).

Internalizing Behaviours

Internalizing behaviours are characterized by behaviours held within the individual and includes challenges such as: depression, withdrawal, and somatic symptoms (Ray et al., 2015). Surprisingly, even though there has been a large body of research completed on play therapy and internalizing behaviours in children, only one study, a doctoral dissertation, met the criteria for inclusion in the systematic review. The study utilized 30 minute sessions, once a week for a total of 12-15 sessions and the children that took part in this study were aged 5-9 (Schumann, 2004). This study included two different measures of internalizing behaviour outcome ratings (Drisko et al., 2020). These internalizing behaviours effect sizes ranged from 0.49 to 0.78 using teacher and parent reports of the Behavioural Assessment System for Children (BASC) measure (Schumann, 2004). The overall average of effect size for internalized behaviours was 0.64, which meets the criteria for a moderate effect size (Drisko et al., 2020). Since only one research study was included in the internalizing behaviours category, the two assessments were measuring the same research participants; this may help to explain the lack of range and relatively consistent findings between these two effect sizes.

Trauma Symptoms

Although there are numerous research studies looking at the effects of play therapy on trauma symptoms, again, only one study met the requirements to be included in this systematic review (Drisko et al., 2020). This study by Schottelkorb and colleagues (2012) examined Post-

Traumatic Stress Disorder (PTSD) symptoms of refuge children, and reported the smallest effect size being 0.39 and the largest effect size being 1.1 (Drisko et al., 2020). This study provided twice weekly, 30 minute sessions over a twelve week period for a total of 24 sessions (Schottelkorb et al., 2012). The children participating in this study were between the ages of 6-13, and were refugees from a variety of regions (Africa, Middle East, Asia, Europe), now living the United States at the time of the research (Schottelkorb et al., 2012). The study specifically looked at the efficacy of using CCPT for trauma, relative to the more traditionally used trauma focused cognitive behavioural therapy (TF-CBT), a modality that has already been identified as an evidence-based intervention and is often used for trauma therapy (Schottelkorb et al., 2012). Results reported that both groups demonstrated a significant decrease in severity of PTSD symptoms from the time of the initial baseline assessment to the follow-up assessment and that there were no differences found between the CCPT and TF-CBT groups (Schottelkorb et al., 2012). The results of this study suggest that both CCPT and TF-CBT are equally effective interventions for helping to treat symptoms of PTSD, and since CCPT is a highly hospitable modality for children, CCPT may provide a more developmentally appropriate treatment for children struggling with PTSD (Schottelkorb et al., 2012).

In their discussion of the systematic review, Drisko and colleagues (2020) highlighted that the 17 studies reviewed met the diligent requirements to be included, and overall the field of play therapy did meet the criteria to be considered a research supported treatment. However, in reviewing the overall body of literature they did also categorize the quality of play therapy research in general to be low to moderate (Drisko et al., 2020). Numerous challenges within the literature were identified, including a tremendous variability of measures used to assess symptoms, and the lack of use of wider-ranging measures which would allow a more rigorous

capture of both the intended treatment effects as well as the assessment of possible unintended treatment effects (Drisko et al., 2020). They also noted a lack of follow-up studies examining how treatment timing and number of sessions may impact effectiveness, as well as a lack of information regarding follow-up measures of effectiveness (Drisko et al., 2020). They identified that while play therapy can be considered effective when a course of treatment ends, how long this impact lasts has not yet been examined and would be a beneficial topic for future study (Drisko et al., 2020).

Current Trends in Play Therapy Research

In order to better understand where existing play therapy research is occurring and areas where research may be lacking, Yee and colleagues (2019) completed a 10 year content analysis of publication trends within the field of play therapy (Yee at al., 2019). The quality of the research was not considered, and instead it serves as an inspection of the current state of research, and highlights the direction that the body of play therapy literature as a whole is heading. The content analysis included 206 articles on play therapy that were published in one of four prominent journals focussed on children and counselling between the years 2008 and 2017 (Yee at al., 2019).

After coding key words of the included 206 articles, seven themes emerged within the body of play therapy literature examined: (a) theory/approach, (b) teaching/ training, (c) supervision, (d) play therapy critique or meta-analysis, (e) parenting, (f) assessment or scale development, and (g) ethics (Yee at al., 2019). The first theme, theory/approach taken, included 92 articles with 63% of the publications being research articles and 37% instead being theoretical, non-research based articles (Yee at al., 2019). Within the theory/approach category the most frequently examined/utilized play therapy modality was CCPT and it was identified as

the focus in 32 of the 92 articles (Yee at al., 2019). The second theme identified referred to play therapy teaching/training where 74 articles were focused on the teaching and training of play therapy (Yee at al., 2019). The third theme, supervision, included 11 articles related to supervision in play therapy (Yee at al., 2019). Ten articles made up the fourth category, critiques/meta-analysis, which reviewed existing play therapy literature (Yee at al., 2019). Seven articles were included in the fifth category, parenting, and covered a range of both research and non-research articles focused on general parenting practices and parent-child interactions (Yee at al., 2019). The sixth category, assessment and scale development, included eight articles focusing on the creation of new measures or the further development of existing assessments utilized in play therapy (Yee at al., 2019). The final category, ethics, included four articles and dealt with broad ranging categories such as best-practices, ethical decision making and values exploration for play therapists (Yee at al., 2019).

Yee and colleagues (2019) identified that a current trend in play therapy publication is an increasingly predominant exploration and utilization of CCPT for a variety of broad ranged child challenges. The authors also highlight that for the total body of publication, only 47% of the articles were research reports (Yee at al., 2019). One surprising finding from their content analysis was the lack of multicultural considerations related to play therapy (Yee at al., 2019). Only 16% of the 206 articles were identified as including a multicultural research sample or addressing multicultural challenges within their topic of publication (Yee at al., 2019).

An additional layer of analysis was also completed to ensure the most recent play therapy articles have also been considered. Articles published within the International Journal of Play Therapy from 2018-2021 were categorized and briefly examined to identify any other discernible trends in the years since the systematic review and content analysis were completed. One noted

trend is a continuation of the exploration of CCPT with 26 of the 96 articles published in the International Journal of Play Therapy between 2018 and 2021 naming CCPT as the focus of their research. CCPT was overwhelmingly the most-often researched modality of play therapy, with 27% of all published studies during that time specifically focussing on CCPT. CCPT was identified as the play therapy modality of choice for research with a variety of very specific populations, for example, using CCPT with children experiencing diabetes, the use of CCPT with children exhibiting behavioural challenges, or using CCPT with children who have experienced pediatric medical trauma.

Two additional highlights were also noted: there was a considerable rise in studies looking at autism and play therapy published in the International Journal of Play Therapy during the 2018-2021 timeframe, with 7 articles being published during that time. This is a significant increase when compared to the previous 4-year span of 2014-2017 when only 2 studies that focused on play therapy and autism were published in the International Journal of Play Therapy. As well, there was a noticeable shift in the literature published in the International Journal of Play Therapy specifically within the realm of child trauma in the 2018-2021 timeframe. Beginning in 2018, articles began to specifically highlight adverse childhood experiences (ACES) as part of child trauma, with six publications referencing ACES and childhood trauma in their titles by the end of 2021. Review of International Journal of Play Therapy articles from 2010 to 2017 highlights that while there were numerous studies examining child trauma during this earlier time frame, there were no research studies that specifically identified ACES and play therapy in their research title.

Mechanisms of Change in Psychotherapy

Despite the fact that psychotherapy and play therapy have been established as being effective for the majority of clients who partake in them, the question remains as to what is it about psychotherapy and play therapy that results in client change? At this point in time we know more about the mechanisms of change in adult therapy than we do about these mechanisms in play therapy.

Adult Therapy

While we have come to understand that therapy works for most clients, the mechanisms of change of psychotherapy continues to be a subject of ongoing research. As previously noted, there have been thousands of studies looking at the outcomes of psychotherapy, and meta-analyses of these studies have been performed examining the effectiveness of therapy (Lipsey & Wilson, 1993; Smith, Glass & Miller, 1980; Wampold 2001; Wampold & Imel, 2015). However, there is far less research studying the process of therapy to better understand what is actually occurring via therapy that helps to create positive client outcomes.

Historically, research in the field of therapy has been heavily influenced by what is considered the "gold-standard" of medical research: randomized controlled trials (Wampold & Imel, 2015). The influence of the medical model of matching treatment to diagnosis also motivated psychotherapy research (Wampold & Imel, 2015). In an attempt to explain and understand why talk therapy worked, proponents of the various therapeutic orientations produced models explaining and research demonstrating how their approach to therapy worked for different psychological problems (Wampold & Imel, 2015). For example, client change in psychodynamic psychotherapy is said to occur through insight into the unconscious via the process of the therapist interpreting the client's free associations. Alternately, change in person-

centered psychotherapy is said to occur through self-actualization when the client experiences a therapist's genuineness, unconditional positive regard, and accurate empathy. From these and a variety of other different therapeutic approaches, came the need to demonstrate their efficacy for various different psychological problems (Wampold & Imel, 2015). As Norcross and Newman (1992) state:

> Rivalry among theoretical orientations has a long and undistinguished history in psychotherapy, dating back to Freud. In the infancy of the field, therapy systems, like battling siblings, competed for attention and affection in a 'dogma eat dogma' environment...Mutual antipathy and exchange of puerile insults between adherents of rival orientations were much the order of the day (p.3).

Proponents of each of the theories provided proof and support that their methods worked. As an early voice against the feuding and rivalry between theories, Saul Rosenzweig noted that regardless of what therapy a client received, the outcomes appeared quite similar (Rosenzweig, 1936). It was he who first evoked the Dodo bird metaphor from Alice in Wonderland: "Everybody has won and all must have prizes" (Rosenzweig, 1936). This astute view recognizing that since all psychotherapy produced similar results, they might do so by way of factors common to all forms of therapy, regardless of the specific orientation of the therapist (Wampold & Imel, 2015).

Jerome Frank elaborated upon this "common factors" explanation in his *Persuasion and Healing* books from the 1960's onward. Once treatments were found to be effective, component studies were designed to help identify imperative and necessary elements of treatment, and these studies further supported the concept of common factors being present in therapy (Lambert 2013; Lambert & Ogles, 2004). Common factors explanations of psychotherapeutic effectiveness have

had varying degrees of popularity, waxing and waning depending on the reputation of the popular theoretical orientations at the time (Wampold & Imel, 2015). Typical components embodied in common factors explanations include hope, expectation, the therapeutic relationship, belief, and a corrective experience (Wampold & Imel, 2015).

Today, there is renewed interest regarding a common factors explanation of therapy. One of the latest versions is Wampold's Contextual Model (Wampold & Imel, 2015). The contextual model posits that there are three pathways that can occur in psychotherapy to help produce client change (Wampold & Imel, 2015). These pathways all have the ability to create change separately, and when they are all active the potential for change is amplified (Wampold, 2015). The contextual model recognizes the fundamental nature of humans as being a social species and that healing occurs through connection with other individuals (Wampold, 2015). One of the benefits of considering the contextual model is that it has the ability to identify the role and impact that both the therapist and client have in the therapeutic process, in addition to the specific actions of treatment (Wampold & Imel, 2015). In previous research that focused only on the treatment, client or therapist effects were lost, rather than incorporated (Wampold & Imel, 2015).

The three pathways in the contextual model are: 1) the real relationship, 2) expectation created by explaining the problem and treatment, and 3) engagement in health-promoting activities (Wampold & Imel, 2015). By way of developing the real relationship, an initial bond between the client and therapist is built on trust (Wampold, 2015). Once this bond is formed, the real relationship between therapist and client, that includes genuineness and experiencing the other, allows for a social connection with an empathic individual (Wampold, 2015). The next pathway, expectations, includes the client's understanding of why they are having difficulties

(Wampold, 2015). Therapy provides the client with an explanation of their difficulties and a means for overcoming them (Wampold, 2015). The final pathway, health-promoting activities, includes actions that are acceptable to the client and that the client believes will be helpful in overcoming their difficulties (Wampold, 2015). For example, if a client is struggling with low self-esteem, self-compassion exercises can help the client become aware when they are being hard on themselves and be able to reduce or eliminate their self-criticism in the moment.

Play Therapy

Play therapy research is following suit with adult therapy research in attempting to better identify how play therapy works. Similar to the numerous theoretical orientations found within adult therapy, play therapy also has a variety of different therapeutic orientations (e.g., cognitive behavioural, child-centered, psychoanalytic). As with adult therapy, each of these theories has articulated how change is conceptualized, and how different change mechanisms help elicit change for the child. For example, a therapist following a cognitive behavioural play therapy orientation would focus on the thoughts and behaviours of the child, while a therapist following a child centered play therapy orientation would provide the three core conditions of unconditional positive regard, accurate empathy, and genuineness.

Comparable to the call within adult therapy to recognize common factors, in the mid-nineties Prochaska (1995) suggested a transtheoretical orientation also be adopted within the field of play therapy. Prochaska recommended that play therapists conceptually ground themselves in a particular orientation, while also utilizing specific interventions that target the challenges of the child, rather than be selected based on their being congruent with the theoretical orientation of the therapist. Within this transtheoretical model is the inherent belief that each of the major theories of play therapy share common therapeutic change factors (Drewes

& Schaefer, 2016). When more of these change factors are mastered and used by the play therapist, they are able to more effectively help the child (Drewes & Schaefer, 2016). Examples of some of the proposed therapeutic change factors include: a) facilitating communication (e.g., self-expression, self-understanding), b) fostering emotional wellness (e.g., stress inoculation, abreaction), c) enhancement of social relationships (e.g., empathy, social competence), and d) increase personal strengths (e.g., problem solving, self-regulation) (Drewes & Schaefer, 2016). The implication of the transtheoretical model and subsequent models such as integrative play therapy is that there are more similarities than differences occurring within the various play therapies (Drewes & Schaefer, 2016). And while specific interventions may be helpful, it is these four broader categories of communication, emotional wellness, social relationships, and personal strengths that are the key elements to successful play therapy. The creation of this transtheoretical model provided a theoretical foundation to considering a common factors approach to play therapy. However, the question remains: What are the actual change mechanisms occurring in the process of play therapy that help to create client change?

Research exploring the change mechanisms of play therapy is far more limited than for adult therapy. Initial research suggests that one common factor, the therapeutic alliance, is the most predictive of positive client outcomes in both adult and youth clients (Horvath & Bedi, 2002; Shirk & Karver, 2003). However, to date we do not know if this is the case for child clients. As well, when researchers examine a topic like the therapeutic alliance, what specific factors are they studying? Shirk and Karver's (2003) meta-analysis of youth and family mental health research highlighted a problem in the current state of youth common factors research; almost every study included in the meta-analysis used a different definition and measurement of components perceived to be crucial to the therapeutic relationship.

Karver and colleagues (2005) created a theoretical model of common factors in youth and family therapy describing how various aspects of the therapeutic relationship interact and affect outcomes. This model hypothesizes the importance of relationship building as well as specific therapist factors such as self-disclosure and direct influence, and client factors such as autonomy and hopefulness (Karver, Handelsman, Fields & Bickman, 2005). The model also highlights a need to more clearly define and understand the terms therapeutic relationship and therapeutic alliance, given that at least three different constructs may be involved: emotional connection (the affective bond with the therapist), cognitive connection (hopefulness about treatment or a willingness to participate), and behavioral participation in sessions (Karver et al., 2005). The authors recommend that these constructs, their relationships with one another, and their unique impact on outcomes need to be clarified before the therapeutic relationship/alliance common factor can be fully understood (Karver et al., 2005).

Kazdin and Nock (2003) highlight the crucial need to identify the mechanisms of change in child and adolescent therapy to help better discern how therapy works and understand the impact of treatment on children. In exploring the state of change mechanisms in play therapy, they accentuate how neglected the topic of change mechanisms with children has been, and remains to be, in current research. They also specify that the expansion of change mechanism research findings is critically important to the field of psychotherapy to help improve client care and ensure these key features that promote change are generalized to clinical practice (Kazdin & Nock, 2003). In fact, in the most recent edition of the *Handbook of Play Therapy* (2016), Drewes and Schaefer explicitly state:

> A greater understanding of change agents is of vital importance to play therapists...we need to substantially expand the number of play therapy process

> research studies in order to further identify and validate the specific therapeutic powers of play (p.55).

Process Research

The central focus of process research is the examination of the elements within therapy that allow or create therapeutic change (Hardy & Llewelyn, 2015). Lambert and Hill (1994) provide a foundational definition of process research and describe how the research 'addresses what happens in psychotherapy sessions, examining variables such as therapist behaviours, client behaviours, and interactions between therapists and clients during treatment' (Lambert & Hill, 1994). Many within the field of play therapy are calling for much more information about how play therapy is effective (Drewes, Bratton & Schaefer, 2011; Drewes & Schaefer, 2016; Kazdin & Nock, 2003). We know from individual outcome studies and meta-analyses that play therapy is effective. However, a necessary next step is a deeper exploration of the process of play therapy. It is now imperative to understand what in the therapeutic process is helpful. As a call to future research, Shelby and colleagues (2016) state:

> Play therapy process research is needed to clarify what it is about play that achieves positive outcomes, including mechanisms of change (i.e., how and why outcomes are produced) and specific factors (i.e., ingredients) or combinations of factors that produce change (p.565).

In the field of adult therapy, process research has explored the experience of the client (Binder, Holgersen & Nielsen, 2009; Carey et al., 2007; Higginson & Mansell, 2008). In the field of play therapy, however, studies exploring the experience of the child and the parent are only just emerging (Bach, 2017; Carroll, 2002). While there have been a few studies exploring the process of play therapy, these studies have been based on the experiences of the therapist or

the researcher observer (Hurlburt, Garland, Nguyen & Bookman-Frazee, 2010; Schottelkorb, Swan, Garcia, Gale & Bradley, 2014). Considering these previous studies, an interesting phenomenon has been found in counselling psychology research where there is often a difference in perception between the client and the therapist regarding what created change (Maione & Chenail, 1999). Recognizing this, it becomes even more important to consider the view of the client.

To date, play therapy research specifically looking at the process of therapy from the perspective of the child client has been minimal. Only two published studies have explored the child's experience of play therapy. Axline (1950) was the first to interview children about their experiences and perceptions of play therapy, and more recently Carroll (2002) undertook a study exploring children's experiences of play therapy. Carroll identified that while children were able to describe their therapists as ‘kind’ and ‘helpful’ they were not able to describe specific therapist qualities to illustrate that helpfulness such as the therapist being easy to talk to and willing to help (Carroll, 2002). Although all the child participants were convinced that play therapy had been helpful, and identified the relationship as being helpful, they were not able to articulate how help had been achieved (Carroll, 2002). One of the limitations of the study identified by Carroll (2002) is that it only explored the experience of the children. While Carroll had also gathered basic data from the therapists of the 14 child participants, she was so amazed by the richness of the children's stories that she elected to incorporate only minimal therapist data into the study.

Considering the process of play therapy through the eyes of the client is a tricky undertaking. Previous research has shown the importance of a collaborative relationship with parents (Holcomb-McCoy & Bryan, 2010), and Bratton and colleagues (2005) highlight that

parents feeling involved in the process of play therapy is a key element to positive child outcomes. Appreciating the special role in play therapy that parents hold, a recent unpublished Master's thesis by Bach (2017) provides an initial exploration into the perceptions of parents whose children experienced play therapy. This qualitative study found four major themes emerging: the therapeutic relationship, changes through the therapy process, outside influences on the therapy experience, and the role of culture (Bach, 2017). One of the limitations of the study identified by Bach (2017) was that she did not reach saturation of the data. As such, the author recommended that additional research be undertaken to gain a more complete understanding of the experiences of parents in the play therapy process (Bach, 2017).

Process research clearly demonstrates that clients do have developed views about what they find helpful about therapy. Their experiences can be invaluable to therapists in better understanding what factors of therapy clients find to be the most useful. As Miller, Duncan, and Hubble (1997) state, "the client is the unsung hero of psychotherapy" (p.34), and one of the interesting challenges in play therapy is that it can be considered to have two important clients: the child and the parent. Exploring the experience of play therapy from the perspective of each in the child/parent dyad promises to provide extensive and rich detail regarding how to provide helpful play therapy to these two very different client groups.

Future Research in Play Therapy

We can confidently state that therapy is effective for the majority of people who engage in it. We also know that play therapy is similarly effective for children. However, how and why therapy and play therapy is effective is still an area of research needing further exploration. Research investigating mechanisms of change in adult therapy has a rich history spanning decades including thousands of studies examining the role of common factors that occur in all

models of therapy. One of the most recent, the Contextual Model (Wampold & Imel, 2015) hypothesizes that it is via the three pathways of: 1) the real relationship, 2) expectation created by explaining the problem and treatment, 3) and engagement in health-promoting activities, that helps to promote client change (Wampold & Imel, 2015). These pathways all have the ability to create change separately, and when they are all active the potential for change is amplified (Wampold, 2015).

Similarly in the field of play therapy, a transtheoretical model of play therapy has been suggested (Drewes & Schaefer, 2016). Similar to engaging multiple paths in the Contextual Model, Drewes and Schaefer (2016) posit that when multiple change factors (e.g., communication, fostering emotional wellness, enhancement of social relationships, increasing personal strengths) are engaged and utilized by the play therapist, that is when client change occurs. However, there is much we still don't know about the process of play therapy.

Process research has been engaged extensively in studies exploring client change in adult therapy. Adult clients, the therapists themselves, as well as participant observers have participated in research studies to help explore what it is within the therapeutic process that helps to create client change (Binder, Holgersen & Nielsen, 2009; Carey et al., 2007; Higginson & Mansell, 2008). In the field of play therapy, the area of process research is further behind. While some process research within play therapy has occurred, much of it comes from the perspective of the therapist or independent observer (Hurlburt, Garland, Nguyen & Bookman-Frazee, 2010; Schottelkorb, Swan, Garcia, Gale & Bradley, 2014). Research of the therapeutic process has identified an important discrepancy which must be considered: often the therapist and the client have very different views about what was considered important for creating client change (Maione & Chenail, 1999). Given that the process of play therapy involves one therapeutic client

(the child) and an additional individual (the parent) who can also impact positive child outcomes (Bratton et al., 2005), future research including children and parental voices seems essential to better understand critical change processes occurring within play therapy.

While there have been some studies exploring child and parent perspectives of play therapy, the field would benefit if play therapy research was expanded to examine the experience of play therapy from both the perspective of the child client and the parent. At the moment, little is known about differences or similarities regarding what each individual in the dyad perceives to be helpful about play therapy. Knowing this would provide a unique and valuable addition to the play therapy literature. Examining these perspectives will allow exploration regarding the parallel experience of play therapy and also allow for a triangulation of data that has been missing in previous play therapy studies. Such research would also allow for a greater exploration of common factors in play therapy. From the perspective of both individuals in the child/parent dyad, do they identify common factors as being helpful, or do they perceive more specific interventions, or other different elements as being important mechanisms of change in play therapy? My study, exploring both parent and child perceptions of play therapy, aims to begin to fill this identified gap in existing research.

Chapter 3: Research Method

The area of research that this study examines is an exploration of both child and parent experiences of the process of play therapy. Specifically, the research question explored is: "What is the lived experience of play therapy from the perspective of both child and parent?" This chapter presents the process undertaken to decide to complete a qualitative research study, how this methodology provides a framework for answering the research question, and also describes the methods used to gather data for my study. Ethical considerations, as well as an exploration of validity and researcher assumptions, conclude this chapter.

Choosing a Methodology

Designing a research study begins with investigating how various methodologies and methods capture different facets of a research question. Crotty (1998) identifies four foundational questions to be considered: a) what *epistemology* informs the theoretical perspective, b) what is the *theoretical foundation* underlying the chosen methodology, c) what *methodology* informs the choice of methods, and d) what *methods* are proposed to be used? Epistemology is defined as the theory of knowledge that informs the theoretical perspective taken, which subsequently informs the methodology choice (Crotty, 1998). Theoretical foundation is defined as the philosophical perspective that informs the methodology (Crotty, 1998). Methodology is defined as the design providing the foundation behind the use of particular methods, and is tied to the desired outcomes of the study (Crotty, 1998). Methods are defined as the techniques utilized to both gather and analyze the research question data (Crotty, 1998). Exploring and understanding each of these questions helps the researcher to better appreciate and understand the impact each question has on their research choices, and the subsequent influence this will have on their desired research outcome.

Epistemology and Ontology

While Crotty (1998) contends that each of these four categories influences each other in a non-hierarchical manner, I have chosen to begin with the most expansive category, epistemology. Epistemology is a philosophy that provides the framework and context around how one understands the concept of knowledge in the world (Crotty, 1998). As a researcher, our personal perspective provides a structure around the type of knowledge that is possible to us, and what we are able to view as legitimate knowledge (Maynard, 1994). Crotty (1998) highlights three possible epistemological frameworks: objectivism, constructionism, and subjectivism. Each of these views helps to provide a framework about knowledge and provides individuals with different contexts of knowing. The epistemology of objectivism describes a theory of knowledge in which things possess truth and meaning intrinsically within them, and research can uncover and discover this singular truth (Crotty, 1998). The epistemology of constructionism describes a theory where all knowledge is socially influenced and created through the interaction of humans and the world (Crotty, 1998). Within constructionism, there are two additional refinements; social constructionism where the view is that our culture and the social relationships we engage in shape our perspective of knowledge, and constructivism which holds that the individual person's point of view is socially constructed, but their view is subjective, valid and equally worthy as the next individual's (Crotty, 1998). The third epistemological stance is one of subjectivism, where an individual's understanding of knowledge and meaning does not emerge from the relationship between the subject and the outside world, but rather the creation of meaning comes from a collective unconscious impacted by values imposed by religion, language, gender, social class, and ethnicity (Crotty, 1998).

The epistemological viewpoint that I believe in as a researcher is one of constructivism, whereby I believe that while knowledge is created through social interactions, that there are different and subjective viewpoints of that knowledge. This epistemological view influences my study in a variety of ways. I understand my constructivist beliefs about knowledge bring certain assumptions into my research study and these can influence the study because of my role as an interpreter of the participants' perceptions of reality. The study can also be influenced because I bring in a view that all participants' perspectives are equally valid and worthy. The goal of my research is to fully explore and understand the subjective experience of each individual regarding their experience of the play therapy process, while simultaneously being aware of my views and their potential influence on this study.

In addition to epistemology, an additional broad perspective of understanding that is important for researchers to identify is the concept of ontology. Ontology is defined as the study of being, and provides an individual with their theoretical perspective of what is reality (Crotty, 1998). Crotty (1998) considers ontology and epistemology as being conceptually interweaved, with ontology providing an understanding of "what is" and epistemology providing an understanding of "what it means to know." Some examples of theoretical frameworks influenced by ontology include: positivism (there is one objective truth and reality); interpretivism (reality is socially constructed by the individual); critical inquiry (reality is created through conflict and oppression and research should promote social change); feminism (reality is created and framed within a patriarchal world and masculine culture); and postmodernism (a rejection of any universality of truth, rather reality is contextually created) (Crotty, 1998). The theoretical perspective I believe in is one of interpretivism. Within the framework of interpretivism, one's truth is viewed to be complex, culturally created, and should be socially interpreted on an

individual basis (Creswell, 2012). This research study fits well into this interpretivist perspective because I am exploring the individual perspectives of individuals who engaged in the play therapy process. This ontology respects the presence of different perspectives and the importance of understanding each individual's lived experience as their truth.

Theoretical Foundation

To choose a methodology that is appropriately suited to answer a specific research question, one must also recognize what ontology and epistemology the researcher is bringing to the study. As a first step there are three expansive and broad perspectives from which to choose as a guide: Quantitative, qualitative, and mixed-methods. In choosing a quantitative perspective, one presumes an objectivist view that utilizes the scientific method of verifiability to discover a truth from which generalizations to the human condition can be made (Johnson & Christensen, 2012). Alternatively, a qualitative perspective espouses subjective report data that is rich in description from which to understand the lived experiences of the participant (Bogdan & Biklen, 2007). A mixed methods perspective blends both quantitative and qualitative viewpoints by collecting both quantitative and qualitative data and integrating this enriched objective and subjective data into the analysis process in order to provide an expansive yet cohesive exploration of complex research questions. (Brewer & Hunter, 1989; Creswell, Plano Clark, Gutmann & Hanson, 2003).

For my study I chose a qualitative theoretical foundation to guide my attempt to understand a complex social phenomena—play therapy—from a constructivist, interpretivist viewpoint (Yin, 2013). Yin (2013) argues that when a researcher has limited control of research events, and is asking a research question that examines a real-life situation, a qualitative approach is appropriate to use. Rather than providing statistical generalization, the goal of

qualitative research is to explore topics which may then allow for an expansion of theories (Yin, 2013). Historically in counselling psychology research (Axline, 1964; Freud, 1909; Watson & Rayner, 1920), qualitative case studies have been used extensively to explore the complex factors that impact the process of counselling and client outcomes.

Highlighting the role of qualitative research specifically in play therapy, Glazer and Stein (2010) state:

> From this perspective, qualitative inquiry is the way we want to engage with those who can share their experiences and thoughts on issues of relevance to play therapy. We regard the respondents not as those whom we study but as co-inquirers into their inner worlds. Qualitative inquiry is an appropriate way to study questions concerning the ways in which we come to know a phenomenon and the way in which respondents create meaning and understanding from a particular experience (p. 55).

Further supporting qualitative inquiry and its role in play therapy research, Carroll (2000), highlights the critical need for additional research to help better understand the actual therapeutic processes of play therapy. Carroll (2000) also identifies the challenges of considering child outcome research in a quantitative manner due to the multitude of variables being studied and the inherent difficulties in quantifying client change using standardized assessment measures. Carroll (2000) argues that one way to study the process of change in individual child clients, while also illustrating the details of the therapeutic interactions, is to use a qualitative design. This allows the researcher to focus on precise and specific details identified by the participant as important, while also being able to reflect on the participant's broader perception of the therapeutic process (Carroll, 2000).

Methodology

Research methodologies are the way one approaches problems and seeks answers (Taylor, Bogdan & DeVault, 2015). Methodology acts as a bridge from the philosophical theoretical foundation to the concrete plan of how we will be gathering and analyzing data. Research methodology includes perspectives such as survey research, ethnography, phenomenological research, grounded theory, heuristic inquiry, and discourse analysis (Crotty, 1998). The research methodology I used comes from a phenomenological research perspective that recognizes how individuals perceive phenomena in the world and then make sense of these experiences (Crotty, 1998). As a methodology, phenomenology has the capacity to study the lived experience of the individual in a manner that acknowledges the participant as the expert on their experience (Van Manen, 1997).

While the origins of phenomenology can be traced back to the philosophers Kant and Hegel, it is Edmund Husserl who specified that an individual's realities are to be treated as pure phenomena and are ideal data to begin analysis (Eagleton, 1983). The goal of phenomenological studies is to explore the lived experiences of the participants and categorize their essences into clusters of meaning that provide greater information of the phenomenon under consideration (McConnell-Henry, Chapman & Francis, 2008). The use of phenomenology as a methodology for studying children can provide challenges, however. The participant needs to be able to describe their lived experience and children may have a limited verbal repertoire with which to do so compared with adults. Therefore, particular attention must be paid to ensure child interview questions are worded simply, and non-verbal answers noted and considered when they occur (Stephenson, 1980). Special attention should also be paid if the child presents both verbal

and non-verbal descriptions of the phenomenon; for example, gesturing by the child may add emphasis or fill-in unspoken words in a meaningful way.

The research question I will be answering is "What is the lived experience of play therapy from the perspective of both child and parent?" The goal is for my research to accurately describe each participant's lived experience of play therapy, and try to understand how they made sense of the play therapy process. Through interviewing numerous parent and child dyads who have attended play therapy, I then will undergo a process of creating themes of participants and eventually identifying similarities and dissimilarities between participants who shared the experiences of attending play therapy. In order to do so I will utilize an Interpretive Phenomenological Analysis method for this study.

Method

Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) was developed specifically for psychology research (Smith & Osborn, 2004). Its creator, Jonathan Smith, describes IPA as "interested in cognitive and emotional entities and, when an IPA researcher is looking at what a person is saying or writing, the researcher is concerned with trying to find out what the person thinks and feels about what they are talking about" (Smith & Osborn, 2004). IPA has been developed as a distinct and rather eclectic approach to qualitative research in psychology that offers both a qualitative theoretical foundation as well as a detailed procedural guideline that may be followed during data analysis (Brocki & Wearden, 2006).

With phenomenology as a guiding philosophical foundation of IPA, its goal is to understand the inner world of the participants (Smith & Osborn, 2004). While IPA originates from and includes principles of general phenomenology, it is an increasingly refined version of

phenomenological research. Rather than only seeking similarity in a common instance, IPA seeks to understand an individual's personal understanding, perspective, and sense making in a specific situation and also identify similarities and dissimilarities of themes across individuals sharing the same experience (Smith, Flowers, & Larkin, 2012).

IPA is also influenced by the philosophy of symbolic interactionism, which understands meaning as arising out of social interactions and communication with others, and that we act in the world according to how we interpret situations (Smith, Flowers & Osborn, 1997). In IPA this is engaged through the use of a double-hermeneutic or process of dual interpretation analysis (Smith & Osborn, 2007). This consists of two parts: first the participant constructs their own meaning making, then the researcher attempts to decode this meaning and create their own impression of the participants meaning making process. This analysis and interpretation is a highly dynamic process and a key element of IPA (Smith et al., 1997). While the researcher makes every attempt to fully understand and access the subjective world of the participant, IPA recognizes that understanding the personal world of the participant is influenced by the researcher's assumptions and interpretations (Smith, Jarman & Osborn, 1999).

In the analysis process in IPA, priority is first placed on the individual case, and only after the analysis of individual participant data has occurred may the more general themes be cautiously examined. This multi-faceted perspective allows researchers to develop a deep understanding of the background and inner world of participants, which are co-created and thereby established beyond the individual's own narrative understanding of self and perception (Smith et al., 1999; Smith & Osborn, 2007).

For this research study, I used IPA as a method to explore the subjective experiences of the child client and parent regarding their experiences of play therapy and the aspects of play

therapy they perceive to be impactful. Therefore, the research question for my project is, "What is the lived experience of play therapy from the perspective of both child and parent?" Gathering these different perspectives and thoroughly examining each individual perspective before considering shared themes allows for a potential triangulation of data, because the individual's experience and perception regarding what creates change in play therapy may be similar to others, but could also be quite different. The aim of this research is to further advance our knowledge of how play therapy helps to elicit client change.

Participants

Qualitative research aims to understand the experience of individuals in a shared context. Determining an appropriate sample size can be challenging, since there are no fixed rules or formula to determine what size the sample needs to be. As an example, looking at the broader grouping of phenomenological studies, Creswell (2012) suggested a sample of 5–25 as an ideal sample size. However, Morse (1994) suggested a minimum of six participants, until saturation has been reached, as the ideal sample size for a phenomenological study.

As guidance to using IPA as a method, researchers again do not have a unified suggestion of how many is an ideal number of participants. IPA research tends to collect a small sized sample, typically from 1-10, in part because of the detailed case by case analysis of transcripts which require significant time and effort (Smith & Osborne, 2007). Smith and Osborne (2007) suggest that a sample size of three may provide a sufficient breadth for a study, by supporting in-depth analysis of each individual's information and still allowing the opportunity for similarities and differences between participants and existing theory to be explored. This small sample size works well within the confines of a defined group of individuals for whom the research question applies and who share a specific experience (Smith & Osborn, 2007).

Purposeful sampling is a technique often used in qualitative research to help identify and select cases that are rich in information (Patton, 2002), and was utilized for this study. Rather than limit participants only to those who had positive experiences of therapy, participants were asked the broad question of whether they had attended play therapy and were interested in talking to me about it. The use of such a broad question then allowed a greater potential for a diverse range of cases allowing for additional variation within the topic of interest (Patton, 2002). This ultimately allowed for the recruitment of a diverse set of individuals who brought a wide range of individual experiences of play therapy.

In this study, eight parent child dyads were recruited, or sixteen participants in total, who experienced diverse experiences of play therapy, including positive experiences, neutral experiences and even negative experiences of counselling. All parents who participated in the study were female and their ages ranged from 31 to 48 years old. Interestingly, 7 out of the 8 parent participants were employed in some type of helping profession (i.e., psychologist, social worker, early childhood educator, occupational therapist). Fifty percent of the child participants in this research study were female, the other fifty percent were male, and their ages ranged from 3 to 9 years old. Unexpectedly, half of all participants had also utilized the services of more than one play therapist, which allowed them to compare the different play therapy experiences they received from different providers.

Data Collection

Members of the Alberta Play Therapy Association (APTA), an interdisciplinary professional organization of individuals who use play therapy in their work with children, were contacted and provided with details of the study. Additionally, various individual play therapists in Western Canada were contacted directly by the researcher. In an email (Appendix A), these

individuals were informed of the current research study and asked if they might display the research poster (Appendix B) in their offices. Finally, the research poster was also posted on a social media website and an online forum focussing on child psychology and well-being.

All interested participants contacted the researcher directly with inquiries about the study. Once all their questions were answered and they indicated they were interested in participating in the study, assent and consent forms fully explaining the purpose of the study, the participant's role and participation in the study, and the risks and benefits of participating were provided and signed by participants (Appendix C). Due to the participation of young children, the researcher also collaboratively went through and explained the assent form with each child to ensure their understanding and agreement prior to any data collection (Appendix D). Confidentiality was also explicitly addressed, and participants were made aware that the researcher would not be contacting their therapist, and that the researcher would not have any access to client files or therapy records. Since a semi-structured verbal interview was used to explore the participant's perception of the play therapy process, these interviews required basic language proficiency, and so it was a requirement for all participants of this study to speak English.

Interview

Questions for the children and parents were all similar in nature with wording being tailored using simpler language for child questions (Appendix E). The goal was for the information collected to accurately reflect the individual's lived experiences, personal perspectives, background stories, and inner world understanding. The semi-structured interview questions were made to be open-ended to help facilitate the individuals' emotions and cognitions regarding their experience of play therapy and what they perceived to be helpful in creating change via the play therapy. Using semi-structured interview questions allowed greater

flexibility in the questioning process, and also allowed the interviewer to follow up on items brought up during the interview that I wished to explore in greater detail.

Bogdan and Biklen (2007) identified how getting to know the child, building a relationship, and putting them at ease are all essential factors in successfully interviewing children. According to Kortesluoma and colleagues (2003), when qualitatively interviewing children on their perceptions of events, the researcher must gain the child's trust and develop a reciprocal dialogue. When interviewing children, qualitative researchers must alter their interviewing techniques and questions to make them attuned with the language and cognitive stage of development of the children who are interviewed (Bogdan & Biklen, 2007). The interview questions given to the child therefore were flexible and could be related to art if the child wished to create some. This helped build the relationship and gain a deeper understanding of that child's experience.

For the child interviews, I asked parents to have colouring supplies as well as paper and a few stuffed animals available by the computer when the child participated in their interview. For child participants, Stephenson (1980) describes how in addition to an interview, the utilization of objects, pictures, or art as symbolic forms of self-referent communication allows children additional outlets to describe their experiences in a rich and full manner. If a child seemed reluctant to speak or to struggle with the interview process, I asked the child if they wished to draw a picture of their answer. While most children actively engaged in answering questions verbally, many multi-tasked during the interview process, colouring or drawing pictures while simultaneously answering interview questions. For example, for one child who seemed to prefer art over talking, I asked her to create a piece of art about play therapy, “Can you please draw me a picture that shows me the most important part of play therapy?” Essentially, I requested a

visual representation of child interview question #5 (Appendix E). I then asked specific questions about the art they created to help elicit responses. It was not expected the artifact itself would be a primary source of data. Instead, the creation of the art helped to build rapport and act as a bridge to the primary method of data collection, the semi-structured interview.

This data collection method of using open-ended, semi-structured interview questions with the supplementary use of art and play helped children to tell their story in a rich and descriptive manner. I also had an expectation that, depending on the age, ability, and temperament of the child, having the child sit for the entire time while I asked questions about play would be unrealistic. Instead, I interacted with many of the children with imaginary fun and was open to the child answering questions while moving about their area. Many children were physically active during the interview running around furniture, or shooting basketball hoops while simultaneously answering interview questions. Green and colleagues (2006) highlighted the importance of making the interview fun, playful, and interactive, and every attempt was made during the present study to engage with the children in this manner.

While in ideal circumstances interviews would have taken place in person, due to COVID-19 regional restrictions, in-person meetings were prohibited. To ensure participant and researcher safety, all interviews were instead conducted using a secure online video platform. Child and parents were asked if they were comfortable completing interviews separately to ensure each individual's perceptions were not influenced by the other participant. However, some parents wished to stay in the room while their child answered questions due to their child's age or discomfort in using the computer equipment alone.

Ethical Considerations

To help with recruitment and to also acknowledge the time each participant gave to complete the interview, each participant received a $25.00 gift card to a business of their choice as thanks for their participation. Participation in this study was completely voluntary and participants could stop the interview at any time. Participants were also informed they would still be provided a gift card if they did decide to withdraw from the interview prior to completion.

Ethics approval from the Research Ethics Board (REB) at the University of Alberta was attained before initiating this study (Appendix F). The risk level for this study was evaluated to be low, as the participants are only asked to talk about their perceptions of play therapy. The participants are not exposed to any risk of physical harm, nor are they engaging in any additional therapeutic process than what they are already seeking out.

Both verbal and written consent was attained for this study. The parents of each participating child were required to sign an informed consent form indicating they gave approval for themselves as well as their minor child to participate in this study (Appendix C). Children were also required to sign the child assent form (Appendix D) before the interview session began. Confidentiality and anonymity were maintained by removing identifiable information and using pseudonyms in all data analysis and reporting of results. All physical data collected such as assent and consent forms that contained identifying names, have been securely stored in a locked file cabinet and all electronic data is password protected to ensure confidentiality.

Analysis and Interpretation

All participant interviews were audio-recorded using a hand-held Olympus WS-700M recording device and transcribed verbatim into a Word file by the researcher. These Word files were then uploaded to ATLAS.ti, a software program specifically designed to aid in the

qualitative research process. Any additional information regarding non-verbal gestures made were also incorporated into the transcripts. Pseudonym names were matched to individuals and only pseudonyms are used to identify participants during data analysis and reporting of results. I followed the four-step approach to analysis outlined by Smith and Osborn (2007), beginning with a descriptive analysis of the individual cases, then next identifying and interpreting super-ordinate participant themes, followed by the identification of any shared master themes seen within participants, and finally completing a comparison of identified themes within the existing literature.

The first step in IPA analysis is to thoroughly and meticulously transcribe the interview including items such as pauses, and any other speech dynamics that occur (e.g., inflections, changes in pace of speech) (Smith & Osborn, 2007). After transcription is complete, the reading and re-reading of the individual transcript is advised (Smith & Osborn, 2007) to ensure the researcher is well situated in the data. During this stage of analysis, I created detailed notes of my thoughts, observations, and reflections that occurred while reading the transcript (Smith et al., 1999). These notes included recurring phrases, questions that arose regarding what the participant said, any personal emotions that I experienced, or any comments I had regarding participant language.

The next step in IPA analysis involved my going back to the transcript and attempting to suspend personal judgement (called bracketing) by focusing specifically on what is present in the transcript and making note of any themes that emerged for that individual participant (Smith et al., 1999). As Smith and colleagues (2012) highlight, bracketing in IPA is not an outright achievement, but rather a cyclical process that can only be partially achieved through purposeful reflexive practices. Following the structure provided by Smith and colleagues (2012), participant

themes were then tied back to concise examples of direct text within the transcript and an analysis of any connections between the themes was undertaken. Individual themes were then further developed into a larger structure through the process of building clusters of related concepts, called super-ordinate themes, which were then organized hierarchically (Smith et al., 2012). Again, as the clustering of individual themes occurred, the participant's original transcript words were double-checked to ensure they do accurately reflect the larger concepts.

As a guide to handling the data in a multiple participant research study, Smith and Osborn (2007) recommend the analysis of each participant interview be completed to this stage before looking at any subsequent interviews. This process was followed in the current study, allowing an idiographic analysis approach that focuses on one participant. Only after completing that participant's analysis to a particular stage did I then engage in the data of other cases (Smith & Osborn, 2007). After completing an initial case to this stage, the researcher has the option of using themes identified in the first case to help orient subsequent analysis, or the researcher may put the table of themes aside from participant one and work on the next participant's transcript starting from afresh (Smith & Osborn, 2007). The approach taken for this analysis was to put the themes aside from the previous participant and start anew with the next transcript. Smith and Osborne (2007) indicate that while the researcher may adopt either approach, the researcher must be sensitive to finding a balance between identifying repeating patterns and themes while also being open to new themes that may emerge with new participants (Smith & Osborn, 2007).

Once the analysis of all individual participants occurred, the third step in the IPA analysis was initiated. A list of master themes across participants was created by examining similarities and differences, similar clusters of themes, identifying underlying functions of themes, as well as identifying any isolated themes (Smith et al., 2012). After these master themes were created and

analyzed, the final step to IPA is linking discovered themes to existing literature to examine how closely the lived experience of these research participants corresponds to existing theories (Smith & Osborn, 2007). This final step of the IPA analysis is presented in chapter five of this dissertation.

Validity

To assess the quality of qualitative research studies, I used Yardley's (2000) four broad principles: a) sensitivity to context, b) commitment and rigour, c) transparency and coherence, and d) impact and importance. Yardley (2000) defines sensitivity to context as the researcher being well rounded in both the literature of the methodology and the topic being researched to ensure they have a necessary level of understanding to undertake a thorough analysis of the data. Before undertaking this study, I researched IPA and had a strong understanding of both IPA in theory as well as the skills necessary to undertake analysis. In addition, I ensured I had a thorough and detailed knowledge of the topics informing my study including play therapy, common factors in therapy, and process research.

In addressing commitment and rigour, processes such as researcher reflection, consultation and discussion and method triangulation all help to achieve validity in a study. I undertook the process of journaling throughout this study, noting personal reactions and reflections to ensure I was aware and engaged in this element of researcher reflection. Smith and colleagues (2012) identified how being open to external audit can help enhance rigour of a study as well. In this study, I utilized regular consultations with my research supervisor as a place to bring data, and subsequent interpretations of data, as a form of external audit. This helped to address an important aspect of validity in this research, and both the critical areas of analysis and interpretation of themes have been subjected to a process of audit and second opinion. Casey and

Murphy (2009) also suggest data triangulation as an additional method of increasing validity. In this study, I used data triangulation to help glean an enriched description of what different people involved in the process of play therapy perceive to be helpful. The individual and in-depth analysis of the child and parent data, and the triangulation of these different perspectives of the play therapy process, contributes to more enhanced findings than if this study had been created with a more homogenous sample or if alternate methods had been used.

Transparency and coherence are addressed in IPA through the use of researcher reflexivity (Smith et al., 2012). To ensure I developed and utilized both reflection and reflexivity throughout this study, I kept a personal journal throughout the project. As a researcher conducting a phenomenological study, it is necessary that I am aware of my inner perceptions and consciousness and recognize how my own memories and past history create a personal bias that can affect the current research. I used the journal throughout all the research stages and attempted to be forthright about my personal perspectives and be vigilant of my own intentionality. By tracking my personal thoughts, reactions and perceptions that emerged during the study, I had a greater understanding of the influence these can create within this research. My aim in engaging in this reflexivity was an attempt to acknowledge my own perceptions and the potential impact they can have on both the gathering of participant data and analysis of participant data.

The final concept identified by Yardley (2000), identifies the impact and importance of the research study, and highlights the need for the study to bring new value into the field of research. Historically, play therapy has been an under-researched area and there has been a renewed call for additional process research in this field (Drewes, Bratton & Schaefer, 2011; Drewes & Schaefer, 2016; Kazdin & Nock, 2003). The objective of this study is to understand

individual experiences of what is helpful in creating client change in play therapy. In doing so, it is hoped that useful information was discovered that will help to inform the field of play therapy regarding client experiences and perceptions of change. It is hoped that the results of this study may help better inform play therapists to understand what child clients and parents perceive to be helpful about the play therapy process, and also help with the training and development of play therapists to understand the necessary and key ingredients within the play therapy process.

Researcher Assumptions

As a researcher, it is important to recognize that the biases and views that I hold will subsequently influence how I see and interpret the data gathered from this research study. An exploration of these beliefs and views is critically necessary in this type of phenomenological research to ensure I am providing a detailed interpretation of the participant's perceptions while also being aware of my own. Since this study used semi-structured interview questions, the direction that I chose to take ad-hoc follow-up questions were directly influenced by my decision of what was important and relevant. I attempted to have heightened awareness of the assumptions and biases that I bring to this research project because they can impact both the data collection and data analysis stages significantly. IPA analysis is based upon the researcher's interpretation of data and creation of participant themes, thus further highlighting the need for my assumptions to be carefully explored and identified throughout this study. For this study, the process of journaling was used as an effort to explore and understand my personal beliefs and biases, and the use of personal reflection that is built into the IPA process also helped highlight my personal insights and reactions to specific data I encountered in the transcripts.

One of the assumptions I have entering into this research with is that I believe therapy is helpful and effective for most individuals who participate in it. While my research is regarding

participant's perceptions of play therapy, and I am specifically trying to better understand what helps to create change in clients, I must be aware that people may have different experiences of therapy. In my semi-structured interview, I have attempted to follow and gather all information accurately and effectively and ensure it is representative of the perspective of the participant.

In addition, I recognize that I bring a humanistic and person-centered perspective to this research study, guided by Rogers' (1951) core conditions of unconditional positive regard, accurate empathy, and genuineness. These conditions were easily noticed by me when a participant spoke of them or similar play therapist traits such as warmth and caring in their interview. Due to my orientation, I was aware that I might be primed to see them. And in recognizing this bias and ensuring that I am truly trying to understand the participant's perspective from their actual view, I made concerted efforts to not have my person-centered lens cloud the data. If a child client or parent identified that they felt a particular intervention was helpful, for example the play therapist challenging negative thoughts, I attempted to explore this information just as fully as if they highlighted warmth and genuineness in the play therapist as being helpful.

On a personal note, the idea for this study emerged from experiences I have had being a graduate student who highly values education, as well as impactful experiences I have had as a mother. Prior to beginning my graduate training in counselling psychology I completed a degree in Measurement, Evaluation and Research Methodology at the University of British Columbia. This Masters degree provided me a strong appreciation of how and when quantitative or qualitative research may best represent a particular research question, and peaked my curiosity regarding how to engage in research with child participants. I feel this experience provided me with a unique foundation when I later began my graduate program in counselling psychology.

When I did begin my training in counselling psychology, it was my desire to be an effective therapist and I became interested in the research regarding effective therapy. While much of the research came from the perspective of the therapist, there was some research completed also exploring what the client found to be helpful in therapy. I primarily worked with adult clients, and it was during a practicum placement that I was also given the opportunity to begin working with child clients. It was here that my experiences as a clinician/researcher/mother all converged into my interest in exploring play therapy.

As a parent, I have had numerous experiences with my children that highlight when one shares an experience with a child, the parent and child can have vastly different perspectives. A humorous health-related example is when I took my then preschool aged daughter to the doctor for an appointment. Relaying the events of the appointment to my husband I recalled the stress of trying to get to the appointment on time during rush hour traffic, and my dismay of also sitting in a waiting room with children who were coughing and sneezing. When my daughter recounted the experience of the appointment to her Dad she talked about the colourful ocean stickers that we followed down the hallway to find the correct appointment room, and the special snack she ate. She and I had very different perspectives of a shared experience, and it almost seemed that we attended different appointments! However, our different experiences of the situation did not ultimately influence any of the medically based results.

Having had this personal understanding of how different parent and child experiences of a shared experience can be, highlighted to me how working with children in therapy can pose an interesting conundrum. While the child is typically the one receiving the vast majority of the clinical work, the parents additionally have an important role in the process of play therapy and do hold some influence over the clinical outcomes that a child may attain in therapy. And so I

began to wonder how to best allow the voices of the child and the parent be heard regarding what they felt was impactful about the process of play therapy. It was these personal and clinical experiences that planted the seed to this doctoral research exploring the different perspectives of play therapy that both parent and child experience, and fueled my desire to explore what each of the participants perceive as being important elements to the play therapy process.

Chapter 4: Results

With a research question of "What is the lived experience of play therapy from the perspective of both child and parent?", this study explored the individual experiences of 8 parent and child dyads. When smaller samples of research participants are interviewed, and the data is analyzed using qualitative analysis, case descriptions may be used to help provide perspective of the lived experience of the of the participant before presenting the analysis of the shared data (Smith et al., 2012).

To prioritize the idiographic approach taken in this research, as interviews were completed they were transcribed and at that point the next interview was scheduled. Once all interviews were completed and transcribed, they were then entered into the ATLAS.ti computer program. This software is one of many programs available to aid in the organization and analysis of the vast amounts of data that can occur in qualitative research. Beginning with the first interview, the transcript was read and re-read and any items of interest, or particular language that stood out, was marked as a notable quotation within the ATLAS.ti program. After two rounds of identifying quotations, the coding process of the individual interview was then undertaken and emergent themes within that particular interview began to be identified. This same process was repeated for all 16 participant interviews, focusing on the emergent themes appearing within each of the individual interviews.

Smith and colleagues (2012) identify the use of contextualization as part of IPA analysis. This can allow for the identification of specific narrative elements within the analysis of the individual case. Contextualization considers the patterns and constellation of emergent themes as being related to critical events as identified by the individual, for example a child who talks about "feeling good" after therapy occurs. As part of relaying the results of this individual

analysis, an introduction of each parent child dyad is provided allowing for detail and context of their experiences and details of their lived experiences to be illuminated through the use of participant quotations. These individual dyads are provided to the reader to highlight the idiographic foundation undertaken in this study while also providing additional familial context. This was done to ensure that the voice of the individual participant and their experience is accurately reflected within this paper.

Once emergent super-ordinate themes were explored within the 16 individual cases, the next step of analysis undertaken is a consideration of patterns held across cases (Smith et al., 2012). In the first step of this analysis, an Excel spreadsheet was created identifying recurrent themes that were found across the 16 participant interviews. Since this study specifically set out to identify similarities and differences between parent's perceptions of the play therapy process versus children's perceptions of the play therapy process, an additional analysis and grouping of parent and child themes also occurred. Three master themes found across all interviews emerged regarding important elements of the play therapy process: Support received, the role of the therapist, and the role of play. While these three themes were consistent among interviewees, there were some differences between parent and child perspectives as noted in the subthemes which make up the larger master themes. The emergence of themes section of this chapter acts as a bridge tying specific participant quotations to the constructed master themes of support received, the role of the therapist, and the role of play. Three colour-coded summary of findings diagrams highlighting the similarities and differences found between parent and child perceptions of play therapy are also presented. To help visually represent these subtheme similarities and differences between the parent and child groups, green and blue colors are used. Green text signifies shared subthemes views between the parent participants and the child

participants, while blue text signifies differences that emerged in the subthemes between these two groups.

Smith and colleagues (2012) identify the challenges in presenting results while retaining the idiographic focus of the individual interview, while simultaneously also presenting the recurrent and shared themes that emerge from the group. In addition to this challenge, an interesting circumstance unfolded during the interview process that was unanticipated and also provided unique data. During the interviews, over half of the participants reported that they had therapy experiences with more than one play therapist. These individuals described how they initially sought out a therapist, and then for a variety of reasons later sought out a different provider for additional services. These parents and children were able to speak at length about differences they perceived between therapists as well as differences in the services they received. While this data was not expected, this rich information containing specific preferences and notable differences between therapy experiences became the basis for including two exemplar cases as part of the results chapter. Two exemplar cases, best-case and worst-case, are presented as a representation of the rich data that emerged. Exemplar cases are often used in clinical nursing as a representation of how to provide best-practice clinical interactions with patients. Given that play therapy is a clinical venture, this representation of results highlights multiple facets of the services received that were recognized as being important and impactful to participants. Some examples of these details include therapist handling of communication challenges and ruptures to the therapeutic alliance, therapeutic and administrative differences noted among clients who had experiences with more than one play therapist, as well as elements of therapy that were more preferred by clients.

Dyad # 1 - Sally and Leslie

Sally is a 46-year-old divorced mother of two girls, aged 8 and 6, who has worked as a pediatric occupational therapist for nearly 20 years. During this interview Sally confidently and enthusiastically answered all questions, and her answers were punctuated with laughter and humour throughout. Leslie is 8 years old and Sally's oldest child. During this interview, Leslie was noted to be somewhat reserved, and spoke thoughtfully, concisely, and quietly. She answered all questions while simultaneously playing with a small sparkly stuffed animal throughout the interview.

Leslie attended four sessions of play therapy when she was 7 years old. Her parents attended an additional two parenting sessions that Leslie did not attend. Sally describes seeking out and beginning play therapy for both Leslie and her younger sister because it was recommended as part of a divorce mediation process. Sally named how play therapy was sought not only to help the children process the changes that were going to occur in their family, but to also help the parents successfully create a cohesive parenting plan between the two households. When Leslie was asked why she thought she went to play therapy, she answered that it was to help her parents teach both her and her sister about divorce: "Because mom and dad wanted us to know, like more about divorce because this was the first time getting for a divorce, and stuff, and to help us know more about it." Sally described how the play therapist they went to was recommended to her through individuals in her workplace as well as the therapist also being recommended by the mediators she and her husband were seeing as part of their divorce.

Leslie's experience of play therapy

When asked about her experiences of play therapy, Leslie described how the therapist would talk to her and her sister and also remembered the fun toys that were in the office: "Well

she would talk to us about my mom and dad and like how they got divorced and stuff (...) she had color changing putty, and um, and when it gets warm you could like play around with it and it would like color change. But it would have to be warm, and sometimes it would get to change back." Leslie spoke about how she would simultaneously talk and play with her therapist and how the toys allowed her to focus on something else, which made talking to the therapist easier for her: "I would play with the toys and talk to [the therapist] (...), she asked questions (...). It was easy because sometimes, putty is kind of like a fidget, so I could like focus and like play with the putty (...) because, so I don't really like when people ask me so many questions, it feels like I'm really having to work. Then I can actually like also do something, um, else." Leslie also described her therapist as "kind and calm" and talked about how she would feel when talking to her therapist: "It made me feel calm too, so I wasn't all stressed out and stuff, less anxious."

Leslie spoke about how she considered play therapy to be a positive experience where she learned about the emotions she may encounter regarding the impending divorce of her parents: "It was fun, it was understandable. And that it was alright. It's like you work with toys and you get to understand like, um you can be sad sometimes at your mom's house or you want to see your dad, or if you are at dad's house and you want to see mom sometimes." Leslie indicated there were no parts to the therapy process that she did not like, and nothing that she would have liked changed regarding the play therapy process therapy or the therapist: "It didn't really have a worst part about it, didn't really have a bad thing. Yeah, I didn't really have a bad part about it."

Leslie did not describe any changes or differences in herself that she noticed during or after attending play therapy however she noted that she did learn some important information: "I don't think it would be different, but I wouldn't know about (...) some stuff that I should have

known maybe (...) um ‘cause um she taught me that I might be sad sometimes, and if I didn’t learn that, I would feel that 'oh I’m never gonna be sad', but I might figure that out by myself but still. Like, it’s kinda like a warning that that can happen." Leslie also named that what she thought her mom liked about play therapy was that mom also had the opportunity to learn more about how to help her and her sister through the divorce: "Maybe, um, that mom could understand a little bit more too about what they could do, and like, with us sometimes, she could more learn what she could do and stuff."

Sally's experience of play therapy

Sally spoke about how both play therapy and the process of play therapy was a very positive experience for her and helped her throughout her divorce. Sally also named one of the most important aspects of the play therapy process was that the therapist was a neutral third party to both her and her ex-husband: "Well it was good for me (laughing) because I felt um, it was someone that Bob would listen to (laughing). Cause she was an expert you know so I felt like that um she's like a impartial third party. So then (...) you know she didn't have bias either way. And then because we both knew she had been a play therapist and well, and a therapist in general for a lot of years and have a lot of experience and especially with divorce, so um, you know I guess that kind of had more weight to her responses. Um, and just knowing that, I knew that she could draw on a lot of professional experience." Sally named how the therapist acted in a role of an educator who advocated for parental actions which would be in the best interest for the children. Both the neutrality of the therapist as well as the professional experience of the therapist allowed the therapist to address potential concerns regarding the divorce to both parents. Sally named how it was therapist credibility that made the parents more likely to take the concerns seriously than if the concerns came from their previous partner: "I didn't ever feel

that Bob listened to me. Or that any of my concerns were valid to him, whereas [the therapist] would listen to my concerns but then she would talk to Bob and then I felt that Bob would listen to her more. Well, that was a huge thing for me, and so I do think that what she said had more weight with him, then what anything that I would say. Like he would say 'oh you're just worried about [his new partner] moving in because of everything that's happened, it's not really because it could affect the kids really in any way.' But then [the therapist] would be like 'well actually you know it COULD affect them, how everything goes down there.'" Sally also felt that as a neutral party, the therapist was able to gather unbiased and more accurate information from the children that the parents otherwise would not have known: "Yeah so [the therapist] asked a lot of those questions, that I thought were just, I don't know, just really interesting information for us to have that I don't know that [Leslie] would have told us. Like I don't think she would have told Bob or I. Or we wouldn't have even really have asked. Actually, part of that too is that I never would have said like 'who do you think is the angriest?' (...) And then the other thing too was if we asked it then I think that we would influence her answer. Whereas I felt because [the therapist] asked it, Leslie wasn't influenced either way."

Sally described how Leslie had also seen a different mental health therapist for a few sessions regarding some behavioural challenges, and Sally was able to notice differences in how the mental health therapist and the play therapist communicated information with Sally. Sally identified the most important piece for her in the process of play therapy was that the play therapist provided her with additional information as well as a level of interpretation regarding how her daughters were feeling about the divorce. This allowed Sally to better recognize how much her daughters were able to understand about their new situation: "Just giving me more information to work with (...) I feel like [the play therapist] saw stuff and then interpreted it. And

then gave me information from it. Right? Or gave guidance, whereas with [the mental health therapist] I felt maybe he, I didn't feel there was as much guidance. (...) Like he would just say oh we talked about this today (...) and then that was kind of it (...) but see I like to get the information of: is she super sad, is she feeling like that she's split in two directions? I wanted to know like what she thought kind of thing. So, I like that information. Rather than just being like, taking my kid and dropping them off."

Sally spoke about how the play therapy process provided her with more confidence around this new situation and named how the involvement of a professional helped to relieve her own worries of the divorce hurting her children and of not doing things correctly: "Well I just feel like it was it was such a new situation to me (laughing) so it was kinda like I don't know, what we do? And I wanna do it right and I don't want my kids to be messed up for the rest of their lives (laughing). You know so (...) I think that's maybe my major fear of being afraid of doing things wrong, but I guess at least feeling like maybe you had some guidance to do things better."

Sally did not name any changes or differences she noticed in Leslie after going through play therapy, but did name that she felt her ex-husband implemented some of the things learned in play therapy in his interactions with the girls: "I think the part that that he did listen to a lot was the part about like, um when the new significant other comes don't make it that all of your time was all together with the new significant other. Make sure they have just dad time without the new significant other. So, I think that part he did listen to." While Sally did not notice any changes in herself from going to play therapy, she did note how taking her children to play therapy allowed her to feel like she had done everything that was needed in this stressful situation: "I don't think it changed things a lot, so if we didn't do it, I don't know how much

would have changed. I think I feel like I felt better that I did it, but (laughing), but whether it changed anything (...). I guess maybe I would wonder what it would have offered (...) I would have thought about like 'oh maybe we should have gone, like maybe, did we miss out on something?' Maybe I would think that."

Similarities and differences between child and parent experiences

Both Sally and Leslie stated that going to play therapy occurred due to the impending divorce. And from the perception of both parent and child, there was consistency that the process of play therapy was perhaps more for the parent's benefit than for the child's benefit. There was an overall goal noticed by both parent and child that therapy would help this family system dissolve in a planned and controlled manner and help minimize disruption to the children while providing support to the parents.

While both Sally and Leslie had only positive things to say about the play therapy process, a noticeable difference between Sally and Leslie's experiences is that Sally would absolutely consider going back to play therapy if the need ever arose, however Leslie is adamant that she does not want to ever go back to play therapy. As Sally states: "It will be interesting what she says to you because she's so dead set of going back to anyone. We can't go back to [the play therapist] just because her role (in the divorce) is only that piece. But she's so dead set going back to anybody to talk about stuff, but yet she always had fun there. Like she always liked it. She still talks, like she'll probably talk to you about the putty there. And so when she talks about seeing [the play therapist] (...) she's like well I'm not gonna go see her again. (...) But then she'll right away be like 'oh she had that putty', like she'll tell you the stuff she played with and she remembers really liking it."

Dyad #2 - Gwen and Regamon

Gwen is a 37-year-old, married woman who has three children. She works for a not-for-profit community agency that provides support for teenage parents. During the interview Gwen demonstrated a lot of confidence in her knowledge of mental health and provided thoughtful and detail filled answers. Regamon is Gwen's oldest child, and is seven years old. Regamon is a very enthusiastic child who, at times in the interview, would shout his answers in excitement. At one point in the interview, Regamon climbed up to stand on top of the desk from where he was answering questions from. Regamon was very willing to answer all questions, and worked hard to provide very thoughtful and vulnerable responses.

Regamon attended 25 sessions of play therapy over approximately one year when he was 6 and 7 years old, and he continues to receive regular play therapy sessions every few weeks. During this time frame, he also attended approximately 9 theraplay sessions where his entire family participated. Gwen describes seeking out play therapy for Regamon because he is a highly sensitive child who needed help with feelings of anxiety and aggressive behaviours that were impacting his relationships at home and in school. When Regamon was asked the reasons why he thought he started play therapy, he answered the question by deferring to his mom: "Well, you can ask my mom that." Regarding finding a play therapist for Regamon, Gwen described that when she started hearing about her son's challenges at school, she talked with a Mental Health Therapist at her workplace who was able to recommend their play therapist.

Regamon's experience of play therapy

When asked about his experiences of play therapy, Regamon began by naming many of the toys in the play therapy office: "I went to her office, I liked the playroom, I remember all the little dinosaur things, dinosaur things on the shelf, those little cushion things, the time limit, the

sand pit, the kitchen." Regamon continued to see his play therapist in person during COVID-19, and then described the differences in how they played that were undertaken due to COVID-19: "In her office now, she gets a load of toys, she makes the rules of the toys, she puts those things in the bin, and we do it one by one, and I get to pick what we do." When asked to describe his therapist, Regamon answered "like a Doctor of Feelings (...) she helps you with your feelings and stuff."

Regamon was overwhelmingly positive in describing his experiences in play therapy: "I would basically describe a fun, happy place (...) I really like it there, it's a long-time thing, it's fun." When asked what made it fun, Regamon described how important the one-on-one time he spends with his therapist is to him: "It's kind of good to have my alone time with somebody (...) sometimes I just need a break from my family, and I always get that when I go with her, just some alone time, I like that (...) I really get to hang out with her, and that's really fun."

When describing things that he did not like about the play therapy process, he named having to share his therapist with his siblings during the family theraplay sessions: "Maybe (long pause) the family one. Like everybody gets to come (voice sounds very sad) I kinda don't like that because [the play therapist] is my fun person that I can do alone. I liked it when mom or dad came, it was usually fun when both of them came, but I didn't like it when my brother and sister came (...) She's my special person." Regamon also named how he disliked having to go back to daycare after a play therapy session was completed: "It's mad too, 'cause I'm just like, seriously? I really have to go to daycare after? I mean I need to slow down (...) after I'm just like, are you kidding? I legit just got some time off, I want to go home, except I have to go back to daycare."

Regarding changes he noticed, Regamon noted how his body and feelings felt different immediately after play therapy sessions: "Well, it kind of relaxes me (...) Well when I get out of

(the play therapist's) my body feels a little bit pumped up because I've been sitting down for like an hour, I mostly get a lot of energy and like run around the staircase like a track." Regamon also noted more longer-term changes in his relationships, noting that he has a best friend now, and he is also a top friend at school: "I'm a friend to everybody in my daycare (...) I'm a top friend (...) How do you become a top friend? Well, you have to be very nice to people and then basically, always try to make up fun games (...) A game that everybody will participate in, they really like new games that they've never seen before, like cats and dogs, I just showed them that today."

Regamon talked extensively about the games he did with his therapist and about how important talking with his therapist was to him: "(talking to her) means to me a lot. Like how I'm going to express my feelings and stuff (...) basically teaching about all the stuff I do." Regamon went on to describe what his life would be like if he did not go to play therapy and had not met his therapist: "All my life would be miserable (...) Well because, basically, my life to me without talking to people and being nice, would be the life of a bully (...) my life is really good here, I have tons of friends. Without [the play therapist], I would kind of have like zero friends, could be a bully and bullying people. That's what my life would be if I didn't have her (...) it turned my life around."

Gwen's experience of play therapy

Gwen began by talking about the role of the play therapist and importance of a neutral adult being a part of Regamon's life: "It's really about helping kids explore their feelings and what's going on for them and helping them have a different outlet to put a label to what's going on for them. And it's somebody neutral, that's not their parents, that's not a teacher, (...) that's somebody who's active in their life, but it's somebody who is neutral and safe, and fun, that they can connect with." When asked about the significance of having a neutral adult be present for

Regamon, Gwen named the consistency of unconditional validation that the therapist is able to provide and why that is challenging for parents to provide their child: "(With the play therapist) there's never a good/bad, this is just where you're showing up today, and I accept you. And let's work through this. And that's really the difference, is that she's just that neutral person that's always happy to see him no matter what, she never judges. She's just there for him (...) it's just that consistency in his life too, where he's always going to get the same thing no matter what. Whereas, you know like with parents it's different. It's always going to be different depending on what's going on. For her she's that neutral consistent person that's always going to react the exact same way every time he does something, or he needs to express something."

Gwen talked about numerous changes she has seen in Regamon, including the addition of coping skills and his meltdowns being shorter in time: "I think for him, I think the fact that he was able to articulate things. (...) Whereas before when he felt chaos, and he felt the disturbances, it would just escalate (...) So I think even the fact that he's able to articulate that, because that gives us a place to work with, and start building that safe security place. (...) So he will say like 'mom, I need you now, mom I'm having a bad day' (...) So I think it's given him language, but I also think too, it has given him some of those skills. (...) So I can see even those little, how he talks about things, or how he can talk about worries, is very different, and how he copes with worries is very, very different too."

When asked her perception of change occurring in Regamon due to developmental growth versus play therapy Gwen spoke about the importance she felt that play therapy had in the changes observed and his skill development: "I really think it is just the way the approach is. Like it's the way his therapist understands him, and works him through it. Like he went through this phase where he was studying for the next apocalypse, because he was worried the world was

going to collapse. (...) So they did a lot of, in their sessions, there was a lot of that playing, and that sword fighting, and that kinda stuff. So, she was able to use strategies, too kind to reframe that for him. And then we saw less and less prepping for the apocalypse because he was feeling more secure, and he had other coping. Things like that. (...) And it was the strategies and the discussions she has with him, and the work she does with him, that makes that difference."

Gwen highlighted the particularly important role the therapist played in both modelling communication and educating her and her husband, and how this in turn changed both her and her husband's behaviours when they interacted with Regamon. Gwen also spoke about how that learning consequently impacted their interactions with Regamon at home: "I think definitely the role modeling piece definitely does help. (...) it was kind of a nice, a helpful touch point, to be like, OK, am I on the right track? She's modeling this, I'm doing this interaction, or she would give me feedback after, like we would do, video sessions and then she would give me feedback after, 'I noticed here you were trying this, now if we could switch it (...) to this or if you could try doing this, then THIS is the reaction we could see'. And so like even just having that feedback, was really, really helpful. Because then I was able to change my interactions so the next time we would do something, (...) I would be like, OK my job is to set these parameters and slow things down for him. (...) Or I could see that she had these calming techniques, so if he would start to kinda get high energy, I could see that she would do these things that would bring it down. (...) and so even just watching her, do those interactions, and then her giving me kinda feedback on mine, I think made a huge difference in how I dealt with those. Because it feels like you have more power, or you have more skills (...) just having those skills, and watching her do those skills, I think was a huge, huge benefit to me."

Gwen spoke about how having the therapist involved in her son's care provided Gwen with a great sense of relief and a greater confidence for Gwen to advocate on her son's behalf to other people in his life: "So that really helped us and it also gave us the language too, so when we would go places or when family would be like 'ummm' or people would kinda have that judgment, you'd be like 'well actually, the professional in his life will say this is normal because of this this and this, and this is what we should do instead.' Um, so let's all get on the same page here, because we don't want to make him feel worse, because he does already feel bad. He knows he disrupts the world. But he shouldn't feel that way as a small child, so I think that's really helped too."

Gwen identified that a key component of their play therapy has been the fit of therapist not only with Regamon but also with the parents, and the vital role that fit played in the play therapy process: "Relationship is key and understanding my child is key. (...) it's like how do you interact with (the) child, how do you interact with myself and my husband, who are also the people going there? So it's always been supportive, if we don't get a good feeling but my kid gets a good feeling, that's only half of it because it's a partnership. We're working together to support this child in building capacity in his life. So, if we don't get a good vibe or if we're not getting feedback or that support we need too as parents, then that's a really big thing too. So, I think relationship is key, and how you approach parents."

Related to the importance of the relationship Gwen also spoke about the communication that can then occur when a strong relationship is created between the therapist and parent. Gwen spoke about communication being a two-way process, with mom sometimes orienting the therapist to areas of concern that mom observed between sessions: "If there are things that I have concerns with, she will go and integrate them into the sessions with Regamon. So if there are

things that I've noticed, or I'm not sure about this, or something doesn't feel right here, she will go and integrate that into the sessions, into their play and into different things. So she can kind of get a pulse of where he's at. Like I've got the parental, you know sirens going, but she can work with him in that way. So a lot of the times I'll be like how was your play today, or what did you do? And he'll talk about, he'll talk about the things that (...) you can tell she purposely interwove them, because they were concerns I had. Like legit concerns. And so she would kind of explore them with him. And kinda use that as that starting point. (...) So the communication really helps too."

Similarly, Gwen spoke about how the therapist respected the child's confidentially by not providing details of what was discussed, but would instead communicate with the parent overall themes of what was worked on: "And she doesn't tell me what he says, like that confidentiality is always there, so there's that safe thing too. She'll talk about themes, or ideas about things, but anything he says specifically, that's between the two of them. (...) Because if he wanted me to know, he would tell me." This communication by the therapist then primed the parent to better recognize and notice small changes or coping strategies the child may be using at home which Gwen would then acknowledge and provide positive reinforcement for: "So he'll explain things, and I'm like 'O my gosh you get this (...) I can see you're getting this, and I can see you're trying to use this'. And I can see the difference in the over two and a bit years that he's gone to her. Like I can see a big difference in him. So that as a parent, is just like the best feeling in the world, because your kid feels competent. And you know your kid feels good about themselves, and you know that's all they want, especially at his age."

Similarities and differences between child and parent experiences

Both Gwen and Regamon described a very similar, overwhelmingly positive experience of the play therapy process. Each of them named the importance of a strong relationship with the

therapist, and named the therapist as being an integral part of successful play therapy. Both independently named how they have recommended their therapist to others with Gwen providing referrals to other parents and Regamon sharing with his friends the great time he has with his therapist and suggesting that perhaps they might enjoy spending time with a therapist too.

Gwen readily identified changes that occurred in Regamon, and further identified refinement of knowledge she and her husband acquired regarding how to better understand their son and improved communication through therapist modelling. As well, Gwen described numerous behavioural changes that she and her husband implemented in their interactions with Regamon. Regamon also identified many changes in himself that occurred over the course of play therapy. While he did not name particular strategies he acquired (e.g., breathing strategies), he did name significant changes in how he interacted with others and the subsequent results of those behaviours. Most significantly he identified that he now has friends, and he is a skilled top friend who knows how to get kids in his class and daycare to participate in fun games with him. Regamon did not name or notice any additional changes occurring in either of his parents or in his siblings.

Gwen and Regamon had very consistent experiences of play therapy and one of the only differences that arose during their interviews was the value of the all-family theraplay sessions. Gwen described both the parent sessions and family theraplay sessions as being critical learning points that allowed the therapist to model communication and also provide feedback on the parental interactions with the children. Regamon however, named the family theraplay sessions in particular as being the one thing about therapy that he would change. Regamon described how he didn't like having to share his special therapist with his siblings, and how during the theraplay sessions he did not get the break away from his siblings that he valued.

Dyad #3 - Alex and Chilly

Alex is a 31-year-old divorced woman with one daughter, Chilly, who is 3 years old. Alex works as a social worker for a community agency. During the interview Alex enthusiastically answered all of the questions, and was very open and vulnerable in her answers. Chilly is a very enthusiastic and high-energy child who ran around and played throughout the entire interview while answering about half of the questions posed. Chilly had a lot of fun pretending she was squirting both her mom and the interviewer (through the camera), with a water bottle filled with sparkles that she carried with her. Chilly preferred to answer many questions with simple yes/no answers, but did elaborate her answers for a few of the questions.

Chilly attended 6 sessions of play therapy over a three-month period, although her play therapy was interrupted due to COVID-19 in March 2020. While Chilly's therapist did offer online sessions at that point, Alex said that she did not feel the telepsychology sessions would be as productive, and that Chilly would not be as engaged since she would have to play with her own toys in her own home for the session. Alex described seeking out play therapy to help with Chilly's extreme shyness and needing to always be in close proximity to mom. Alex also wanted to build coping skills to help Chilly manage some anger and other big emotions that were occurring. When Chilly was asked the reasons why she went to play therapy, she answered: "I do not know, I can’t tell you."

Alex described the frustration and challenges she had in even finding a play therapist, and how it was the recommendation from a friend who is a provisional psychologist that helped her finally find their therapist: "It was a little frustrating even though I had connections. Like even just doing general Googling, there was not a lot of information, or the same two or three names popped up. Like I can honestly say if my girlfriend hadn’t given me the information for this one,

I'd probably never would have found it. Because there's not, like it's everybody knows [one agency] and that's it. And that's probably why it had a wait list. But it's really the only name, like even when we have clients who are in play therapy or refer it, that's usually the one that everybody goes to because they know it."

Alex also spoke about her frustration when she was inquiring with various professionals about play therapy. Alex describes how she was told that play therapy was not evidence-based and that perhaps she should look into other alternatives: "People were (...), almost against it when I'd mentioned it (play therapy), because it's not evidence based (...). Like especially, because when I was also looking for a therapist, my mom's a nurse, a pediatric nurse, so she had asked around at the Children's (Hospital) for recommendations, and even from them it was, 'it's not evidence based, try this, try that'. Which I found interesting that there wasn't as much, and not that I needed evidence based, but not as much encouragement and backing from professionals at a Children's Hospital, for it."

Alex identified how it was because she works in community healthcare and was familiar with the benefits of play therapy that she had the confidence and fortitude to seek out a play therapist on her own. However, it was still a challenging process: "Well it made me second guess for a moment, but not enough to not do it. Because I knew, and I think having the education background that I have, I was able to trust myself. But I worried about, like some of my clients and stuff, those lower income families who I recommended play therapy, they hear something negative and they're not going to do it. Because it's whether it's not evidence based, or it's not recommended, or talked about, or easy to access. It's almost like it's a more prestigious level of therapy because it was so hard to access, and it was so challenging to even get recommendations.

That it's not easily accessible for anybody and everybody who needs it. Whereas it should be, because with younger kids the talk therapy doesn't work."

Chilly's experience of play therapy

When asked about her experiences of the play therapy process, Chilly described enjoying playing with sandbox with her therapist: "I liked everything about the sandbox, I don't forget anything about it (...) I used to play in sand boxes with [the therapist], and she likes to play with me too." Chilly also described how there were some toys for older kids (such as toy guns) tucked away in a closet, but these toys made her feel uncomfortable when she saw them: "I didn't like the stuff in the closet, toys in the closet, that they made me scared." When Chilly was asked about how her mom might have felt about play therapy, Chilly described how her mom "liked it" because Chilly liked everything there: "Everything was fun there for me." Chilly also described how if she had a friend who was going to go to play therapy but was feeling nervous, that she would go with them to help: "It's ok (...) because I come with her (...) Mmm Hmm and I'd go into the room so she no be afraid anymore."

Alex's experience of play therapy

Alex spoke about the importance of the role of the therapist, and how she noticed her own feelings of guilt and shame coming up around needing to take her child to play therapy: "It was good. [The therapist] was very knowledgeable and very good at approaching it, but I did feel, like I was nervous and I felt, almost a bit of shame, as in I'm like a family support worker, why does my child need this? Like why do I not know what to do to help her? So that was my own thing to deal with, um, because I knew it wasn't really what was going on. But there was still, like it crossed my mind a couple of times, like why. Why didn't I do things right, I guess."

Alex talked about one of the critical pieces of the play therapy process for her was the feeling of validation she received from the therapist and not feeling any judgement: "I think the lack of judgment. Like I feel like I judged myself a lot more than I was ever judged by her. Like I said, I'm a professional social worker, going through this divorce, and why did I end up in this marriage? I think I was judging myself 'cause none of those questions were ever posed or brought or put to blame as to why Chilly is the way she it, and is going through what she's going through. So I think that's huge - nonjudgement. Knowing that anybody and everybody was doing the best they could with what they knew, and trying to manage it, and then tried, I don't wanna say fix it, but tried to get the supports in place because I recognized I couldn't do it by myself. But there was no judgment in that."

Alex spoke about the confidence in her own skill development and refinement of understanding of her daughter's needs that occurred during the process of play therapy: "It brought back more of that confidence. Because now I can feel like, yes, we never really finished the sessions because of COVID, but I don't feel as lost as I did in November or December when I first looked for therapy for her. Like I know that (safety) net is still there, but I also have more practical skills that are directly related to what her and I need. As opposed to what I teach to families or I read from books, this is very catered to our situation, and how I work and how she works. And I don't know if I would have gotten that any other way, or from anybody else, had there hadn't been one person seeing both of us and our story, and understanding, who we are and why we are the way we are."

Alex named many changes that she noticed in her daughter once she started play therapy, and also named that she felt that much of the change that occurred was her own personal regulation of her emotions during stressful moments with her daughter: "I've also noticed too

that she's able to talk more a bit about her feelings, and be more aware of how her body responds when she's angry, or feeling more confident talking about them. Before, she was very much, she would internalize and then have these HUGE tantrums, that were, like I just had to sit there and wait it out almost. (...) But now during them, she will come in for hugs a lot sooner, she won't slam doors and scream. (...) 'Cause I would get frustrated sometimes, and I would start crying (...) But now I find I can, hold onto my own emotions a bit better during that, or verbalize them but not, show them. So I could say that I'm upset or I'm hurt, but I won't be crying myself, so I think we just better able to manage each other's feelings. We're both highly sensitive people, so when we, have feelings, they're big (...) but I had to realize that I'm the grown-up, and she's a child, and I need to deal with my own stuff separately (...) Like I don't get lost in my emotions and it helps with that regulation piece, so I can regulate her, because I know I have the skills, and I know what to do. Yeah, it's empowering for me and I think, empowering for her in a way, like I really think the play therapy changed me more than it changed her, even though it was meant for her."

Alex also described the importance of having the therapist utilize a systems approach to the therapy and create custom-made interventions specific to their family challenges: "And I had more, I guess confidence in the strategies too because [the therapist] just didn't sit with me and tell me these things. She sat with me, then she watched Chilly interact and how she interacts with her world and then could give me strategies catered to Chilly's personality and circumstances and mine, it's like it's more custom."

Alex was overwhelmingly positive speaking about her experiences of play therapy and only named how the therapist navigated the relationship with her ex-husband as potentially being a negative aspect. In considering it further however, Alex is uncertain whether more therapist

engagement with her ex-husband would have actually been helpful to her in the long-run: "In the moment I probably would have liked to have more engagement with Chilly's dad (...) I guess a part of me would have wished [the therapist] would have followed up with him? But I know that's not her role, we had invited him to one of the (...) parent sessions and he slept through it, so that's his piece. But had you asked me a couple of months ago I would have wished, for [the therapist] to have done more with him but I realize looking back now that that's not what I needed. (...) It would have been nice for her to reach out to him but then it just would have been the next thing, and then I would have been wishing for the next person to maybe do that. But I don't think he's capable of being what we need. So I guess it was a lesson in disguise."

Over the course of the interview Alex also expressed gratitude in being able to participate in this research study and reflect on her experiences of play therapy. Alex identified that there was no formal termination of play therapy because of how therapy stopped due to COVID-19: "I think it was nice for me to be able to talk about it, 'cause I never really got to figure it out. I guess I knew these pieces, but never verbalized the impact. But now reflecting on it, because I feel like had we transitioned out properly and gotten that closure, I would have been able to reflect a bit and put these pieces together, but now I can see the benefit behind it, and it's now piqued my own interest in learning more about play therapy and how it can further support my child or myself."

Similarities and differences between child and parent experiences

Both Alex and Chilly had very positive experiences of play therapy, with both of them identifying that they enjoyed the time with the therapist, and looked forward to their next appointments. Alex and Chilly both identified that they felt connected with the therapist and knew the therapist liked and respected both of them.

It can be noted that Alex's and Chilly's experiences of play therapy were actually quite different. Chilly identified her entire experience as being play-focused with the best aspects of the therapy as playing in the sandbox, and enjoying the time she spent with her therapist, who she felt also really liked playing with her. Alex instead highlighted the tremendous amount of work associated with play therapy, for example scheduling the appointments at just the right time for her daughter's nap schedule, incorporating homework, as well as the work associated with increasing her own emotional regulation. Alex named the importance of being able to learn skills to use with her daughter that were tailor made for their family situation, and the confidence she felt in being able to utilize those skills as necessary elements allowing her daughter to begin to successfully regulate her emotions. An additional difference noted is that Alex identified how she would readily re-engage in play therapy in the future if additional challenges occur, and felt relieved to have that as an option. However Chilly imparted a great deal of trust in her mom, and related that she felt that her mom now knew everything that was needed to help with her big feelings, and reported that she felt they would no longer have to go see the play therapist.

Dyad #4 - Rose and Violet

Rose, is a 46-year-old stay-at-home parent who provides the majority of caretaking for her daughter, Violet, due to her husband's considerable work demands. During this interview Rose was soft-spoken and had a gentle laugh that would accentuate many of her answers. Violet is an enthusiastic and spontaneous 6-year-old who planned to begin Grade 1 virtually in September due to COVID-19 restrictions. Violet very enthusiastically answered all my interview questions, and attempted to make sure I understood exactly what she was trying to describe; at times going to great lengths to find the exact word she was looking for. During the interview Violet simultaneously coloured pictures which she then showed me, and at the end of the

interview made sure to take time to introduce her cat to me. Violet was a confident participant, who felt very comfortable correcting me if she didn't feel I quite reflected back the answer she intended.

Violet attended nine sessions of play therapy from one provider, when she was 5 to 6 years old. Rose described the reasons for seeking out play therapy as Rose needing some extra support around potentially making a school change for Violet during Kindergarten, and also to help with Violet's emotional regulation and to reduce fighting that was occurring with both classmates and teachers. When asked why she went to play therapy, Violet replied, "Because he [the therapist] is a little smart." Rose named significant challenges to finding a play therapist and even more challenges in finding a therapist who would also be covered under their health insurance. Rose identified how she went to numerous family doctors and pediatricians before a pediatrician finally gave her a list of therapists. Rose indicated she then spent numerous days placing phone calls to all the therapists on the list, many of whom she found out did not work with children as young as Violet, or only provided couple's counselling.

Violet's experience of play therapy

When asked about her experiences of play therapy, Violet began by naming her favourite activities in therapy including playing puppets and a Guess Who card game with her therapist: "Well, it’s like this game that you choose, choose, a person’s card and see and guess, and the other one, then the other person like (...) guesses. (...) They do like a hint or a clue (...) what kind of person it is, and, what kind of like name it is (...) I loved it, it was my favorite game." Violet also named how she remembered she received a new sticker at the end of each session which she enjoyed very much. While talking about the variety of fun games at play therapy, Violet also identified how there was a game with a picture of Sponge Bob Square Pants that made her feel

very uncomfortable: "He was on the game cover (...) YEAH! and I very didn't like it, I don't like (...) Sponge Bob (...) I get very upset."

When asked about what her therapist was like, Violet described him as: "He's old (...) and he wears glasses (...) he was happy, most of the time." At this point Violet shared information about a rupture to the therapeutic relationship that occurred in their last session before therapy was stopped due to COVID -19: "Like that's the day that, that I really um, like I didn't like him (...) so I never seen him again (...) *sigh* well there was like, something wrong. Like I tried to do something to him I think? Oh and and I gotted very mad at him. (...) He was like so sad (...) and scared." Violet then went on to describe how sad her therapist was through showing the interviewer various different shades of blue coloured crayons: "When it was the last time I saw him, this was the kinda (...) tears he was using, that kind of colour (initially showing interviewer one blue crayon, then showing interviewer a couple more different shades of blue crayons), well he wasn't crying, but he was sad (...) like that you get the blues."

Violet described how she thought her Mom really enjoyed the play therapy process, and identified that mom liked it because she liked the therapist. Violet also described her differing feelings about play therapy: "She's very happy about, but I don't really like it (...) she's sad because she wants to go to, play therapy with, again with me, but she doesn't know my feelings. That I don't want to go to play therapy. I don't like [the therapist] anymore, but my Mom does." Violet went on to name how her therapist's life would now be over since she no longer went to therapy: "His life is gone, not the whole world's life is gone, HIS (play therapy) life is gone." When asked what her life would be like if she had never attended play therapy and had never met her therapist, Violet (who lives where snow is a rare and magical entity to her) replied: " I would be so happy that that day, it would be snowy (...) the clouds would create snow, for a snow day."

Rose's experience of play therapy

Rose spoke about seeing numerous doctors and consulting with her child's school to try to access mental health services for her child. Rose also expressed concern about accessing mental health help through her child's school: "It was a little discouraging because you want to do something to help your child, and you see that they're suffering. At school (...) they have their children's, you know, their psychotherapists they have children seen through the school district that we live in (...) especially like where we live there's this stigma that if you're taking your kid to a therapist there's something wrong with your kid. And I didn't want her labeled like 'that's a problem child' or 'that's so and so, we know that she's got problems.'" Rose reports that she spent a couple of weeks trying to find someone who provided play therapy for children as young as her daughter and was also accepted under their health insurance: "It was this huge sheet that the doctor gave me, and I went through every single one, and some people didn't take that age group (...) so I kinda knew you had to search and it took me like, I want to say maybe 2 weeks, um just calling (to find Violet's play therapist)."

Rose described the reasons for seeking out play therapy was to help with behavioural challenges due to anxiety that she saw occurring in Violet, as well as identifying Rose's own increasing anxiety that was occurring with every phone call from the school: "So here's she's in class, she's experiencing anxiety and on your end you're at home, just like if that phone rings you're really scared as to what's going on. (...) Cause I just I really felt in my heart that I knew something was wrong. And if I didn't do anything about it, we would probably still be in the same predicament. I would have the same anxieties like getting a call every day from the teacher (laughing) you know that kind of stuff. It really did happen to me and it was really no fun for me

you know, when your kids in kindergarten and you shouldn't have to experience that at all. No one should."

Rose described how the play therapy was at a conveniently located office building and both Rose and Violet would look forward to going to the sessions. Rose described how Violet found the toys to be fun and found the therapist engaging, and Rose found the space to be calm: "He was just super helpful like I said, he has this very calm demeanor about him, that just really just really like put me at peace, being in his office you know any anxiety that I was feeling, I just felt really reassured that he was the person for it. He just was so sweet and just very calm, and Violet walked into his office and she checked out the toys and she really, she just really liked it, he just really was this calm we had been searching for." In describing seeing the play therapist engage with Violet: "It was like seeing Santa Claus (laughing) with kids and it was just like wow (laughing) (...) So Santa's like this greater than life type of person, so like he just had this, I guess aura about him, that you know my daughter just really gravitated towards. 'I want to play with you ok, let's do this', or 'ok I'll tell you about me'. So he was just able to, you know, get my daughter to think and talk and, you know, and settle down. And he was he's just like, (...) he really had the patience with her. Like you know lots of people, even myself I sometimes lose my patience and he just was really very calm and just wonderful with understanding that she's in a new place, she's only 5, she's looking around his room asking him questions."

Rose also spoke of the importance for her as the parent to listen to the therapist and take an active role in learning to better understand how to help her daughter through modelling of the play therapist and practicing the assigned homework: "It's important for parents to also listen, to be very subjective, not just, this is (my) very narrow-minded thinking, like you really have to open yourself up to the whole therapy process. [The therapist] helped me with like a behaviour

chart (...) he gave me really good ideas helpful, helpful ideas that we implemented at home, like having a chore, like making (her) bed, brushing teeth. Those very simple things that she would feel like 'hey I'm proud of myself I accomplished these things' and then you know getting rewarded. And we would change the reward and he just really suggested a lot of things that were very, very helpful."

Rose described how she noticed significant behavioural differences in Violet after starting play therapy which she attributed to both the therapy and to the change in school: "I would say that she was able to you know communicate better and we weren't having as many instances with her um acting out at school (...) all of that very dwindled down, like any kind of fighting."

As part of the changes noticed, Rose also talked extensively about changes she saw in herself that occurred during play therapy. Rose spoke about how it was the validation and support of the therapist that helped her to be more confident in making the difficult decision to move her daughter from a school down the street from where they live, to a Montessori school further away: "I said you know, I'm really concerned like I really want Violet to play, to be in an environment where she can get up and walk around and it not be like a penalty for her. And so you know he really helped me. He didn't help me find this school, but he really helped me like validate my feeling of you know I should take her out of this school, and so I was able to find the Montessori school. (...) Well it is was definitely encouraging you know, someone who's actually been an educator in the public school district to really validate and to say that's not typical. That's very atypical, for a kindergartner to be told to sit and work through lunch. That's not normal, for a kindergartner to be stressed, to memorize and to do these things, just because they

want to prep kids for the test and not to learn. And so that really did, it helped me. It really tremendously helped me."

In addition to the independent play therapy that Rose sought out, the school also engaged some behavioural interventions to help Violet. Rose named significant differences between how the behaviour interventionists worked with Violet at school and how the play therapist worked with her daughter: "At school with their behavioural people that basically come in and they assess like how they're doing behaviourally in the class, and so like it was really different from that to where (the play therapist) was. For them I think it was like 'we want to see this' and they're not going to explain, they are just expecting this behaviour and then you're going to get a reward. And so, like I kept telling them, you're not training a monkey. You know my daughter is a person, she's an individual and the way I see it is just: here's a treat, come fetch, do this. And that's not how I parent. And that's not how I want to see anyone else being treated. So you know seeing that model from [the play therapist] and it being very gentle, and very patient. It was completely different."

Similarities and differences between child and parent experiences

Rose named the challenges of finding of a play therapist to be the most difficult and negative aspect of the play therapy process. Otherwise, Rose found play therapy to be a very helpful and positive experience. Similar to her mom's view, Violet talked about how fun play therapy sessions were initially, and that she looked forward to them, until that last session where the rupture occurred. Early in the interview Violet described the fun she had while playing with the toys at play therapy, but once she began talking about the play therapist and their rupture, her overall summation became much more negative. Violet still very much remembered the rupture in the last session, and she remains quite angry with the boundaries he set when she tried to hug

and kiss him hello at the beginning of that last session. While Mom was aware that there had been a rupture in the final session, it was only during Violet's interview for this study that she understood how the numerous other previous positive experiences that Violet had in play therapy were now overshadowed by the rupture with her therapist. A couple of days after this research interview was completed, Rose emailed me and provided an update. She indicated that she spoke with the therapist and asked that he reach out and speak to Violet and they would hopefully be seeing him once again when COVID-19 restrictions allowed.

A distinct difference observed was between Rose's and Violet's perceptions of changes that occurred. Rose named numerous changes she saw in both herself and Violet's behaviour, noting an overall increase in Violet's confidence and expressing herself in non-violent ways. Rose indicated that the school teachers and administration also noted positive changes in Violet's behaviour that was additionally demonstrated by the elimination of daily phone calls to Mom from the school. In contrast, however, Violet did not notice or name any changes in either herself or her Mom that occurred during or after she attended play therapy.

Dyad #5 - Allison and Gabe

Allison is a 38-year-old, married woman with two sons who works for a community agency providing resources and supports for teenage parents. During the interview Allison was confident and enthusiastic in her responses to the interview questions. Gabe, who is 9 years old, is Allison's oldest son. Gabe is an enthusiastic child who preferred to conduct the interview with his camera off. He provided answers to approximately 75% of the questions due to challenges in remembering some details.

Gabe attended eight sessions of play therapy approximately four years ago. Allison describes seeking out play therapy for Gabe because of his explosive anger and the impact it was

having in their family. When Gabe was asked the reasons why he began going to play therapy, he reported that he knew his mom wanted him to attend, but he had no idea why he went. Allison was in a unique position to be able to speak about the play therapy process from two different perspectives, since her youngest son also attended play therapy with a different therapist than Gabe's, and continued therapy right up until the COVID-19 interruption in the spring of 2020. The younger son declined to take part in this interview, telling his mom that he misses his therapist and he did not want to feel sad having to think about her. Allison described how when she went to find Gabe's therapist four years ago, she had talked to their pediatrician who was unable to provide her with any recommendations. For Allison, finding Gabe's therapist ended up being a very self-directed process where she researched and found his therapist through a Google search. When she needed to find a therapist for her younger son years later, she described how at that point she had begun working at the community agency where she currently works, and she spoke with the Mental Health Therapist at her workplace who highly recommended her youngest son's current play therapist.

Gabe's experience of play therapy

When asked about his experiences of play therapy, Gabe began by describing the toys he played with, including Lego, stress balls, and board games. He then gave both a description of the room’s bins and shelves, as well as its size. Lastly, he talked about the proximity of the play therapy office to a local library and grocery store which they would go to once his play therapy session was complete. When asked specifically about what he remembered of the therapist, he replied: "Mmm, I didn’t pay very much attention to that part of the therapy."

When asked about how he felt going to play therapy, Gabe initially described it as: "Good, good because ... a lotta good. Well... kinda good (...) Um you know like that feeling

when you have like butterflies in your stomach? (...) we would go there about twice a month (...) Um one of those times during the month, I would probably, at like the first one during the month, I would get butterflies in my stomach." Later in the interview Gabe further refined his feelings about play therapy identifying how many activities were tied to talking with the therapist: "Some of the activities were boring because all the activities that had questions (...) Uh well most of the time it was answering questions, so we would spend 45 minutes just answering questions." When asked how he would navigate this balance between playing and talking, Gabe identified that he would speak up to his therapist to let her know there was too much talking occurring, saying: "I don't wanna answer this question" or "More play, less talk."

Gabe described how his favourite part of the play therapy process was being able to get a break away from his brother as well as doing the activities that occurred immediately after he attended a play therapy session: "Getting to go twice a month to not have to see my brother, and just at the end getting to have a cookie (from the grocery store) and getting to have a book (from the library) and iPad." Gabe identified his least favourite part about play therapy as being the play therapy itself and having his morning routine be interrupted to have to go to therapy: "The actual play therapy itself (...) I know that there was one bad thing about play therapy but I just can't put my finger on it (...) Annoying (...) Cause I would be like watching my cartoon and then Mom would say 'it's 9:00 in the morning, time to go' and I was like 'I'm still watching my cartoon' (...) And then she would just make me miss, and then, she would make me have to stop my cartoon." When asked what he would say to another child about what to expect regarding the process of play therapy Gabe replied: "It's fun if you like chatting a lot. It's fun if you like answering questions."

Gabe described two specific interactions with his therapist that he identifies as still thinking about: "The first time she asked where would your dream vacation be, and I said Hawaii, and she asked why (...) But when she asked that, it was time for me to go, so I actually never answered that question." He also described a time when the play therapist asked him to draw a picture: "She would try to make it fun (...) But whenever she would ask like 'draw your favorite thing' and then it was just like two scribbles, and then she would say 'good job', and I'm like 'uh that's a bad drawing'."

Gabe did not notice or describe any changes he identified as occurring during the time he went to play therapy, and noted that he went to play therapy for both the reward after and because his mom wanted him to go to play therapy: "It was like something for my Mom, I did it because my Mom wanted me to (...) so and I never wanted to do it so, so at the very end I would get to have a cookie and a book and my iPad." When asked, Gabe was unable to name what his mom's impression of play therapy was and was unable to say whether it might have been a positive or negative experience from her perspective.

Allison's experience of play therapy

Allison spoke at length about the challenges she had even deciding to engage in the process of play therapy and how confusing and overwhelming it was to have to evaluate whether play therapy was needed or would even be helpful: "And then even just trying to decide (...) like it took us a long time to even commit to doing it because you'd go back and forth right? 'Cause nobody could tell you for sure if it was something that was necessary or something that was going to be beneficial, and so it's like do I have to do this? Do I not have to do this? (...) You're learning as you go too, and so you have a hard time gauging of like, is this just normal development, and I should just roll with this, or is this not? And then you, you get mixed

messages from everyone around you as well, some people saying 'oh no, that's not the norm' and other people being like 'oh yeah I've heard of kids being mad like that, it's fine', and you're just like your head is constantly spinning. So I feel bad. [Gabe] was definitely our guinea pig when it came to all of this, it was kind of that trial and error (laughing)."

Allison identified that because her boys saw two different therapists, she is able to recognize two very different approaches the therapists took to play therapy. From that, Allison highlighted that she feels the critical piece for her in the play therapy process is communication with the therapist: "It was like those two parallel, two very different, like experiences, so like with Gabe, um, as a parent it was really a struggle, 'cause there was very little sharing back (from the therapist). There was very little like, of that piece back, especially directly about his sessions, so I never like went in at the end. We never talked about it, it was just like kinda his space. But then one of the things [Gabe's therapist] did do was she ran like the 10 week parent focused play therapy group, where she kinda talked broad strokes (...). So it was kind of interesting 'cause like for Gabe in terms of like his behavior or understanding like what HE was processing, there was very little for me as a parent (...) But the experience with my youngest, with (his therapist) was um, very different. Right? Every 3 to 4 sessions that he had, we would have a parent session. Where it was just us coming in, and I found that to be incredibly like, incredibly useful. If I was going to recommend play therapy to somebody I would tell them to ask the play therapist if they do that. Because what I loved, is in that case (her youngest son's therapist) was really great about, being clear to us that she was going to maintain (his) confidentiality. But she also talked to us (...) about what am I seeing, right? And what am I seeing change in his play? So that also gave us a sense as parents that like OK he is growing, and he is using play to work through things and that there's that working through it is happening."

Similarly, Allison also highlighted the differences regarding where the two offices were located, and how the isolation of her younger son's therapist's office actually made it a more engaging experience as compared to Gabe's therapy where she would squeeze in her grocery shopping while Gabe was in his appointment: "With Gabe there was always this kind of feeling of because there was less of that kind of parent engagement, it always kinda just felt more like a chore. Right? (...) it's a pain, were going to get you here, and while you're here I'm going to run off and do all of these other things, right? So that always kind of felt like ah, like I was never really sure it was worthwhile (...) But with (my youngest son) it was very different. Because I know when we started off with the parent sessions, one of the things [his therapist] asked me, and her space was not somewhere...there was nothing else around it. So you kinda had to stay. (...) She's like, 'what a great opportunity for you and your oldest to hang out for an hour', (...) and when she said that I thought 'you know that's a really good point.' I have this whole hour with my oldest so, like I can remember we would bring charades games, and it would only be the two of us in the waiting room, and we'd be playing charades right? (...) It wasn't just like (the youngest) is going to therapy. I really felt like it was set up in such a way that when we left it was like, yeah (the youngest) went to play therapy but we're all leaving with things, and in a really good positive space."

Allison went on to the talk about how the additional communication that occurred with her younger son's therapist allowed a critical recognition to occur in their family, the act of feeling "cued" to the changes that were occurring in their son. So when he incorporated small changes into his behaviours at home, these changes could be recognized, highlighted and reinforced by her or her husband, almost creating a positive feedback loop: "It was fantastic, I think it made all the difference. Because then it allowed both my partner and I to see when we

got that feedback, and we can see it then. We could see changes at home, that maybe we wouldn't have seen before. Right? Subtle changes that you know in the busyness of life we probably would have overlooked. But because we had (our younger son's therapist) there cueing us to, 'hey, he's shifting from this is where he was, and this is where he's at now'. When we saw things we would be able to afterwards be like 'okay we saw that he lasted like an extra couple of seconds before the blow-up happened.' (...) And I think we probably would have missed a lot of that. And it also makes me wonder like with Gabe, that's entirely possible, that there was those same things happening, but we just missed it, because no one was cueing us into what we're looking for, and what it was that he was actually kind of processing through."

Allison also spoke about how she feels the action of play in children is a needed and necessary step which allows them to develop into who they are supposed to be. She highlights how she now validates and does not try to control or judge her children in their play because she feels that it is through play that children move through their developmental stages. "You're constantly getting these messages as a parent that you're responsible for controlling your kids' behavior right? And that you have to be on top of them. In play they learn how to BE people, right? So you're like 'Oh I want their play to reflect how they should be in real life.' And to have a professional sit down and be like, 'actually play is how they work through all their feelings and all their emotions, and everything they're dealing with, so that they can BE fully functioning people.' That was revolutionary to me. Right? To have that awareness that it is through play, and THAT is how they then become functioning people. So it's like, (...) the way they play means that then they can BE who they are outside of play because they've had space to like process and try on different things and explore, yeah so that that was huge for me as a parent."

Allison described how for her the support and validation she received as a parent from her youngest son's therapist was a critical and key piece to her feeling like play therapy was a helpful and successful process and provided her with hope: "It was fantastic, and I think that with [my younger son's therapist] especially, that was something that she was very clear right from the get go that she considers that part of her role as the therapist's role of providing that parental support. So she's playing with the child but she would like encourage us all the time to email, if something comes up, like in between sessions (...) And I think having that type of professional support for parents is just so important because you don't get that 'you're doing a good job' from a lot of people (...) I think that sometimes through the play therapy, it did help me, put into perspective that one bad patch, or like messing up as a parent (...) even for a period of time, that you can always circle back. That it didn't do damage that's going to last forever, right?"

Allison was able to name some small temporary changes that occurred in Gabe's behaviour immediately after he attended play therapy sessions, however she did not feel that there were longer lasting changes or differences that occurred for Gabe. Conversely, Allison was able to describe significant changes in her younger son after he began attending play therapy and attributed much of the change to the therapist teaching him how to feel and move through his emotions through the process of play therapy: "So with Gabe (long pause) I think some of the differences that I definitely saw with Gabe was that there would be this, it kinda built in some lull periods in our life. Because it was a period where he was getting somebody's undivided attention, for that whole span which has always been very important to my oldest, it's very important to him. (...) And so I definitely saw the benefit for him of just being able to have another adult who was just like totally about him for that period. With [my younger son] oh Lord there were so many, I definitely saw more benefits (...) it was just really interesting to me like

when she would share those things and I could see how without talking about feelings she helped him figure out how to feel them."

Allison also spoke about how if she had to go through the process again, she now better understands the importance of the fit of the therapist with the family. "Different fit, different fit (...) I didn't KNOW. So by the time you find somebody, you go in, you do the first session, as a parent you tell them what your concerns are, like it is so much emotional work for yourself, that the thought of doing that again, with somebody else, like that fit unfortunately it didn't even factor into like really my thinking. It was like, oh well I guess child therapists are child therapists. And then you start the experience (years later) with [my younger son] and it was so different that I was like 'Oh my God'. Like if I had to do this again, there would totally be more talking for me as a parent to 6 different therapists to find the right fit. (...) So I think that's the piece too, like that fit it can feel exhausting I think as a parent 'cause usually by the time you are looking at therapy, you've reached the point where you're already at your max as a parent. The idea of having to like do that search, seems overwhelming. And yet it's probably the most important piece, right?"

Allison also speaks on the impact of fit with therapist has in communication that occurs with parents, specifically regarding a parent's willingness to be vulnerable about what is occurring in the household. She also notes how this additional information from the parent then provides the therapist with important contextual information to apply in their work with the child: "I think that the fit really comes down to as a parent, this didn't happen with Gabe, and I think, it might have been more of a teaching style, right? It didn't require me as a parent to be vulnerable at all. It did not require me as a parent to like kinda open up to the therapist, or share what was going on from a parent perspective in the house. And so there was always kinda that

barrier. And then when we first met with (younger son's therapist), when I sat down, it was more of feeling very quickly in the conversation that this is a safe place for me to be vulnerable as a parent. This is a safe place for me to share like, the things that I'm carrying with me that I'm sure I screwed up my kid. (...) And I think that's the fit for me, is that you have to feel comfortable as a parent, to be vulnerable, yourself. Because that's where I think that most mentorship and relationship came from, right?"

Allison named the significance of the role of the therapist and the impact of bringing in a professional to help support their family system: "So I think for me like our lives are quite different, because we have gone through that process and with the both of them. I think it gave them both some of the skills that they needed that I couldn't give them at the time. So like at the time I was so overwhelmed, and I was just so out of my element that I wasn't able to give them, even if it was just the space, to explore a little thing, I couldn't do it. So I think it helped move them through some things that they, some developmental things that they were going through, but at the same time it also equipped me to be able to help them through the future ones. And to know when I've reached my capacity, earlier. Like with both of them it was like oh I had exceeded capacity for a while before I went to get help, and now as a parent, I'm a lot more alert to like watching and being like 'ok, do we need help?'"

Allison also talked about barriers she experienced in trying to access play therapy services for her sons: "It would be so amazing if, I don't know, if it would be in schools, or child care centers, or doctors' offices, but just if there was the increased awareness that they had, to be able to make some of those good referrals to families that they know. So I think that is probably the biggest barriers, is that when you first start looking, if you don't have someone who can give you a referral, and who knows you and knows a good place to start, then you're really working

off a website. Largely, you're overwhelmed anyways so you're probably going to pick the first person whose website works (laughing). (...)I would love to see it become more of a, not like a regular referral, but just to have people who work with kids more aware of play therapy and the benefits, and more linked into that community of play therapists, to be able to help bridge parents to play therapists when it's necessary, when parents want that."

Similarities and differences between child and parent experiences

In their separate interviews, Allison reported that she felt Gabe's therapist was not a very good fit for her, because there was no connection and communication regarding what Gabe was working on. Gabe, similarly, did not consider the therapist to be a particularly meaningful contributor to the therapy process, and he did not mention the therapist at all in his description of play therapy. When he did describe interactions, they were events in which he felt a disconnect from the therapist, for example asking about his dream vacation and not waiting for his response, and the therapist praising his scribbled picture. Both Allison and Gabe also similarly described how when Gabe attended play therapy, it was not a distinct stand-alone event, and how instead therapy was treated as one stop within a larger process that included getting groceries, going out for a cookie, and stopping at the library to get books. Gabe did not name any type of change or differences noted after going to therapy, and similarly Allison named no long-term changes she noticed after Gabe attended play therapy. Allison did make note that for a couple of days after a session there would be a temporary lull in Gabe's challenging behaviours where the family would get a bit of a reprieve.

One difference that was noted between Gabe and Allison's experiences was the perceived length of time that play therapy occurred. Gabe reported that he felt like he went to play therapy

every couple of weeks "for about a year", whereas Allison reported that he went every couple of weeks for a total of eight sessions, and that his play therapy was completed in about four months.

Dyad #6 - Amy and Rodger

Amy is a married, 41-year-old woman who works in the mental health field as a Registered Psychologist. During this interview Amy provided answers with a warm and calm demeanour and displayed great conscientiousness; after answering a question she would at times check if she should provide more information. She lives with her husband and son, Rodger. Rodger is an energetic and talkative 5-year-old who was excited to be beginning Kindergarten the week after this interview took place. While Rodger enthusiastically answered all interview questions, he also simultaneously drew numerous pictures during the interview, proudly displaying and explaining them to me.

Rodger attended six sessions of play therapy from two different providers, when he was four years old. Amy describes two very separate and specific reasons for seeking out play therapy for her son. The first round of play therapy consisted of one session, and was sought to help manage some vivid nightmares Rodger was having. The second round of play therapy occurred approximately six months later and consisted of five sessions to help Rodger with some significant fears he was having regarding germs. During his interview, Rodger independently named both his nightmares and germ worries as being the reasons behind why he thought he went to play therapy.

Rodger's experience of play therapy

When asked about his experiences in play therapy Rodger described the process as "very veeeery fun, fun, fun, fun, fun". In naming what he enjoyed so much about play therapy, Rodger identified that it was the toys he enjoyed, in particular a small ball that could then stretch out to the size of a basketball; this toy stood out as being particularly fun for him. While Rodger

described play therapy as being fun, the reason it was fun was because he got to play: "I loved it (singing) playing, playing plplplplplaaaying". He indicated that the part he liked least about play therapy was the talking, "I didn't really like how I had to talk. I liked just playing." When asked what it was about the talking that he did not like as much, he replied "Well, I didn't really like (talking) because the more we talked, the less time I would have to PLAY!" In describing the play therapy process Rodger did not spontaneously talk about, or describe either of the play therapists he saw. He also reported that the therapist he preferred to see was influenced by the amount of time he got to play with the therapist, and so he named his second therapist as being his favourite.

Rodger talked about and described a variety of play-based exposure interventions that were used during his therapy. For example, when addressing his nightmares, he reports drawing a picture of the bad dream on a piece of paper: "um you know how a picture gets drownded in water? (...) You know what we did? We like um put it in water and kinda washed the dishes (...) I think we put a little bit of soap in there so and then we picked all the things, paper, and it was all gooey and we put it in the GARBAGE! (*yelling gleefully*)". When describing the activities he participated in regarding his germ fears, he relayed how he and his second therapist drew pictures of the scary germs and then talked about knights in his body that would keep him healthy: "I remember me like, I had a lot of germ worries and I was like blowing on my hands because I thought that, mmmm, that would make the germs go off because that was my big thing (*demonstrates how he used to blow on his hands*) cause that's how I thought the germs would go away (...) we kinda, well we talked about a knight and your fighters can fight that little germ."

Rodger identified that change had occurred over the course of play therapy, with his nightmares disappearing and his fears of germs dissipating. Roger described these changes as

occurring because he forgot about his troubles since he was busy playing: "Hmmm, well before I was really, really worried, but after I'm not even talking like I remember (...) But before I just need to talk, and I think there was some germs and like I blow on my hands (...). When asked how the therapist helped him, Rodger replied: "Hmmmm I think I just forgot about it (laughing) ... And I remembered about toys so that I forgot about it, because I was so playing with toys."

Throughout the interview, Rodger was drawing pictures which included pictures of him with his mom and dad. When asked what his life would be like if he had never gone to play therapy, Rodger named with confidence that his mom or dad would have been able to help him with his challenges: "Well, Mommy and daddy would teach me instead, or Mommy would become one (a play therapist)".

Amy's experience of play therapy

When asked about her experiences with the process of play therapy, Amy was able to name play therapy as being tremendously helpful: "And it’s effective, I mean if I was explaining our own experience of it, I would have to say it worked better than I ever could have expected it to work (...) cause our kid did like a 180 degree turn and got so much better in both experiences and it worked fast too." When speaking of the noticeable and rapid changes that occurred Amy reports: "I feel like the change was very dramatic and I would say it worked quickly, I mean we came in, I was worried about my child. I thought, you know, is he going to have to be medicated because it looked to me almost like a tic. It was almost continuous at points where he was doing this, like, blowing on his hands ritual. And I was really very concerned with him. And really I think by about session two or three, like the behavior had almost totally extinguished (...) by session five I almost felt a little silly taking him."

Due to her training and career as a Psychologist, Amy was highly trained in a variety of exposure-based mental health interventions, and had tried to help her child in numerous ways before seeking out play therapy. She spoke about how many family members and friends were also giving her tips and advice of what might be helpful as Rodger's fears became more noticeable and debilitating: "I was trying to help him and, it was, before we took him into therapy, it was such a helpless feeling as a mom to see your child suffering. And to, you know, really to have had so many failed attempts to help him. I just couldn't seem to figure out what to do and you know friends were sending me random books (...) to try to figure out what to do." Amy spoke about the benefits of the help coming from someone other than a parent. "I think it preserves your relationship with your child, because it is frustrating when your child has a problem that you can't help them with. So you know putting that in the hands of a professional means you can just be the mom you don't have to be trying to be a therapist and a mom."

Amy also spoke about what she perceived the difference to be regarding the help she tried to provide her son before seeking out play therapy versus what the play therapist was doing in session: "Maybe she was confident enough to push him a little bit more. As much as you try, as much as I believe in exposure, when it's your own child getting scared you know you end up compromising a bit, right? So maybe he wants to wash his hands and I don't think he needs to, but when he starts getting more and more and more upset, I would sorta like break down and let him. Or you know he'd say 'well can I at least like use Sani(tizer)?', and I'd say yes, so I think she had the confidence to really tolerate a little bit of distress on Rodger's part in order to help him, and maybe that was the piece that I was missing".

Having accessed services from two different therapists for the two different concerns, Amy was also able to speak on the differences she saw between therapists. The first therapist

Amy describes as being a very effective play therapist. However Amy also states that she had some concerns regarding aspects of the therapists administrative practices and professionalism: "You know the interesting part is that what she did with Rodger was really effective (...) he was having these terrible nightmares and he was getting fearful about going to bed. She did some play therapy with him and they worked with the dream and it solved our concern (laughs). You know the funny thing is but we just couldn't face it to go back (to that therapist when he started having germ fears)."

When describing this first therapist who they saw for one session, Amy named a multitude of challenges and frustrations including the session starting late, the therapist not reviewing the informed consent form that was vague and non-specific, and the payment process: "We arrived and she was running late and you know it happens (...) I don't think we got in there until about ten to seven and our appointment had been at six so we were just really shocked that there was an expectation that we'd wait 50 minutes with you know an active four year old, right? And it was coming close to his bedtime, and then there was like no apology or recognition even on her part that this was like out of order (...) and there didn't seem to have been a huge crisis. Like cause I would understand OK, like if she came in and said 'I had a suicidal client, I am so sorry', but that was never, like that never happened."

Amy also spoke of worries she had regarding the lack of review of the vague informed consent form: "She didn't really do like a thorough informed consent, (...) because there was no informed consent discussion, there was just this part of my mind that was worried about what ARE the limits of confidentiality? (...) I don't know this woman, I mean what if she for some reason interpreted one of his dreams, like let's say if Rodger said 'Oh I dreamed that mommy and daddy hurt me' or something you know? What if she got really alarmed? I would have

appreciated her being more clear about what her process would be if she had heard anything that concerned her about Rodger's safety. And because she didn't go into that, I guess I was a little bit unsettled by that."

Amy also spoke about how the first therapist only accepted cash or cheques for payment, and the uncomfortableness she encountered during the payment process. "It turned out she accepted like cash and cheques, so I was like OK, that surprises me, in this day and age but (...) I can go with it old school. So I ended up somehow forgetting to bring my chequebook that day so (...) I was like I guess I'll just end up paying cash. And then she almost forgot to give me a receipt, and of course I wanted to put it through on my benefits. And then I remember, I handed her the money and then she sorta said 'Oh I feel like we just did like a really shady deal'. And I was like, is this your job or not? Like why are you making it weird? This shouldn't be a new thing for you, right? So why are you acting as though I'm doing something oddly here? Like, the fact that she wasn't going to give me a receipt I was like, 'who is this?' I was just so put-off by that (...) she just didn't seem to have any polish."

In contrast, when Amy spoke of the second therapist, who she felt was an outstanding fit for their family, she was unable to name anything that could have been altered to make those interactions even better: "It was wonderful, I mean I had so much respect for watching her work. She was extremely enthusiastic, extremely confident, very energetic, and that confidence was very reassuring to me." Amy also spoke about the relief and hope that she noticed when she knew there was a good fit between the second therapist, Rodger, and her and her husband. "Once we had a professional on board I felt reassured, I felt hopeful. I felt relieved because I knew we were in such good hands, I could just see the improvements so quickly, yeah I felt a very strong sense of trust you know that she was she knew her stuff and she was going to help our child."

Similarities and differences between child and parent experiences

In their separate interviews, Amy and Rodger both named that change had occurred for both the nightmares and the fear of germs that were the reasons therapy was sought out. While Rodger liked both therapists very much, he preferred the second one only because he got spend more time playing with her. In contrast, Amy strongly preferred the second therapist. This choice did not have to do with more effective treatment. Instead, Amy noted a greater overall sense of confidence and trust in the therapist which she evaluated by taking into account effectiveness of therapy, fit with both parents and child, as well as professionalism and conscientiousness in business practices.

A noted difference between Amy and Rodger's experiences of play therapy was that Amy was uncertain if Rodger actually liked it: "He never loved it. Like I would say to him 'how are feeling about going,' and he didn't hate it, he didn't love it. Like it didn't seem to have a huge impact on him." In contrast, when speaking about play therapy in the interview, Rodger was very animated and noted how it was: "Very veeeery fun, fun, fun, fun, fun" and also sang his response to how fun the playing was: "I loved it (singing) playing, playing plplplplplaaaying". Similarly, Rodger was equally uncertain of his parent's experiences of play therapy, naming their experience as "neutral", however when asked, Amy described her experience as very positive: "You have faith in the process, it's really worked you know in the past, and gives me more reassurance going forward."

Dyad #7 - Kate and Jack

Kate is a 45-year-old teacher who has worked in early childhood education for over a decade. She lives with her husband and two sons. During the interview Kate was engaged and enthusiastically answered all interview questions. Jack, who is seven years old and Kate's

youngest son, answered most questions in a concise, quiet manner. During the interview he shot a small basketball through a hoop on his closet repeatedly and spent the majority of the interview time standing or retrieving the ball while simultaneously answering interview questions.

Jack attended approximately 12 sessions of play therapy, which was interrupted due to COVD-19. While the parents did continue to complete parent sessions online with the play therapist, they elected to wait until late summer for Jack to again resume in person play therapy. They felt that play therapy virtually for Jack would not be as engaging or helpful. Kate described the reasons for seeking out play therapy as Jack having significant challenges with anxiety, and experiencing numerous body sensations of anxiety which he found to be very upsetting. Kate also described how Jack was missing lots of school, and also missing out on fun after school and sports activities with his friends because he would feel sick to his stomach. When asked why he attended play therapy Jack described the reason as being "mostly about my worries." Kate described how she received the referral for the play therapist through a Psychologist acquaintance through her son's school. Once she reached out to the office, they were then placed on a six-month waitlist. It was only then that she and Jack finally had the opportunity to meet the therapist and see whether the therapist might be a fit for them: "But it took a while, and I was thinking 'should I get on another list? What if he meets her and it’s a no-go?' (laughing) I read as much as I could, but (...) I was trusting and knowing [her acquaintance] and trusting her judgement that she hires good people that she has great people in her clinic. It was good to have that personal connection that we knew her from school. Yeah, it’s hard … that was tricky. It was a lot of anxiety for me waiting and hoping that we weren’t hindering him or making things worse. But it worked out."

Jack's experience of play therapy

When asked about his experiences of the play therapy process, Jack began by naming the things he did there: "Drawing on the white board, talking practice, talking (...), sandpit." After describing what he did there, he then described the play therapy room as having "a bunch of bins" and the play therapist as "good" and "calm." Jack described what he enjoyed about play therapy: "(it's) exciting (...) umm she has toys that I might want to get that I never saw before." Jack named the Nerf Guns as being his favourite toy to play with. In describing things that he liked least about play therapy, Jack replied: "Sitting down a lot." Jack described how if he had never attended play therapy, what his life would be like: "Boring, a lot of extra (computer) game time, less exercise, sitting, more eating more drinking." When asked any changes he noticed while he was going to play therapy, Jack replied: "Less stomach aches." When asked about what he thought about his Mom's experience of play therapy, Jack stated that his Mom "liked it" for a few reasons, "a lot of toys, a lot of talking (...) learning to help me."

Kate's experience of play therapy

Kate spoke about initially taking Jack to his pediatrician and numerous other specialists to rule out any physical causes of the uncomfortable body sensations that Jack was experiencing. Kate noted how her pediatrician did not have any play therapy referrals when she inquired, and so Kate had to seek out play therapy on her own: "We were talking for a while about that it might be beneficial, and when we started to see a lot of physical symptoms, a lot of things going on the doctor had ruled out. They (...) ruled out kind of any other stomach problems, and he was missing a lot of school (...) one of the mom’s (at school) owns a psychology clinic, they get really great recommendations all the time, so we started there."

As an experienced teacher who worked in early education with at-risk children for more than a decade, Kate described how she was already familiar with many of the play strategies and coping skills through the work with her own students. She noted the critical role the therapist played for her son to be able to learn the needed coping strategies and information about anxiety: "And it's that not-mom connection. Because literally, I'm like I literally, spend all day teaching regulation to kids. But when it's your own kid, they're flipped. They can't listen to you. (...) it's just that connection it's just different. And it takes that kind of parental thing out of it. But he's learning the things that I'm hoping that he'll learn, that are important. But it's not coming from me. (...) I think that's really important whether it's a teacher, or therapist, someone who is not the parent to do that. Because that heightened emotional connection you can't step aside from it. That's really important, as long as they got that connection to a third party, that was a key element. Because there is nothing necessarily earth shattering or different that she is teaching than all my instruction, and things that I do all day. But that it's that other person saying it maybe a different way and his ears are more receptive because it's not mom or dad."

Kate named how feeling like there was a good fit between therapist and parents as well as the child was an important piece: "We are very aware of that [my husband] and I have both been to therapy ourselves, so we know when you get someone who gets you, what that feels like. He came out of that first session very lifted. There's always a visible kind of lifting after he sees her. (...) And we could just tell. And when we had our parent conference with her, we just knew she got it. Like she got it from the history and from the meeting with her I had done. And she understood him. We were like 'oh ya, she totally gets this guy.' (...) That connection to him and connection to us as parents was really important. And if it hadn't been there, we probably would have switched, or been like 'ok we need to get on another list, as long as it is, and get on another

list and try again'. Cause we weren't going to stop trying, 'cause we felt it (...) was definitely was an ongoing and going to be increasing problem if we didn't deal with it."

Kate also spoke about the special way that meeting a child through the act of play allows the play therapist access to information they might otherwise never get through only talk based interactions: "(It's an) opportunity that a psychologist would provide to let children play, which is what they do naturally, and how they work things out. So to go alongside them (...), it gives them a chance to act out what they are feeling, what they are doing, give them some encouragement, some materials. (...) Getting it out in a very safe and appropriate way for what they needed. I like that approach, cause the kids play. It's what they do, they don't necessarily sit still and talk like this for an hour. (...) And so that helps sometimes break the ice. (...) It's kind of what they need, instead of I suppose just sitting and expecting to connect and converse, and then especially if you are anxious, and that might just be a shut down. So the play and the toys and the accessibility of that is just a really good in."

Kate named how having an experienced and trusted professional involved in the care of her son provided a sense of relief that the parent did not have to bear the responsibility of their child's challenges on their own: "It's very helpful, and it definitely makes you feel good that there is someone else recognizing the same things you are recognizing. It kinda reassures you that you are on the right path with what you are thinking and what your concerns are. (...) And then it's not something that you just made up, that there is this issue that we need to address. And so it is validating whether it is an allergy or anything you are seeing as a parent when someone professional validates it."

Kate named numerous changes in Jack which she attributed to the process of play therapy: "Definitely, a little bit more lightness, and ability to cope with things and even verbalize

kind of what some of the fears and anxieties are. As opposed to before, when it was kind of total shut down and just you know, shaking and holding a bowl, and sure he's going to be sick. Now he can verbalize more and say you know like 'I'm really scared of storms, I'm really scared of failing grade four, I'm really scared of a heart attack.' All these different things. He can verbalize like he couldn't before. Then we can talk about it and work through it and say 'ok what's going to help you feel better through this moment and then what can we do going forward.'" Kate also identified ways that she had changed her interactions with Jack to help align with language and exposures being used in play therapy: "It makes us feel good (...) she usually does a five to ten-minute fill-in for me, either before or after the session so we can talk together. And just work on what she worked on, she will send me information about this book we read, or these are the words we are using, so we can use the same words. And do a check in about is he just avoiding anything he is fearful of? (...) So I feel like she checks in with us."

Similarities and differences between child and parent experiences

Both Kate and Jack very much enjoyed the process of play therapy and were happy when they could again resume in person play therapy after the months of shutdown due to COVID-19. Both were able to name changes seen in Jack during the course of play therapy, with Kate highlighting that Jack being able to identify and name his emotions as being the biggest change. Jack named his ability to participate in sports and other fun activities as well as a reduction in stomach aches as the changes he noticed most. Kate expressly talked about the importance of the right fit of the therapist with the family, and noted that if this part was missing for either parent or child that she would have started the process of finding a therapist all over again. Jack had little to say about the therapist herself other than she was "good" and "calm", but named play therapy as being enjoyable and "exciting".

Kate and Jack had very consistent experiences in the play therapy process. One difference that was noted between their interviews is that Kate identified and spoke about a notable increase in Jack's use of coping strategies and skills (i.e., use of breathing techniques, identifying emotions, naming worries), whereas Jack did not identify that he was using any new strategies to help his body feel differently. Jack did perceive that his body felt different and his stomach aches decreased, and this allowed him to participate in more fun things, but he did not attribute this change to him doing anything differently.

Dyad #8 - Diana and Paige

Diana is a 48-year-old divorced woman who works in the field of mental health as a Registered Psychologist. During this interview Diana provided answers with enthusiasm and often peppered her thoughtfully considered responses with humour. She lives with her daughter, Paige. Paige is a quiet and reserved 8-year-old who played throughout the interview with a rock collection and with various other toys. Paige provided brief answers to approximately 50% of the questions and answered the remaining questions with "I don't know."

Paige attended 10 sessions of play therapy approximately a year and a half ago. Diana describes seeking out play therapy to have additional supports in place for Paige while going through the process of her parents' divorce. When Paige was asked why she went to play therapy she replied, "I don't know." Diana described finding Paige's play therapist as being a "relatively easy" process. Diana found their play therapist through talking to a colleague, who is also a Registered Psychologist. This individual had taken their own child to this particular play therapist and was very happy with the experience.

Paige's experience of play therapy

When asked about her experiences of play therapy, Paige began by saying "we just played". When asked for more detail Paige described enjoying playing in the sandbox with animals. "I liked the sandbox (...) and animals and stuff you can put in it (...) the sand would make them stand up (...) and sometimes I would put little pretend food in it."

Paige described how during play therapy, she played with the therapist, and that talking did not play a very large role in what they did together during their sessions: "Playing (...) usually, mostly play." Paige described that at the play therapy sessions, "There's lots of cool stuff there" and reported to her mom that she liked play therapy. She also reported that there were no changes that she would make to the process to make it better.

Paige did not name any changes or differences that she noticed occurring during or after the play therapy process. Paige described that she felt that her Mom probably liked play therapy, and that her Mom's favourite part was "playing with me."

Diana's experience of play therapy

Although Diana did not find it challenging to get connected to a play therapist, she did talk about the tremendous challenges she faced in the scheduling of play therapy sessions with her ex-husband. Diana reported that if the therapist had weekend availability as well as online booking capability, that those would have made the task of booking sessions far easier: "I thought it was a bit challenging just because it was sometimes three schedules to coordinate (...) And negotiating that as well between custody schedules was challenging. So I felt like it would have been super helpful for like Saturday availability and things like that so we didn’t have to pull out of school or get time off from work, would have been super super helpful. (...) I do think that would have been a significant barrier for people that would have not had very supportive

employers, or single parents I can't imagine, 'cause it was tricky. So that actually that variable ended up causing a lot of time sometimes between appointments, just because we couldn't coordinate everything. (...) I think the other issue is there wasn't really an online booking option, which I think would have been great. It would have, certainly like some of the therapy time was taken up trying, it's kind of like organizing a summit. So it would have been great if we could just do that on our own."

As an experienced Registered Psychologist herself, Diana was able to speak about how the experience of play therapy was different from what she thought play therapy would be like, as well as noticing it was quite different from her own clinical orientation of how she conducts therapy: "I thought that it would be sort of far more structured (...) So I was surprised, I didn't sort of expect that it would be so non-directive. Like I didn't realize that like children would be given so much choice and sort of freedom in that. And that there would not necessarily be any sort of very specific kind of goal for exploration, or skill building. So I was surprised. Now I know that really the purpose of it is really to, as far as I understand, really sorta connect with the child. I think that there's some skills with affect identification, regulation, that sort of thing. (...) And I confess it was interesting because during the process, one of the things, again, my own clinical bias kinda came up, as like 'How is this helpful?'"

Diana talked about numerous personal qualities she felt were important to be an effective play therapist: "First of all, she appears to have no social anxiety (laughing). (...) And I feel like play therapists probably, like I feel like the best ones would probably have natural affinities to things like improv and acting, and just sort of like their capacity to get into character, to mimic or to enter sort of like a kind of scene you cannot predict. And also the level of cueing, you know, cause again she was sort of like trying to teach me, I was very struck by like, you know, her

finger is on a pulse in a different area than my finger is when I do work. (...) And she is so like animated, and again she is playing like a natural kid, right? (...) And (the play therapist) was just really, there is a level of spontaneity that I think you need as a play therapist that is, I would argue that's a talent issue. I do not think you can teach that. I think that's how you are and you can use that superpower in your clinical work. But there's a level of spontaneity that you really do need to have and also a lack of social anxiety. Like I feel a bit stupid as an adult doing some of those things."

Diana also named how for her to have confidence in the therapist, it was very important for the therapist to have excellent academic credentials and to be able to clearly articulate how the therapeutic work is being informed by science: "Because I'm a snob, I ask them about their training and background. I totally would. I'm also a snob in that I absolutely ask them to articulate for me their theoretical orientation, and they better be clear in their communication of that. And I want them to have like a really nice balance between, so when I talk to them, I need to know that they're on the ball. I want to know (...) that there is science behind whatever the ridiculousness that I know they're going to do."

Diana spoke about what she valued when she was brought in and participated in some of the play occurring in sessions with Paige: "I feel like that, for me, was an opportunity to comment on like a lot of awesomeness of my child. Just in terms of some of her natural tendencies. I know that Paige loves animals. (...) So it allows me to just again comment on some like natural, really positive qualities that I kind of see, which is awesome. Give [her] a little bit of positive feedback, which is good."

Diana told me about changes in her daughter trying to share her feelings, as well as differences she noticed in their connection with each other that she attributed to the process of

play therapy and the play they incorporated at home: "Paige is not necessarily a kid who you can tell how she's feeling, like at all. (...) She keeps things kind of inside. Like I often will find out things that I feel are kind of important, way after the fact. Or that she had big feelings about something, way outside the moment. And it'll be funny because I'll be 'Jesus, like that's been weeks since that (happened)'. (...) She does not especially like feeling things. (...) So it's interesting because the play therapy and like our kind of special play time, she seemed very invested in. Like she would kind of seek me out to do that. (...) She is not very excitable either. And she seemed to have a lot more kind of energy about that. She really liked that. She would comment on feeling a bit irritated that we didn't get to it, if I'd forgotten about it. (...) but I do feel like that was different, engagement was different. Sort of like, seeking out that sort of connection, that was different and actually still is, right? If I kind of say 'do you want to have some special play time'. It is very rarely that she would turn that down."

Diana spoke about the importance of the role of the therapist as a neutral party that helped mitigate tension, and how one of the critical aspects of play therapy for Diana was the validation she received from the therapist regarding challenges she was having with her ex-husband: "Very comforting. (...) And also there was disagreement about the nature of the situation. It was super helpful to feel validated that there was something potentially going on. (...) And so I appreciated the neutral third party. I didn't have to endure any kind of gaslighting, or anything like that. (...) The responsibility of like, giving me information, and just going like 'there might be sort of some issues here', was just not delivered by me (to the ex-husband). And so there was less opportunity for like tension and conflict."

Diana also spoke about the benefits she saw with the process of play therapy, specifically regarding helping Paige identify and express feelings through other ways than only talking: "I

think certainly how to connect and relate for the specific purpose of affect identification, tolerance, and then expression. Because again, my mode is to ask a question about it and have a conversation, which is - yeah, not happening with that age."

When asked if she would make any changes to the play therapy process to make it better, Diana relayed that access to online scheduling would be the one suggestion she would make for improvement to the process: "I certainly think that as unsexy as this is, is scheduling. (...) and I appreciate, 'cause I don't want to (work weekends and evenings) in private practice either (...) So like professionally I get why you wouldn't. But I think that the difficulty is, again like, coordinating schedules, is really crazy, particularly if the parents are split. (...) So I really do think like having some kind of, like a Saturday appointment would be great."

Diana also relayed an appreciation for a special "kid room" that her therapist made available for their sessions: "So there was an extra kind of like little room, which was great, which wasn't the waiting room, but like a room kind of past the hallway, which I did appreciate, because, again, when you don't have child care, right? (...) So even if the two parents need to go in, right? It was really helpful to actually not have to find a sitter and coordinate that mess, right? Like it was crazy. So, I appreciated that there was a tiny little room (...) and Paige got to sit in there and play, but she wasn't in the waiting room with strangers (...) So I did feel like that was one thing that if it wasn't there, that would also have been a huge problem."

Diana also spoke about the balancing act and multiple roles a therapist must take within the process of play therapy with a family: "I appreciated that it's the transition of skill. People shouldn't be in therapy forever (...) I just think that ultimately, probably those therapists do want to give some of their skills, they want to transfer some of their skills to those parents. And so they have to also be like a good sort of coach, or teacher, as well as being a good therapist. So

they need to be able to teach and coach me, and they need to be able to kind of engage and be ridiculous with my child, and they also need to academically engage me, just as my own adult person, outside of that. So there's probably multiple hats that they are playing, and they need to sort of be able to kind of seamlessly shift between all three of those things for them to be good."

Similarities and differences between child and parent experiences

Diana reported liking all aspects of play therapy, with Paige specifically identifying that she enjoyed the toys and playing at play therapy. Both Diana and Paige enjoyed the opportunities that they had to play together in the sessions and during the play homework they would complete at home. Diana noted that being able to have time together for play allowed her to recognize and appreciate some of her daughter's great qualities and foster a deeper connection between them, which Paige corroborated. Diana and Paige also both talked about how the therapist's interactions with Paige were very child-centered and play-based. Paige named how she did not really notice a lot of talking occurring when she was with the therapist and just enjoyed playing in her play therapy sessions. Diana named that she was surprised how child-driven the sessions were, and noted that she feels the child guiding the play allowed for a connection to occur between Paige and the therapist.

One difference noted between the interviews was that Diana noticed changes in her own cognitions and values around connecting with her daughter through play, and also reported noticeable changes in her daughter. These were specifically regarding Paige being better able to identify affect, Paige using more language to express feelings, and her daughter also feeling more comfortable sharing feelings with her mom. However, Paige did not name any changes or differences she noticed in herself or in her parents over the course of play therapy. A final difference noticed between Diana and Paige's interview was around the value of the play therapy

process. Diana reports that it was a helpful, and meaningful activity for both her and her daughter to partake in, while Paige reported being neutral regarding the value or benefits of the play therapy process.

Emergence of Themes

Once coding and analysis of individual transcripts occurred, themes started to become noticeable from within the data. Some of the early groupings that emerged were: what play therapy actually provided including the most important/helpful elements, therapist impact, and a sense of curiosity regarding the play in play therapy. Further analysis of these initial broad themes as well as the multiple subthemes constructing them was conducted, and ultimately three master themes emerged within the parent and child interviews regarding play therapy: support received, the role of the therapist, and the role of play. Within each of these three master themes, notable similarities and differences in how parents and children conceptualized the theme was captured in the detail of the subthemes. This section will use a selection of quotes from participants themselves to help highlight the formalization of these master themes and provide additional refinement of detail to highlight both similarity and variability in parent and child perceptions.

Theme #1 Support Received

Shared Perspectives

Child Development

(Gwen - parent) "so (now) he'll explain things, and I'm like "O my gosh you get this, like you get this, I can see you're getting this, and I can see you're trying to use this". And I can see the difference in the over two and a bit years that he's gone to her."

(Alex - parent) "I think figuring out the role of what her new family is, and how it looks different from the families that she sees with her friends, and the families that she sees in books, and the role of dad that she sees in TV shows, and recognizing that that's not the dad that she has, that's not the family that she has, um, I think that was the biggest, biggest piece."

(Rose - parent) "I would say that she was able to communicate better and we weren't having as many instances with her acting out at school (...) I think it just maybe gave her more confidence like to talk to be able to talk to someone, and just feel much feel better about herself, like I think that helped."

(Leslie - age 7) "Because mom and dad wanted us to know, like more about divorce because this was the first time getting for a divorce, and stuff, and to help us know more about it."

(Regamon - age 7) "So I was gonna be a bully and do mean stuff, and play therapy helped me be a nice version of myself."

Parent Development

(Sally - parent) "I think for me that that was the most helpful part of it. Like I guess because we went more for our education, like our helping with us, because it was supposed to help us with our parenting plan."

(Allison - parent) "That parental support, that parental education, that is something that if I were going to recommend it to somebody else I would tell them like ask specifically around that, find out what your therapist's approach is toward that. Because I think that is the most important piece as a parent to get."

(Gwen - parent) "So that really helped us and it also gave us the language too, so when we would go places or when family would be like "ummm" or people would kinda have that

judgment, you'd be like well actually, the professional in his life will say this is normal because of this this and this, and this is what we should do instead."

(Leslie - age 7) "that mom could understand a little bit more too about what they could to (with the divorce), and like, with us sometimes, she could more learn what she could do and stuff."

(Jack - age 9) "Mom liked (...) a lot of talking (...) learning to help me."

Relationship with a Liked Therapist.

(Sally - parent) "I felt like I really liked (the therapist) and trusted her so, and I didn't feel like she was judging my parenting or anything like that."

(Gwen - parent) "I think too there was a lot of validation (...) that I was doing things right, and that I was trying (...) and sometimes they work and sometimes they didn't. I'll say this is what I've done (...) but I haven't really seen a difference. And she's like "ok you're on the right track".

(Allison - parent) "What made the biggest impact was that relational piece, having those separate parent sessions for the hour. Where we'd be able to come in and it be done through a relationship, that I think made the bigger impact. (...) it was relational, we' be there and we'd be able to see we'd have that support and that mentorship for both (parents) and that made a huge difference."

(Regamon - age 7) "my life is really good here, I have tons of friends. Without (the play therapist), I would kind of be, have like zero friends, could be a bully and bullying people. That's what my life would be if I didn't have her (...) it turned my life around. (...) She's my special person."

(Leslie - age 8) "she would talk about to us about my mom and dad and like how they they got divorced and stuff. And sometimes we would get to play with toys. I liked the putty there and talking with her."

Other Notable Perceptions of Support Received

Administration and Scheduling.

(Rose - parent) "so we did see (the therapist). I liked him from the get-go and I like his office, it was very convenient in town, and um, it didn't seem like it very overcrowded with other patients (...) we would check in and there were other therapists that were there at different times, so I liked the office."

(Amy - parent) "she was very up front about the costs and then gave us lots of options for payment. And I think maybe even we were running out of time in the first session she said 'oh you know if you prefer we can put it on Visa or you can also just e-transfer me', so I had a lot of different convenient options to pay and I also got she trusts us to pay, and thought that's a very nice courtesy she extended to us."

(Diana - parent) "There was an extra kind of like little room, which was great, which wasn’t the waiting room, but like a room kind of past the hallway, which I did appreciate, because, again, when you don’t have child care, right? And all that kind of stuff (...) it was really helpful.".

Tailor-Made Interventions.

(Gwen - parent) "if there are things that I have concerns with, she will go and integrate them into the sessions with him. So if there are things that I’ve like noticed this, or I’m not sure about this, or something doesn’t feel right here, she will go and integrate that into the sessions, into their play and into different things. So she can kind of get a pulse of where he’s at."

(Alex - parent) " I also have more practical skills that are directly related to what her and I need, as opposed to what I teach to families or I read from books, this is very catered to our situation, and how I work and how she works. And I don't know if I would have gotten that any other way, or from anybody else, had there not been one person seeing both of us and our story, and understanding, who we are and why we are the way we are."

Exciting Environment.

(Jack - age 9) "Exciting (...) she has toys that I might want to get that I never saw before."

(Paige - age 8) "You just play, (...) there's lots of cool stuff there."

(Leslie - age 7) "Like we mostly just played with the putty because of that was our favorite things and sometimes we would, reads books and we would color sometimes, and make art. (...) It was fun because, um yeah (*laughing*), it's just fun"

(Violet - age 6) "We'd like go do stuff, then, like stickers, yeah after I get a new sticker every time."

Child Felt Good.

(Regamon - age 7) "Well, (play therapy) kind of relaxes me"

(Leslie - age 7) "It made me feel calm too, so I wasn't all stressed out and stuff... less anxious"

Theme #2 Role of the Therapist

Shared Perspectives

Neutral Third Party - Expert.

(Sally - parent) "She's like a impartial third party. So then, you know she didn't have bias either way. And then because we both knew she had been a play therapist and a therapist in

general for a lot of years and have a lot of experience, and especially with divorce, you know I guess that kind of had more weight to her responses."

(Gwen - parent) "And it's somebody neutral, that's not their parents that's not a teacher, that's not somebody who's active in their life, but it's somebody who is neutral and safe, and fun, that they can connect with."

(Rose - parent) "it was very helpful for her to talk to an adult, and to feel safe, you know and that she could talk to him and really um, maybe share something that she wasn't going to share with me."

(Kate - parent) "As long as they got that connection to a third party, that was a key element. Because there is nothing necessarily earth shattering or different that she is teaching than all my instruction, and things that I do all day. But I said that it's that other person saying it maybe a different way and his ears are more receptive because it's not mom or dad."

(Amy - parent) "I think it um, preserves your relationship with your child because it is frustrating when your child has a problem that you can't help them with. So you know putting that in the hands of a professional means you can just be the mom you don't have to be trying to be a therapist and a mom.

(Regamon - age 7) "like a Dr. of Feelings (...) she helps you with your feelings and stuff"

(Violet - age 6) "he's a little smart"

(Leslie - age 7) "she's kind of like a teacher"

Modelling.

(Gwen - parent) "And so it really was able to, to give that language, to be able to explain to people so that they could better understand him and they could better understand why we do certain things differently, because he needs things to be done differently."

(Alex - parent) "Then we had another session just her and I. Where she kind of talked about this is what she's seeing, and then some recommendations for me to do at home, some homework and stuff, and then I would get an e-mail from her two or three days after each session with notes on the sessions, just little updates of, this is what she noticed and this is what (the child) worked on, just so I didn't have to get that information from (the child)."

(Leslie - age 7) "she used a kind voice, and she like has a calm voice, that she's not like *screaming*, you know (...) It made me feel calm too."

(Regamon - age 7) "(talking to her) means to me a lot. Like how I'm going to express my feelings and stuff (...) basically teaching about all the stuff I do."

Trusted, Non-Judgemental - Kind.

(Alex - parent) "So I think that's huge, nonjudgement, knowing that anybody and everybody was doing the best they could with what they knew, and trying to manage it, and then tried, I don't wanna say fix it, but tried to get the supports in place because I recognized I couldn't do it by myself. But there was no judgment in that."

(Allison - parent) "When we first met with (the therapist), when I sat down, it was more of feeling very quickly in the conversation that this is a safe place for me to be vulnerable as a parent. This is a safe place for me to share like, the things that I'm carrying with me that I'm sure I screwed up my kid. (...) So it's that feeling of like very quickly I felt like this is a safe person for me, to be vulnerable to, and to tell the truth to."

(Chilly - age 3) "I used to play in sand boxes…with (the therapist), and she likes to play with me too."

(Jack - age 9) "(the therapist) is good, and uh, calm."

Teaches Parental Awareness - Teacher/Guide.

(Allison - parent) "I think (the cueing) made all the difference. Because then it allowed both my partner and I to see then when we got that feedback, and we can see it, then we could see changes at home, that maybe we wouldn't have seen before. Right? Subtle changes that you know in the busyness of life we probably would have overlooked. But because we had (the therapist) cueing us (...) when we saw things we would be able to afterwards be like okay we saw that, he lasted like an extra couple of seconds before the blow-up happened (...). And I think we probably would have missed a lot of that."

(Kate - parent) "We hear sometimes some of those things that she's talked about, and told me they talked about will come out, and he's trying to use them. You know, he'll say "ok like, let's belly breathe, let's do this". He can kind of get there sometimes. So we're getting there."

(Leslie - age 7) "well she's talking about, if we kinda like understand the divorce, and stuff."

(Rodger - age 5) "And she teached me when I touch money I don't have to wash my hands, I don't need to worry about germs."

Other Notable Perceptions of the Role of the Therapist

Flexible Professional.

(Gwen - parent) "So even just educating other people in his life so that they're prepared about these kinds of things. So they know how to interact with him differently so there's more consistency across his life too and he doesn't feel like the odd one out in a strange setting, that's not home or with family."

(Rose - parent) "He was extremely helpful. Like from the get-go he said I will go to her school and I can go physically and watch her and observe her, and I can do that, which ultimately

he did like towards the very end (...) he did go for an hour and observed (the child) and he did discuss with me at the at the at that appointment that what he had observed: she's focussing, she's able to sit, she's able to do her work."

Decoder Interpreter.

(Sally - parent) "we had more of that knowledge where they were at in that process and (...) if they've registered that there's a divorce they draw a break between the mom and dad in the picture. Not like how they drew it, with mom and dad holding hands (laughing) and us holding hands with them (laughing). (...) I thought that part was interesting because then oh ok, I felt we got some actual information of like where the kids thought processes were."

(Alex - parent) "it's being more in tune to what (my child) needs, and how she's seeing the world, because I don't think that I would have been able to see it on my own. Like I don't think I would've been able to piece together, that piece about her dad, um, I wasn't as in tune to her in that way, so it was nice to have that piece I guess, for her as well because she got more confident in me that mom knows."

Theme #3 Role of Play

Shared Perspectives

Connection.

(Allison - parent) "Because I saw, how much better in their relationship as siblings got. Because they would work things out through play, and they would figure out how to negotiate with each other. How do we make the game fun for each other."

(Amy - parent) "He's quite verbal but I think for this problem he didn't have words for it (...) And then maybe the story telling like the story about the little girl with the Worry Zoot, that engaged him a lot and gave him some words for his experience."

(Leslie - age 7) "so I don't really like when people ask me like so many questions, it feels like I'm really having to work. Then I can actually like, actually like also do something (when she is playing while talking)."

(Regamon - age 7) "I really get to hang out with her, and that's really fun."

Fun.

(Alex - parent) - "She got to pick a Kinder Egg or a toy, and she always went for the Kinder Egg (laughing) (...) I don't buy her Kinder Eggs, so (laughing), and I don't want to say it was like a reward for her playing, but it was kind of that, that positive end piece, like maybe what she played with brought up things, or having to suddenly stop playing to go because the clock was out. So it always ended on a positive for her, which kind of would entice her to go back next time."

(Rose - parent) "I think you know, definitely playing and interacting with him, and then the reward part. Because he just had like so many stickers, and Wikki Stix, and I think that part, he just it was like, like I say Santa Claus, he was so generous, he gave her every color of that little wax stick, and (...) so yeah I mean he was just really he was very loving and just very giving."

(Kate - parent) "He came out of that first session very lifted. There's always a visible kind of lifting after he sees her. And he was quite happy about it, and he got a candy at the end (,,,) but it was exciting and she's got a wall of toys and everything to play with you can imagine."

(Leslie - age 7) "I have two best parts: the putty and the toys, and like the talking because it's actually like helped me really understand, yeah it helped me really to understand."

(Regamon - age 7) "the fun part is (...) all the games we get to play."

(Chilly - age 3) "everything was fun there for me."

(Rodger - age 5) "I didn't really like how I had to talk. I liked just playing. I loved it (*singing*) playing, playing plplplplplaaaying. (...) Because the more we talked, the less time I would have to (*yelling*) PLAY!!"

Other Notable Perceptions of the Role of Play

Trusted.

(Allison - parent) "In play they learn how to BE people, right so you're like 'Oh I want their play to reflect how they should be in real life'. And to have a professional sit down and be like, 'actually play is how they work through, all their feelings and all their emotions, and everything they're dealing with, so that they can BE you know fully functioning people'. That was revolutionary to me. Right to have that awareness that it is through play, and that is how they then become functioning people."

(Amy - parent) "She just could engage him in a way that I really wasn't able to. She was so creative with having puppets and pictures, they drew some yucky germs on paper and then they played games with touching them. She sorta used the toys to illustrate everything and so I think that it was more engaging for (him), he enjoyed it more. Whereas if I were trying to talk to him I think I tried to talk to him too much and that's not how kids really communicate sometimes."

(Kate - parent) "Play is (...) there is something about it that is relaxing and knowing that it is not going to frighten my child, it is not going to intimidate them. It is going to open up something."

Magical.

(Diana - parent) "I confess that when we are doing (play), I still feel that pull to like kind of question, cognitively, sort of like the meaning of things. (...) So (the therapist) and I giggled a

little bit. And I confess it was interesting because during the process, one of the things, again, my own clinical bias kinda came up, as like “How is this helpful?”

(Amy - parent) "I thought of play therapy, almost like interpreting dreams, like it has meaning and I believe in it, but also it’s very mysterious in the way that it works, like I don’t fully understand. Because really talented play therapists see such symbolism in the play. You know and if you’re not trained in it you might miss so much information. (...) It was in a mysterious way that I didn’t fully understand but I did believe in it, it certainly worked."

Control.

(Regamon - age 7) "Before COVID, I got to pick all the toys and what we did."

(Leslie - age 8) "like we mostly just played with the putty because of that was our favorite things and sometimes we would read books and we would color sometimes, and make art. (...) we got to choose what we got to do."

(Gabe - age 9) "I would either just say “I don’t wanna answer this question” (...) or “more play less talk”

Summary of Findings

Green = similar experiences. Blue = unique experiences.

Figure 1 - Theme 1: Support Received

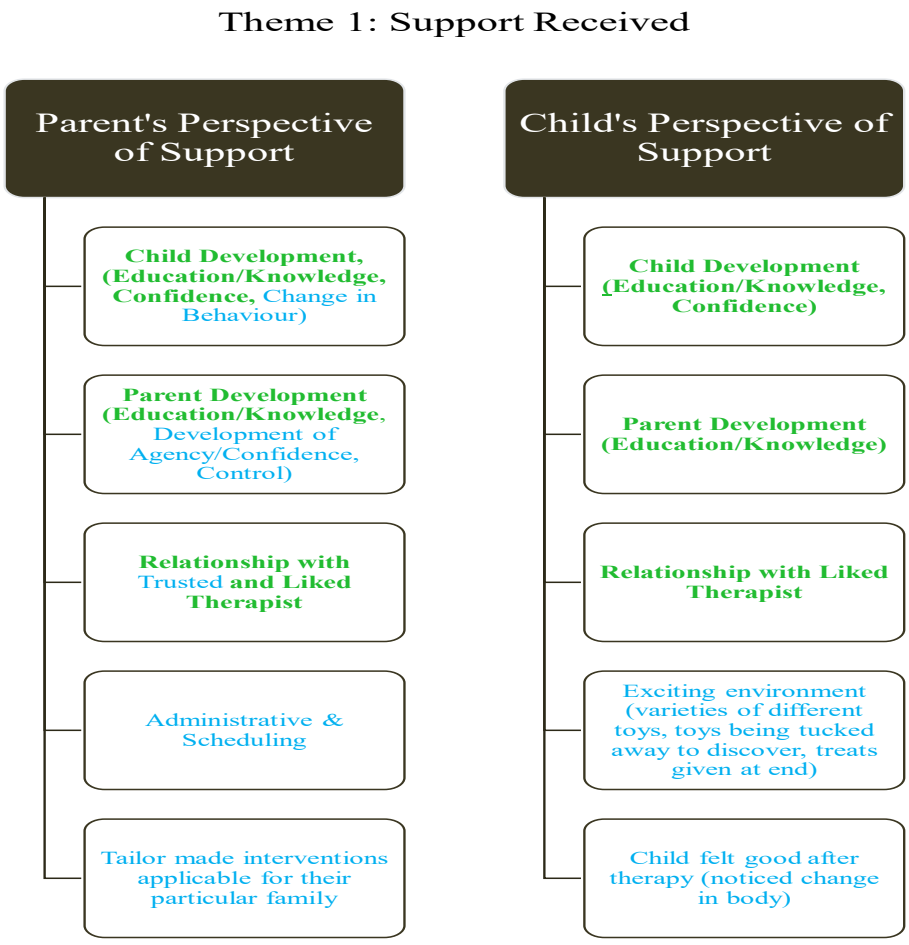


Figure 2 - Theme 2: Role of the Therapist

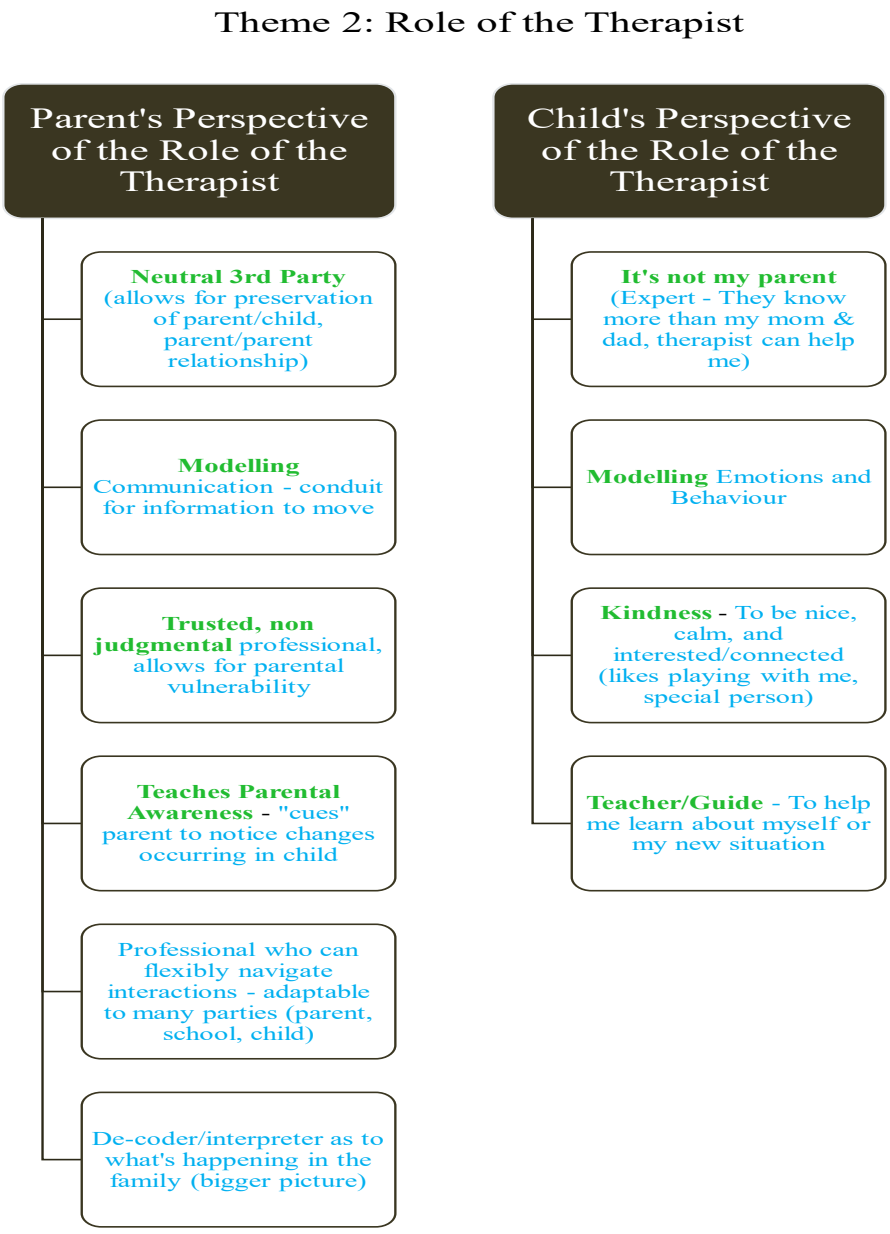
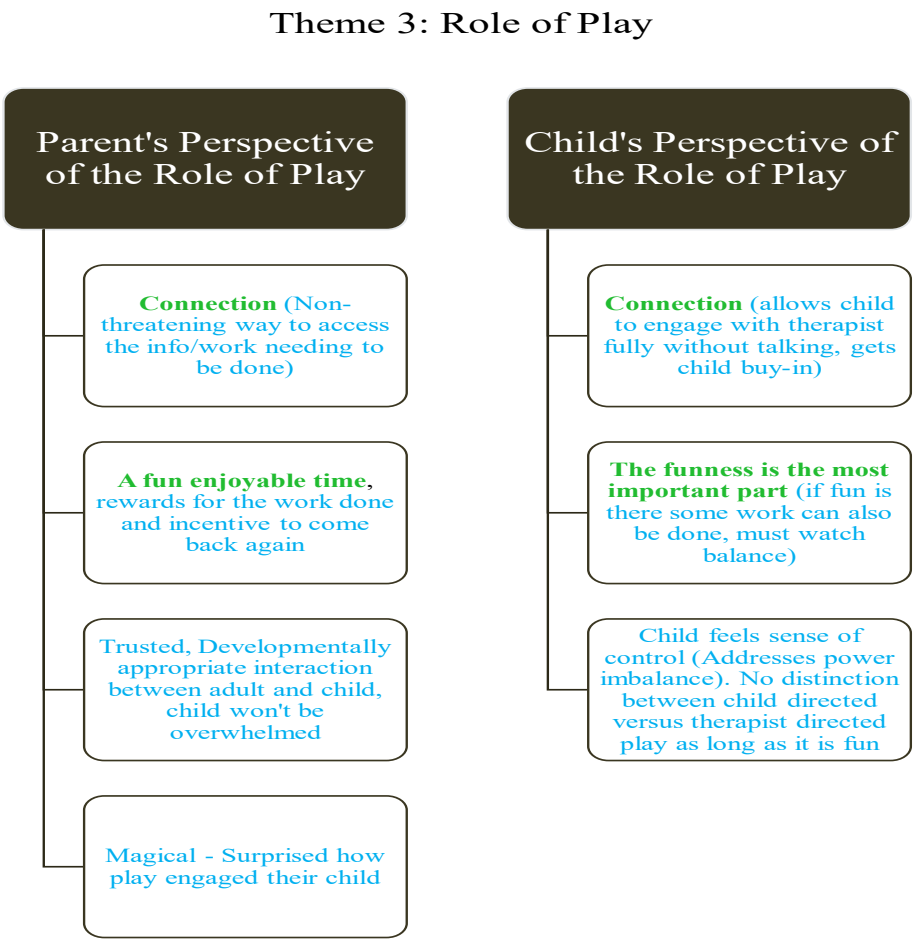


Figure 3 - Theme 3: Role of Play



Exemplar Cases

It was unexpected that half of the individuals participating in this research study would not only be relaying their experiences of play therapy, but would also have experiences of play therapy involving multiple therapists. Participants naturally drew comparisons between their therapists, the clinical work done, and other preferences they experienced in their diverse therapy experiences. The following two exemplar cases are used to help highlight and refine subtle, yet important, differences identified by participants as being impactful to their therapeutic process. All names used are pseudonyms.

Exemplar - Best Case

I finally arrive at the conclusion that I need extra help for my 9-year-old son Bobby this Friday. It has been a particularly hard week on the entire family. The school called three times this week to tell me about aggressive behaviours that were occurring with his Grade 4 classmates and teachers. I knew things were not great. I have also seen Bobby direct that same aggression toward his family at home, particularly toward his younger brother Tim. His behaviour at home has been volatile for a while now, with him talking back, refusing to go to sleep, and the entire family walking on egg shells. I have hit my rock bottom.

The idea of finding help wasn't new. I talked to the pediatrician about Bobby's behaviour last year at his annual check-up, but then I second-guessed whether we could maybe handle this on our own, and wondered if perhaps this was a developmental stage that he would grow out of. I notice that nobody really talks about kids' mental health and so it's a bit of a guessing game. Family doctors and pediatricians talk about physical growth and development. Schools talk about intellectual growth and behaviours that are important at school like listening, making friends, being social with others, and being able to sit still. But nobody seems to be checking in on kids'

emotional development and mental health. Although I have strong knowledge about mental health and am professionally trained to help others, as a parent I feel lost and overwhelmed in helping my own child. I reached out to my good friend Sarah, who I opened up to about some of the worries I have regarding Bobby's behaviour. Sarah is a Registered Psychologist who works with adults, however she is able to provide me with a couple of referrals to play therapists she knows professionally and shares some of the great feedback that she has heard regarding these therapists.

The therapists each have excellent websites that describe themselves, their education, and how they approach play therapy with kids and families. One of them even has an online scheduling portal where you can book your appointments online. That's fantastic! OK, that's the therapist I am going with. Her name is Hannah, and I book a session for next week. The next day, I receive a brief phone call from Hannah and we have a quick conversation regarding my concerns for Bobby. She lets me know she will be sending me some additional paperwork and consent forms to fill out before the first session and also lets me know that the first session will be a parent session just for me and my husband John. I mention to the therapist about needing to find a babysitter for the boys so we could come to the session, and the therapist let me know she has a small special play room where Bobby and his brother Tim can privately play, and it is located immediately beside the parent session room. Perfect! Hannah is a great listener on the phone and I could already tell she understood the kind of challenges our family is facing. I am also struck by her professionalism, informing me about how she does therapy, talking about administrative details like her fee, billing to insurance, and her cancellation policy. I hang up the phone and already I feel just a little bit better.

Over the next couple of days I complete the required paperwork and submit it electronically. For the session on the weekend, I had booked a time when I know we would all be as rested as possible and I make sure we all have a good breakfast that morning. I tell Bobby and Tim that they can earn cartoons when we return home from a successful outing, and we pack a bag of books and small activities as well as a few snacks to keep them entertained on the drive there. We pull up to the strip mall located in a light industrial area and I am grateful for both the deserted streets on the drive over, as well as the huge parking lot with free parking. I look around and notice there is really nothing else to do around here. There are no nearby grocery shops, no libraries, and no coffee shops.

We enter the building and I see the waiting area is both kid-friendly and comfortable. The boys immediately go to the toy area in the corner and begin exploring the toys. The lady at the administrative desk efficiently processes our payment and provides us with a receipt that we can submit to our insurance for reimbursement. She then asks if we would like a coffee or water and lets us know that our therapist will be with us shortly. Right at our scheduled time, Hannah comes out and introduces herself to the family. She guides us all down a short hallway and stops at a very small play room. She lets the boys know they are welcome to play with the toys in there and shows them that we will all be in her office right next door, and they can come get us if they need anything. The room, although small, has cabinets with bins of toys and books and the boys immediately start exploring.

The three of us move into the next office and sit down. The therapist has a copy of our signed consent form and goes through all the details of it point by point. She specifically highlights the importance of confidentiality, as well as the limits to it. She tells us she will not talk about the specific things that Bobby talks about in their sessions, but may instead talk to us

about themes that she is seeing in her interactions with him. A really important point she highlights and requests, is for us to not ask Bobby a million questions about what he did or what he talked about in play therapy. She assures us that through our regular parent sessions that we will have an understanding about the type of work they are doing, and that this is a way to keep play therapy fun and private for the child. About halfway through our time together she briefly steps out of the room to check in on the boys. They are doing fine and are both happy to keep playing for a while longer.

During our talk I share a lot of information regarding what we see at home and hear about from the school, and also talk about some of the worries I have as a parent. What did I do wrong for him to be acting this way? Did we create these behaviours in him? Why do I get so upset when he freaks out? Will Bobby have anger problems for the rest of his life and die penniless and alone? John is a quiet guy who isn't at home with the kids as much as I am because of his demanding work schedule. The shame inside of me is overwhelming as I share my worries of having created this problem through poor parenting. He comforts me as I cry while describing how difficult it is to try to manage Bobby's explosive temper. I think he now understands a bit more how Bobby's behaviour not only impacts the family functioning, but also how it impacts my self-esteem and self-confidence as a Mom. Bobby knocks on the door and says he's thirsty, and John takes a moment to help him get a drink of water from the lady at the front desk.

When John returns, Hannah reflects how worried and alone I have felt trying to navigate Bobby's behaviour. She talks about how mental health challenges are just like a broken arm, if your child needs some help, you seek out a professional who is qualified to help. I appreciate her normalizing what is happening, and I feel some relief and some hope that maybe things can be different. I also feel some comfort that there is another set of eyes on the situation, and notice

that the pressure I have been carrying for a long time, has been reduced just a little bit. Hannah runs through an approximate timeline that she feels treatment may take, and talks to us about the role that play takes in her therapy and how it allows her to make a connection with kids. She also talks about having an uplifting "up and out" with her child clients, where she will offer them a sticker or a small toy to take home after a session. She mentions she might sometimes offer a small sweet treat like a package of Fun Fruit or a Kinder Egg once in a while, but only if we say it is OK for our child to have a treat like that. I really like how she explained what to expect in play therapy and also that she asked our permission for her to give a treat once in a while. It makes me trust her judgement and I also feel respected that we're the parents and our views will be honoured in these situations.

Hannah finishes up with us and asks if we have any questions. She lets us know we are welcome to send an email or we can call and leave a message if we need to contact her before our next session. She also mentions that it is most helpful if both parents attend the parent sessions so that one parent does not have to try to teach the other one about what was discussed. She asks who would be bringing Bobby to the next session, and I said it would probably just be me since it wasn't a parent session. She makes a comment about how if I brought both boys it would actually be an opportunity to spend some one-on-one time with our youngest son Tim reading or drawing together, while Bobby is in session with her. She says it in such a gentle and kind way that I did not feel any pressure to do this, but rather see the opportunity for time with Tim that I otherwise wouldn't have recognized if she had said nothing. We gather the boys from the private play room and they both eagerly pick out some stickers from the choice of stickers that Hannah offers them. The boys happily chatter and compare the stickers they chose as we

walk back to the waiting room. Since we already paid for the session, we just spent a moment with the lady at reception and book our next session in two weeks' time.

Driving back to the next session two weeks later, it's just me and the boys since John had to go into the office to catch up on work this morning. I am looking forward to Bobby having his first session with Hannah, and I am also looking forward to spending a bit of quiet time with Tim. We arrive at the office and the boys rambunctiously enter the office and head over to the toy area in the waiting room. I check in with the lady at the front desk and pay for the session. I look around the office while we are waiting and the boys play. It is a nice space, nothing fancy, but clean and tidy and welcoming to families with both the toy area and some child sized seats in the waiting room. There is one other family waiting as well, but there is enough space for everyone that it doesn't feel crowded.

At the appointment time Hannah comes to get Bobby. She briefly chats with me and says she will come and get me and bring me in for the last five minutes of session. Although Bobby has seen and been introduced to Hannah, he doesn't really know her yet, and so he is a bit hesitant to head into the play therapy room with her. Hannah is very relaxed and doesn't miss a beat. She kneels down on the floor and starts engaging with Bobby and talking to him about the toy he is playing with. After a couple of minutes she mentions that there are a lot more toys in the play therapy room and asks if he is ready to check them out. Bobby says sure and asks if I will be in the waiting room just in case he needs me. I reassure him that both Tim and I will be here, and I will join him near the end of his session. They walk down the hallway together and head into the play therapy room. Tim and I settle into reading a book together and just as we start a quiet game of charades, Bobby peaks his head out of the door of the therapy room and calls for me. I go to him and he advises me that everything is fine, but he just wanted to double-check that

I was still there. I smile and point to the chair in the waiting room to show where I was sitting. He seems satisfied and shuts the door. Tim and I continue our game and I notice that it is a nice change to be able to spend a bit of time with my youngest son. I realize that as a busy, working family of four, this time together does not seem to happen very often.

With five minutes left in the session, Hannah comes and gets me from the waiting room. At that point Tim is comfortable being in the waiting area by himself and he once again busies himself with the toys in the toy area. The administration lady also mentions she will be able to keep an eye on him if anything comes up. I head down the hallway to the play therapy room and Bobby is busy drawing a picture when I come in. He happily shows me the drawing, as well as a life-sized body outline of himself that he and Hannah had worked on. Hannah tells me that Bobby would like to tell me about the drawing. He carefully shows me the different regions of his body which are coloured in different colours. He explains to me how his tummy area is coloured a dark blue because that's where he feels nervous in his body. He also shows me how his chest and hands are coloured black because that's where he feels anger in his body. The therapist describes and demonstrates some of the breathing exercises they worked on together and also mentioned that when Bobby feels big emotions he will try to take a couple of seconds to take a couple of breaths before he reacts to the emotion. I mentioned what hard work they did today and Bobby kind of looks at me funny and says that it was all actually pretty fun and that he just played. Hannah gives Bobby the choice of a Fun Fruit or a sticker and Bobby chooses the Fun Fruit and asks if he can have one for Tim as well. Upon receiving the treats he bolts down the hallway and gleefully gives Tim the packet of treats. They both giggle and enjoy their treats sitting together squeezed into one chair. Hannah walks me down the hall and says goodbye to the three of us. I book another session with the administrative lady, and we gather up our things and

head out. Bobby seems happy and relaxed, and Tim also seems happy. Perhaps Tim is happy because we got to spend time together, but I know it could also be because of the surprise treat situation. I find myself smiling and cracking a few jokes with the boys as we walk out to the car. The boys are excited to head home and they remind me that they can now have an hour of cartoons with their lunch for their successful trip this morning.

On Wednesday I receive a call from the school and find out that Bobby was aggressive towards another student. My heart drops. I thought things were maybe a bit better at school, but instead I hear how Bobby shoved and shouted at a classmate during lunch recess and this caused the other student to cry. I thank the office staff for notifying me and I let them know I will talk to Bobby when he gets home. I hang up the phone and I feel the familiar, overwhelming feelings of dread and despair. I remember that Hannah said to let her know if there was important information that came up between sessions, so I sit down and write her an email. I let Hannah know that the school had called today and how it took me by surprise. In the process of writing the email, I remember that Bobby was very tired this morning and ate next to nothing for breakfast before he went to school. I wonder if he even touched the packed lunch he took with him to school today? Writing the email is weirdly comforting, even just having someone to send the information to seems to help shift my own worries. After sending the information off to Hannah, I prepare myself to be ready for Bobby's volatile mood when he returns home from school. I take 15 minutes for myself to breathe and meditate just a little bit so that I can remain calm. When Bobby steps off the bus with Tim I can see in his body language that he is exhausted; his shoulders are slumped and he is dragging his feet. Rather than immediately question him about his behaviour at school, I take a deep breath and give him a hug. He melts into it and just wants to be held for a moment. After a minute we start heading to the house and

he says he had a rough day. I get a snack for both Tim and Bobby and I ask if he wants to talk about it. He tells me a little bit, including that the other student made fun of the purple jacket Bobby wears because a female student also has the same coat. Bobby says he didn't really think before he hit his classmate, and that it had all happened really fast. I felt disheartened that he wasn't able to stop his reaction in the moment and lashed out. I also recognize that in not confronting him immediately when I picked him up at the bus, this allowed him some space to talk to me about what happened. Previously, I would have started questioning him about his behaviour before trying to find out his side of the story, and he would have become defensive and angry towards me. I quietly unpack his lunch box and notice that he ate almost nothing from his lunch. When I ask, he says that he was really excited to try to be one of the first kids out for recess so he would have more time to play, and so he just had a bite of everything. We didn't really talk too much more about the incident at school, other than to gently remind Bobby of other alternatives to hitting when he feels upset.

I make sure that Bobby has a good supper and a quiet evening so that he is ready for an early bedtime. I check my email and find that Hannah responded earlier in the day. Her response is brief, but in it she thanks me for telling me about what happened and said we would catch up at our next parent session. I reply back thanking her for getting back to me and I also let her know I now think that Bobby felt both angry and embarrassed when he was teased about his coat and that he was also likely both tired and hungry when the conflict happened.

For our next session, it is just Bobby and me since John and Tim decide to have some one-on-one time together bowling. It is nice to drive to the session and chat with Bobby, who seems excited to be going. We arrive and he promptly goes to check out the toy area while I pay for the session. At our session time Hannah comes and gets Bobby, and he goes with her down

the hall chatting excitedly about the toys he wants to play with, and doesn't even glance back at me. I find myself having a moment of surprise that he went so easily with her, and then feel a wave of relief. I briefly wonder about the magical nature of play and how it is able to engage children so completely. I take a big breath and relish the little bit of quiet time I have just for me. This is glorious! I take a book out of my purse, breathe a happy sigh, and immerse myself in the story.

Close to the end of the session, Hannah comes and gets me from the waiting room. She leads me down the hallway and I see they have been reading a book together. Bobby tells me that the book is about bullying and that it was a good story. He asks me if I knew that he was being bullied when he was teased about his jacket at school. He then looks down and sadly tells me that he was being the bully when he hit and shouted at his classmate. I ask if they talked a lot about what happened at school, and he answers no, they actually played with figurines in the sand table for most of the session and it was only in the last little bit of the session that they read the book together and chatted. I am surprised to hear that they didn't talk too much about the situation or explore how he was feeling about it, but I leave it alone. I do trust Hannah and what she's doing, so I just smile. Bobby is offered the choice of a sticker or a smelly eraser when he leaves this session and he chooses the smelly erasure. He sniffs it deeply as we walk down the hall together. When we get to the waiting room, there are a few people waiting at the front desk for some reason. Since we have already paid we are able to just leave and I know I can book our next session online when we get home.

During the drive home I am intensely curious regarding what they did in session. What did playing in the sandbox look like, what did they talk about in the room? I hold my questions back, remembering what Hannah said about the importance of keeping the details of the session

private and fun for the child, and how being questioned after the play therapy can take away the child's perception of enjoyment of the experience. Instead, I ask Bobby how he is feeling right now. He says he feels good. He tells me it's fun to go and play with Hannah and he smiles as he shyly states that he knows she likes spending time and playing with him. I ask how he knows this and he shrugs and says that she always plays whatever he wants to play, and she is always excited to see him. Bobby then switches the subject and chatters at length about the cartoon he wants to watch when he gets home, and he also wants to know when Tim and John will be back from bowling. Bobby seems relaxed and at ease, and I notice that I am actually enjoying spending time with him. When I stop and think about it, I really can't remember the last time I noticed enjoying my time with Bobby. Outings with him for about the last year have been incredibly stressful. I realize that I have been selecting my outings with him very carefully, not wanting have to deal with his tantrums and behaviour outbursts in public. Things are starting to feel a just little bit different now. Perhaps I feel a bit more confident in my ability to gauge how he is feeling, and if something were to occur I at least feel confident that I can regulate myself better in that situation.

For the next couple of play therapy sessions, I have both the boys with me. We have now developed a nice routine on those weekend mornings. I make sure that the boys have good bedtimes on the Friday night and make sure to start our Saturday mornings with a good breakfast. This puts us all in a better mood for the drive to the office and I notice that there is less bickering between the boys on our drives there. We seem to have hit a stride for these play therapy sessions. Bobby seems to really enjoy his time with Hannah and Tim and I also enjoy our time together in the waiting room while Bobby has his sessions. The boys both know that if

the morning goes well there will be cartoons allowed with their lunch and this seems to be a motivator for both of them to try to get along with each other on these mornings.

The next session is a parent session. The boys are able to spend a bit of time with their grandparents this weekend, so it is just me and John heading to the parent session together and then we get the rest of the day together afterwards. It feels a bit weird. We don't get a lot of time outside the house together without the boys. It reminds me of a simpler time, before we had the kids. Although my parents have taken the boys to babysit before, I have not felt as comfortable in them babysitting for about the past year just in case Bobby had one of his epic meltdowns. Now that he's not having daily meltdowns I feel a bit more confident that my parents can handle the boys, and I coached them before today letting them know some of the red flags to watch for before Bobby typically explodes. We arrive at the office and are greeted by the administrative person. We pay for the session, and take chairs in the waiting room. We chat with each other about how we feel the last little while has gone for Bobby and the rest of us. I remember that we had a rough day last weekend, when Bobby had a couple of big screaming tantrums, but they aren't occurring as often as before we started play therapy. Hannah comes and greets us in the waiting room right at our appointment time. I very much appreciate her always being on time. We head to her office and she asks us how we are doing and how we feel things have been going at home. I mention that we are noticing fewer blow-ups at home, but they are still happening, and I tell her about his tantrums last weekend. I notice both John and I feel more comfortable disclosing vulnerable information about ourselves and our worries about Bobby. She asks us about our reactions to his tantrums and although we typically try to use time-outs, John does disclose that he yelled at Bobby during and after his tantrums. Hannah very gently asks John if he knows about the impacts of children being yelled at, and he sheepishly says no. She very

kindly validates that we often recreate the patterns of interaction that we ourselves saw as children, and fills him in on what the latest research suggests regarding children's brains and the impact that yelling has on children. She provides a couple of other different strategies to fall back on in those explosive situations, for example the parent being allowed to time themselves out whenever they are feeling overwhelmed. She also talks about the difference of a parent being a thermostat versus being a thermometer. She goes on to explain when a parent is a thermometer they take on the temperature of the child and mirror it, which then raises the overall temperature of the situation. However, if the parent instead becomes a thermostat and can come in with a cool demeanor, this cool setting can reduce the heat of the child. We both jot down notes to help us remember these tips when we are in the heat of the moment with Bobby. Hannah asks us a few more questions about triggers, and the specific behaviours we notice in Bobby that we find most activating. For myself, I dislike the explosive noisy tantrums, and I notice I quickly feel panicked. For John, he dislikes when Bobby ignores him because it makes him feel disrespected. Through this process of sharing, we now know specific details of each other's trigger points, and it seems like we'll be able to better recognize and support the other parent when their trigger situation occurs. Hannah talks to us a bit about themes of power and control she is seeing in Bobby's play with her. She tells us that she will gently invoke some of Bobby's emotions, like frustration and anger in their play therapy sessions, and allow him to practice experiencing and expressing them in a different way with her. She talks about some of the regulation techniques they have worked on together, and shows us breathing techniques we might see Bobby trying to use. She also talks about how they have been identifying where in his body he feels emotions and then they try to name the emotions as he notices them occurring. She talks about the book on bullying they read together and another book that explains fear to children. She provides us with

some handouts about anxiety in children and highlights how anxiety is sometimes demonstrated behaviourally through lashing out and anger. She also gives us a website to look at for some great suggestions of family activities to try out together. Finally, she also gives John and I some suggestions for our own coping strategies when the tension is high in the household.

I feel like we learned so much during this parent session regarding what Bobby is working on. It seems like a key piece for us is to be cued to watch for small signs that Bobby is attempting to do things a little bit differently. I recognize and appreciate that Hannah is a master of not revealing anything that Bobby said to her in their sessions. I learned so much about Bobby but I also feel his confidentiality was respected. I also appreciate how Hannah talks to us and empathizes with how hard this situation has been on us and the whole family. I'm not sure why, but I feel a greater sense of hope that life is not always going to be like this. And I feel tremendous relief knowing there is a second set of eyes on what is going on. Almost like a safety net for Bobby, and for me too, that I don't have to be the one to try to figure this all out on my own. John and I leave the session feeling connected not only as couple, but as a team of people who all really want our family to function better together.

The next few play therapy sessions go smoothly for Bobby. He doesn't mind going to the sessions and the times when I take Tim with us, we enjoy spending time together as well. We have all gotten comfortable with the routine. Getting the boys to therapy is still work, but honestly getting the boys anywhere is work. It feels like I have more balance in my life and our family also seems to be exhibiting a bit more calmness as well. I notice that the lows in the family are less intense and they are occurring less often. I have caught Bobby beginning to get frustrated and see him trying to use some of his breathing techniques. He is really working hard

to try to control and change his explosive reactions. The end result is we all feel like we are functioning better as a family and we are enjoying more of our time together.

Reflecting on the past few months, I never could have imagined how it was all going to play out. I remember being so hesitant and nervous to engage a professional in our lives to help with Bobby's challenging behaviours. And now, having created that relationship with Hannah and received so much support, I wonder why I waited so long. The process of play therapy has not been an easy one. Play therapy is really hard work for parents. Getting the child to the sessions, engaging with the child in the homework, being open and vulnerable to your own emotions and sharing them with the therapist; these pieces all take a lot of time and effort. It's funny, because when I ask Bobby about the play therapy process, he always just names it as being "fun". It doesn't seem to feel like work for him. He enjoys his time connecting and playing with Hannah, and while he does seem to learn about things in his session, the take-away learning seems to be less important to him. Instead, it is about him being engaged in the here and now. The play seems to be a way for Hannah to connect with him, almost like she is able to speak his natural language and connect with him through activity. Perhaps that is the paradox of play therapy, that while we think of it as being therapy and work for the child, in fact perhaps much of the work and change is actually occurring in the parent? I reflect that people in a family are not completely separate entities from each other, and so it makes sense that for change to occur in a child that change must also occur in the parent and in the family system as well. When Bobby talks about his therapist he talks about Hannah being a trusted and special person in his life, an adult who he can be with and connect with, who is also not a parent. And that role in itself seems to be critical. Their relationship is unlike what my relationship with Bobby is. I could not have been the neutral, supportive person he needs because I am caught in the middle of the family

dynamic. I believe even if I had talked and acted exactly like Hannah to Bobby, that he still would have interpreted it differently because it came from his mom. Through our time with Hannah I learned so much about the impact of my own reactions and behaviours on Bobby, and I appreciate that the interventions created by Hannah seem to be custom-made for our family. She knows Bobby and how he reacts, and she also knows John and me and how we react. I think this is the difference between reading about strategies from a book to use with your child, versus getting tailor-made strategies from a play therapist. Some of the book strategies might work in your family, but perhaps they don't. I realize with Hannah it's a dynamic and interactive process where I can let her know what worked or what we struggled with, and she can help refine the activity as needed. I think I am much more accountable and have more agency in this process than if I just tried followed recommendations in a book. For me, one of the most important pieces in this process is that there was no judgement for seeking out help. Rather, we have a partner and a teammate in this process of helping Bobby and providing him with the support that was needed.

Exemplar - Worst Case

I finally arrive at the conclusion that I need extra help for my 9-year-old son Bobby this Friday. It has been a particularly hard week on the entire family. The school called three times this week to tell me about aggressive behaviours that were occurring with his Grade 4 classmates and teachers. I knew things were not great. I have also seen Bobby direct that same aggression toward his family at home, particularly toward his younger brother Tim. His behaviour at home has been volatile for a while now, with him talking back, refusing to go to sleep, and the entire family walking on egg shells. I have hit my rock bottom.

The idea of finding help wasn't new. I talked to our pediatrician about Bobby's behaviour last year at his annual check-up, but then I second-guessed whether we could maybe handle this on our own, and wondered if perhaps this was a developmental stage that he would grow out of. I notice that nobody really talks about kids' mental health and so it's a bit of a guessing game. Family doctors and pediatricians talk about physical growth and development. Schools talk about intellectual growth and behaviours that are important at school like listening, making friends, being social with others, and being able to sit still. But nobody seems to be checking in on kids' emotional development and mental health. My career allows me flexibility in my work day so that caring for the children and providing a stable home can also remain a priority. However, I find myself often feeling lost and overwhelmed trying to understand Bobby's challenges; mental health is a field I know very little about. The family doctor last year had mentioned that there are play therapists for children, but did not have a referral sheet to give me. Rather, he suggested looking up local play therapists and see what I could find. He also made a comment that he actually knew very little about play therapy and was uncertain if it was proven to be an evidence-based therapy that could be helpful for children. He went on to say he wasn't quite sure how playing might help with the challenging and aggressive behaviours Bobby was showing. After that conversation I found myself not knowing what to think. Now that our family has hit a crisis point, I spend hours over the next week researching everything I can find about play therapy to help decide if it might be beneficial. After all my research, I come to the conclusion that play therapy actually makes a lot a sense in my mind. It uses play as a developmentally appropriate point of engagement for the child, and helps the child to express themselves in non-verbal ways. I talk with my husband John about play therapy and what I have learned. He doesn't quite know what to think about it, but he trusts my judgement and suggests we give it a try. Although it has

taken a lot of time, personal research, and reflection, I now feel comfortable moving forward and starting the process of finding a play therapist.

I Google play therapists in my city and carefully look through a few of the websites. Some are better than others, and I like the ones that provide more information about the therapist and their approach to play therapy. It feels like I can make a bit more sense of who the therapist is and can get an idea of what play therapy would be like for Bobby. A couple of the therapists are of similar distance to our house and I decide to call the one that is located near a busy shopping area and local library. I notice there is no online booking portal, so I call and leave a voicemail saying I would like to a book a session for Bobby.

Two days later an administrative assistant calls to book the appointment. I'm a bit surprised how long it took to get back to me, and I tell her I have a few questions. The administrative assistant assures me that all my questions will be answered at the first session when we sit down with the therapist. She lets me know that for Bobby to be able to have counselling that both parents must sign the consent form, so plan for myself, John and Bobby to all attend the first session. It would have been great to speak to the therapist first, but I appreciate that the therapist must be busy, so I book a session for Bobby on a Tuesday night next week. I feel a knot of anxiety in my stomach thinking about the work it will take to get everyone there on a school night. I hang up the phone feeling great trepidation, and I realize this is so foreign to me that I really don't know what to expect.

On the day of the appointment, I get the kids home from school and have them eat an early dinner so that we can get to the appointment on time. Unfortunately, John is running a bit late from work and so he hurriedly eats his plate of supper in the car while I drive us all to the appointment. The office is located just off the busy downtown center, and while it is not a

tremendous distance from our house, the traffic makes the drive longer than expected. I had no idea it would take us this long to get to the appointment and the boys are restless. I make a mental reminder to myself that the boys need some books and other activities to make the drive less miserable. I see there is a lot of shopping in the area and there is also a branch of the local library close by. I am surprised by the busyness of the area and that the only parking that seems to be available is paid parking. I guess that is just an additional cost we'll have to budget for.

I pay for an hour and half of parking, and we all hustle into the building since we are on the verge of being late. The reception area is simple but nice, and John and the boys sit down in the waiting room while I talk to the person at the front desk. She requests that we fill out and sign paperwork and consent forms which John and I do, then we all sit and wait. Fifteen minutes after our appointment time Nancy, the play therapist, comes out and tells us that she's running late and she'll be back for us in a little bit. The waiting room is comfortable but small, but there aren't any toys or books for the boys to play with. Since the boys are getting restless John and I give them our phones to help keep them distracted. Another family comes in all of a sudden making the room seem quite full and cramped. Another 30 minutes passes and finally Nancy comes back and asks for us all to follow her. I'm surprised we are starting our session 45 minutes late, and I wonder if maybe there was some type of emergency she had to deal with? I never find out; she doesn't say anything to us about running late and doesn't even apologize for keeping us waiting.

The boys start playing with the toys in the play therapy room immediately while we talk with Nancy about the questions I have regarding what her play therapy sessions look like, and how long Bobby might have to come to therapy for. She answers and tells us that the play therapy sessions will just be her and Bobby, and that she does a quick debrief for the parent in

the last minute or two of the session. She then asks if we have any other questions and I can't think of anything else right in the moment. She begins to chit-chat with us about seemingly non-related topics like what John does for work and asks if he enjoys the work he does. Her questions seem very casual and a bit peculiar considering we started the session so late. John answers them briefly, and I pointedly look at the clock to help signal that I don't want to waste therapy time on non-relevant, casual conversation. Therapy costs a lot of money and I feel like we need to use the time appropriately. Finally, Nancy asks Bobby if he is ready to start. Although he seems a bit cautious, he is already pretty comfortable in the play therapy room with all the toys, and so he agrees. Tim has a bit of a meltdown because he now has to leave the toys in the playroom. John offers to take Tim out to a cafe down the street in an attempt to shift Tim's frustration. I remind John to add more money to the parking meter, since we started the session 45 minutes late, we will need to pay for some more time. When John and Tim head out I feel like I finally have a chance to breathe and think.

Sitting quietly in the waiting room, I wonder how the session is going with Bobby. I think about the consent paperwork we had to sign and realize that although Nancy went over it briefly, I had assumed she would go through it more thoroughly regarding how she actually uses all that information in her work. Nancy doesn't really know Bobby or us yet, and so I find myself worrying about what the process would be if Bobby says something that was concerning to Nancy, or if she had concerns about something she saw in his play. Would she approach us and talk to us about it, or is she required to report all concerns immediately? I realize I don't have any answers and this makes me feel worried and uncomfortable.

Near the end of the session, Nancy comes out and invites me back into the play therapy room with Bobby. She proceeds to tell me that they talked about a few things, like Bobby's last

birthday party and his friends at school, and that they had a good time. I look at Bobby to see if he has anything else to add but he does not. Nancy then smiles and offers Bobby a Fun Fruit snack for the good session, and he excitedly accepts it. I find myself both surprised and quietly angry that she never asked if he could have a treat like that. What if he happened to have an allergy? I hope that Bobby finishes the treat before we see Tim because there will absolutely be a fight over those Fun Fruits if Tim sees them. Since Nancy's administrative assistant seems to have left for the evening, Nancy spends the last of the session time and beyond booking the next session for Bobby. We spend more time than I would like clumsily going between my schedule and hers to try to find a time that works for everyone and that is not too late for Bobby. I again find myself thinking about how expensive therapy is and how I dislike having to spend any therapy time on these necessary but annoying administrative pieces.

The three of us head back down the hallway towards the waiting room and I mention that I still have to pay for the session. On Nancy's website I saw she only accepts cheques or cash as payment, so I prepared ahead of time and brought cash to pay for the session. At the front desk I give her the money and she counts it and then makes a weird comment about feeling like we just completed a shady deal. I don't know how to react to the comment, but her lack of professionalism makes me feel uncomfortable. She seems to forget about giving me a receipt and so I remind her that I need a receipt to be able to submit the expense to our health insurance. She fumbles around on the computer trying to create a receipt. I look at Bobby and he seems happy, and thankfully he has also finished his Fun Fruit treat. I accept the receipt from Nancy, and considering how awkward it was to get it, I double check that it contains all the necessary information because I don't really trust her organization skills at this moment. It looks fine so Bobby and I head back to the car.

John and Tim meet us shortly. We quickly have to head home since it is almost an hour later than we expected it would be due to the session starting late. John and I both ask Bobby all sorts of questions about what he did in session. What did they talk about? What did they play with? I am desperately trying to get a sense of what his experience was like with Nancy and honestly I am trying to gauge whether the hour is worth $200. Bobby reports that Nancy seems OK, and that they drew pictures together and talked about bullies. I feel some relief; that's more information than Nancy told me about the session, and Bobby does seem pretty content. When I ask him for some more details about what they talked about Bobby suddenly says he's tired and doesn't want to talk anymore. I'm left feeling like I might know some of the topics they covered, but cannot piece together what Bobby might need to be working on for homework, or if I need to be helping him with anything between sessions. Maybe I'm supposed to feel a bit removed from Bobby's therapy process? I come to the realization that all of the paperwork and consent forms have been completed, so now when Bobby has a session I might be able to leave when he is with Nancy to do some quick shopping or go to the cafe up the street. I just have to make sure to be back for the last couple of minutes of the session for the debrief and to pay. I feel a bit excited that this might end up being a bit of time for me to do something just for myself too!

A couple of weeks pass and it is time for Bobby's next session. For this one, I book an appointment time during his school day during the week. Since only Bobby and I have to go, I pick Bobby up after lunchtime at his school. He is happy to miss a bit a class time to go to his appointment, and I hope that this timing will be a better fit than when we had our session at the end of the day last time. Bobby seems talkative and relaxed about going to see Nancy again, or perhaps he is just happy to miss some school, I'm not really sure. The traffic is still congested driving to the office, and I realize because of the proximity to shopping and the library that it

might always be a challenging area to drive around and find parking in. Once again, I find myself frustrated having to pay for parking and I remind myself to look up where there is less expensive or free parking available in the area.

We arrive at the office and I'm already thinking about what I am going to do with the 45 minutes I have available when Bobby heads into his appointment with Nancy. I check in with the person at the front desk. Bobby has his iPad and I have my phone to help pass the time while we wait for Nancy. This time Nancy is just a few minutes late coming to get Bobby and I check with her if it's OK that I leave for 45 minutes and be back for the end of the session. She indicates that it is not a problem and tells me to enjoy my time away. Bobby and Nancy head down the hallway to the play therapy room and I head outside.

I grab a quick tea from the cafe down the street. It sure is convenient to be able to drop my child off at therapy and have a bit of time to myself! After the tea, I still have some time so I stop at a nearby shop to pick up a couple of items for supper. I make it back to the office with a few minutes to spare. Nancy comes down the hallway a couple of minutes later and brings me back to the play therapy room. Bobby is busy playing the in the sand box. Nancy tells me they did a bit of playing in the sandbox together but mostly they talked today. She did not give specifics about that they talked about, but she does mention that it was a good session and she says that is all the time we have for today. Bobby receives another candy treat for his good session and we all head back down the hall together. I pay for the session and book a similar daytime slot in two weeks time.

We head out to the car and Bobby seems a little more reserved after this session. When I ask him how it went he says it was ok, and that he really liked when they played together today, but that Nancy also wanted to do a lot more talking this time. I ask him about the talking and he

says that Nancy was asking him a lot of questions and that he did not find it fun answering them. I ask what kinds of questions they are and he says Nancy wanted to know more about his school and other things like that. When I ask if he wants to see Nancy again, Bobby shrugs. He names all the fun toys that he has seen tucked away in the bins but hasn't yet been able to play with, and says he does have fun when they play together. But he also says he feels like Nancy is expecting to talk more with him and he doesn't find that enjoyable. Bobby tells me he has been comfortable enough to tell Nancy that he wants to play more and talk less in session. I'm proud that he is able to speak up for what he prefers, but I find myself questioning how much work can get done during a play therapy session without talking?

Since Bobby and Tim go to after-school care a couple of days after school, I drop him off at his after-school care so that he can interact with his friends and finish his normal daily routine. We pay a lot for the after-school care, and I want to make sure we use the service and get our money's worth out of it. Bobby is furious when I pull into the after-school care parking lot. I realize that he assumed that he was going straight home after his session. He yells at me that he just needs a break after play therapy. I begin wondering if maybe the play therapy process is more work for him than I realize? I assumed that he was playing and enjoying it, but honestly I am not really sure what is happening in the sessions. Does it feel like work for him to have to go to sessions and have to talk in play therapy? I feel like I have many questions and no answers. I hope Bobby's mood can recover from this, and pray that he doesn't lash out at anybody in after-school care. His temper still seems to be so volatile. After all the stress of getting Bobby dropped off, I am exhausted. Rather than go home and start cooking supper ahead of time like I had planned, I lay down for a nap to try to recuperate from the stressful afternoon.

Over the next two weeks, I personally don't see any changes in Bobby's aggression at home, but things do seem a little less volatile at school. I still get at least one phone call a week telling me about some situation that occurred with another student in class or at after-school care, and I notice my stomach still drops every time I answer the phone. I find I cannot consistently know if and when Bobby is going to have a bad day, and this lack of predictability around his behaviour is exhausting. I find myself walking on eggshells around Bobby. I don't want to set off his temper, and in turn I am probably not consistently enforcing all the consequences to his behaviours that I should be. I also think some of the frustration I am feeling is that I don't clearly know what will help shift his behaviours and help make changes for him at school and at home. Is he supposed to be working on skills or homework that I don't know about? I don't notice that his reaction to situations is any different than what was occurring before therapy. Am I missing something? But I can honestly say that outside of taking Bobby to therapy every couple of weeks, I am not doing anything different either. It feels like his bad mood determines the kind of day everyone else in the family is allowed to have, and I sometimes feel resentful towards him.

After a particularly hard evening with Bobby where he angrily shoved his little brother, I reach out to Nancy in an email asking for some suggestions about how to manage Bobby's temper. A couple of days later she writes me an email back that does include some general information regarding anger in kids and how it is often routed in anxiety. In her email she also provides information on the impact of parents yelling on child anger and I am unsure how to take this information. I am not really a yeller, but my husband certainly can be when he loses his patience with the boys. I feel like there must be a reason she included this information in the email and wonder if maybe Bobby mentioned something to her in a session? I make sure to read through the information. If it will help our household then I am willing to give it a try. Later that

evening after the boys are in bed, I talk to my husband about the email from Nancy and mention the information she gave about the impact of yelling on children. I can tell John is immediately defensive about the information I try to provide him, and is not open to hearing about new ways of interacting with the boys. John grows quiet and we end the evening not really talking to each other. I feel like I probably should have chosen a time when he was not exhausted from his work day to share that information with him. I feel stuck. I realize I certainly can't force him to change how he interacts with the boys, but I can only try to change my own behaviour with them and see if that makes any difference.

The next session is once again a weekday session that I booked for the afternoon. I pick Bobby up from school and he immediately asks if he is coming back to after-school care after the appointment. I am hesitant to tell him yes, because I don't want to be the target of his anger, but I also don't want to lie to him. So I let him know he will be coming back to after-school care, but that we can also stop at McDonald's for a treat after his play therapy session and before I drop him back off at school. He doesn't seem happy about it but the offer of the treat seems to have appeased him a bit. If it takes a bit of bribery to have the drop off be easier than it was last week, I am willing to do it.

The traffic doesn't seem quite as bad today but I am once again frustrated by the parking situation. I had done some research this past week to see if there was free parking in the area, but there is no free parking less than four blocks away from the office. Bobby is already in a testy mood, and so I elect to just pay for parking again. I guess there is a price I am willing to pay for convenience and for not having to walk with an unhappy child. We get to our appointment right on time, and Bobby takes a seat while I check in at the front desk.

Nancy is almost on time today, only five minutes late, and I do the hand-off of Bobby and head outside to make the most of the free time I have. I stop at the cafe for a coffee and then proceed to walk around the nearby library browsing the books. I arrive back at the office five minutes before the end of Bobby's session and wait to be called back. Nancy comes and gets me in a few minutes and she lets me know that they spent a lot of today drawing pictures and talking together. I can't quite tell how Bobby might be feeling by the look on his face today. He doesn't look very happy, but I'm uncertain if he might be unhappy because it is time to leave, or because he has to go back to school, or if something else is going on. I begin to ask Nancy a question regarding specifically what they worked on, but she brusquely cuts me off stating that those details are private. I am caught off guard and so I meekly thank her for the session and head to the front desk with Bobby to pay for the session. I find myself feeling uncertain of what is actually being done in therapy and also find myself wondering if they are working on any of the problems I identified in the initial paperwork I filled out. Other than when I wrote down our initial reasons for seeking out therapy for Bobby, there has been no mention of his anger or what they might be working on to help with his anger. In her email last week it almost seemed like she was suggesting that Bobby's anger might be due to our parenting, but there has been no direct communication between Nancy and us. I feel so far out of the loop of Bobby's therapy this communication gap feels really uncomfortable.

Bobby and I head out to the car. As promised, I go through the McDonald's drive through and he gets a treat to help make the transition back to after-school care a bit easier. He eats while we drive and I ask him about the therapy session. I want to know what they are doing in their sessions. Are they talking about his anger and outbursts at all? He shrugs and lets me know it was fine. When I again press him for more details he says that he played a board game with

Nancy which was fun, but then Nancy asked him to draw a picture of his school. Bobby described how he just scribbled a few lines down and handed it to her and she declared how good a drawing it was. As Bobby is telling me this, he laughs bitterly and says he didn't put any effort into the picture and that it was a garbage picture. I realize that he too seems to be finding play therapy to be a bit frustrating and confusing. I hear how he likes to spend one on one time with Nancy playing board games or otherwise playing, but I am also hearing that Bobby really is not enjoying the talking parts of therapy and is maybe not completely trusting that Nancy is being genuine with him. When I ask if he wants to see Nancy again, he still seems divided. He mentions how he doesn't like the disruption of leaving and having to go back to school, but also that he does really like when they can just play together. Although he doesn't explicitly state it, I personally wonder if he is just not feeling a strong connection with Nancy, and that there might be a personality mis-match between them.

Over the next two weeks, I again don't notice any significant changes in Bobby's behaviour. I am still getting calls from the school, and bedtime continues to be very stressful in the house. I try to manage as best I can, but I am getting exhausted. The fighting for hours around his bedtime is one of the worst parts of my day. I am trying to make sure I'm not yelling at Bobby during these stressful times, but I am also acutely aware when John does yell. I cringe when it happens, and I wonder how I can get him to be more open to engage differently with the boys? I feel like John and I are out of sync in how we are parenting right now and it doesn't feel like we are on the same team. Any self-care or time together as a couple that John and I might have is eroded away by Bobby's evening temper tantrums and refusal to stay in bed. I feel like I am a shell of the person I am supposed to be in this world, and all my energy is being consumed by parenting one of my children.

The next session is again a weekday session. As usual, I pick Bobby up from school and he sadly asks if he is coming back to school after the appointment. I tell him yes and also remind him that we can stop for a treat after the session and before I drop him back off at school. He is instantly angry and I hear him muttering something under his breath. When I ask him what he said, he freaks out and screams how he hates how I try to control everything in his life. I hold back my tears and quietly tell him that he has now lost his McDonald's treat and he is also grounded for the rest of the day. He continues to rage at me for the duration of drive. In addition to the stress of his anger, there is also some unexpected construction and the traffic today is extra heavy. Despite my best efforts we arrive five minutes late and we both run into the office still angry at one another. To our surprise, Nancy seems to have actually been on time today and is waiting for us in the waiting room. She reminds me that she still has to finish the session at ten minutes to the hour and curtly asks that I be on time for the end of session debrief with Bobby. She and Bobby head down the hallway and I sit down in the waiting room for a moment to collect myself. I am livid. I can't even begin to understand how it's OK for her to be late for every session and never apologize for it, then the first time I am late she has the nerve to make a snarky comment about it?

I head out to the nearby cafe because I just have to get away from the waiting room for a while. While having my tea I mull over what just happened and I recognize that I am not only feeling angry about Nancy's comment, I am also feeling hurt. I feel so completely unappreciated in this venture right now. It has been my initiative alone that has gotten Bobby into play therapy, and I have to work incredibly hard to even get him to his sessions. John has tapped out and put the responsibility on my shoulders to carry this through which I am also frustrated about. And since getting Bobby to play therapy itself seems to be adding stressful interactions between us, I

am having to manage his temper tantrums more than ever. I feel so incredibly sad and alone in this process and dread having to engage with Nancy when I go back to pick up Bobby.

I'm extra careful to come back on time. Nancy does not come and get me to bring me into the session for the last couple of minutes, instead she brings Bobby back down the hallway and chats briefly with me in the waiting room. I nervously ask how the session went and she seems slightly cool and says the session was "fine" and that she would she see us in a couple of weeks. While it would have been uncomfortable to have an honest chat with her, I am disappointed that she doesn't seem to feel I am important enough to try to repair what happened earlier today. I would love to be able to talk to Nancy about what they are working on in the sessions and also share with her how hard this process is right now for me, but right now I don't feel like I can trust her at all. I realize that the play therapy is for Bobby but I think I expected have to at least a little bit of engagement with the therapist to share what is going on for me.

I pay for the session and Bobby and I head out to the car. Bobby closes the office door on me as we leave and proceeds to tell me he is still angry at me for taking away his McDonald's treat. I am so defeated right now, Bobby is angry at me, I feel like Nancy is angry at me, so I relent and tell him I'm sorry and we do stop and get him a treat before he heads back to after-school care. I'm so exhausted, I don't care that I gave in to his demands and I just need things to get a bit easier. After Bobby receives his treat he is a little bit more pleasant on the car ride, but he still throws a massive tantrum as we arrive back to the school. As he finally heads into the after-care center, yelling back at me that I'm the worst mom in the world, I break down in tears in the car. Where did I go wrong here? And why is nothing getting better?

The next session is another weekday session. I pick Bobby up from school and he once again asks if he is coming back to school after the appointment. I tell him yes and remind him

about stopping for a treat after the session and before I drop him back off at school. We pay for parking and we arrive on time for the appointment. Bobby and I take our seats in the waiting room. As we wait for Nancy, Bobby is enthusiastically talking about one particular stretchy figurine toy he is looking forward to playing with in therapy today, and he is excitedly telling me all about it. Bobby has gotten himself very stirred up, and when Nancy comes to get him, he impulsively runs up and gives her a quick hug. Nancy seems to be taken off-guard by the gesture and she reminds him about boundaries and how it's not okay to touch someone without their permission. This correction is done in front of other people who are also in the waiting room, and I know immediately that Bobby is going to be upset by this interaction. I look at Bobby and see that he has a look of both hurt and anger on his face, and I wonder how this is all going to unfold. I decide to stay in the waiting room for the entirety of this session, as I am uncertain how Bobby might react. About 35 minutes later Bobby comes out of the session with Nancy and says he has to use the washroom. When he comes back, he asks that I come back into the play therapy session with him. Since it's getting close to the end of the session anyway Nancy says that will be fine and we all head back into the play room. I can see that Bobby has been playing with the sand box and notice that there is also a lot of sand scattered on the floor. Nancy indicates that they have been playing and mentions that Bobby seems unhappy but he has not talked about why. Bobby rudely turns his back to Nancy as she is talking and refuses to even acknowledge her. I am instantly embarrassed by his reaction and so I begin to fill the space and talk to Nancy about the hug that happened in the waiting room. I apologize for his actions, and tell her I'll try to make sure something like that doesn't happen again. Nancy doesn't really acknowledge my discomfort, and seems uncomfortable herself. She fills the remaining time lightly chatting about herself and how she got into her career. At the end of the session she offers him his treat,

however he refuses it. I understand immediately just how angry he is, and I know I will be dealing with his anger for the rest of the day at least. We pay for the session and leave. On the way back we go through the drive through for his treat as promised. It helps lift his mood a little, but he doesn't want to talk at all on the drive back to school. I again find myself wondering why Nancy is not addressing any of the communication challenges and interpersonal gaffs that have occurred between us and her. Is it my job to bring up these things and specifically say that I would like to talk more about some of these uncomfortable occurrences?

Bobby is once again furious when I drop him off at after-school care and I am exhausted. I head home and even though I am so tired I start supper early because I know Bobby is going to be a tornado of negative, angry energy when he comes home. I find myself so resentful toward Bobby that instead of taking some well-deserved time to myself after a hard afternoon, I am instead preparing supper early. I know once Bobby sets foot in the door I will be 100% occupied dealing with his rage and demands for the rest of the evening, and I find myself feeling alone and overwhelmed thinking about it.

Reflecting on these past few months, I never could have imagined how it was all going to unfold. I remember being so hesitant and nervous to engage a professional in our lives to help with Bobby's challenging behaviours. And now, while I feel like perhaps some elements of the play therapy may have been beneficial, I am left feeling that what we gained from play therapy was not enough. Play therapy is really hard work for parents. Getting the child to the sessions, trying to not yell in the heat of the moment when I react to Bobby, these pieces all take a lot of time and effort. I do think he sometimes liked his one-on-one time with Nancy as a break away from the family, but I question whether he made a strong connection with her. So although he enjoyed his time playing with Nancy, I wonder what exactly he learned in his sessions because I

didn't see him trying to do anything differently. For myself, when I think about my time with Nancy I tend to remember the unusual situations, for example the many times she was late or seemed disorganized, or the couple of times I questioned her professionalism. It is weird how I tend to focus on those negative interactions with her rather than the times she was kind to Bobby.

Through our time with Nancy I did start to learn about the impact of my own reactions and behaviours on Bobby, which was helpful. And when I did ask Nancy for tips she would provide some information, however it didn't always feel like it was directly relevant or applicable to our situation and it was never followed up on to see if we were successfully able to integrate it into our family. On the whole, the process has been less than satisfactory, and it does feel like something was missing for both Bobby and I in this journey of play therapy, and ultimately I decide to stop booking any more sessions with Nancy.

Chapter 5: Discussion

The elements that help to create change within the process of play therapy are not well understood. Research on change processes in play therapy is limited, with much of the existing literature on effective play therapy coming from the perspective of the trained therapist. In counselling, however, a mis-match has been identified regarding elements of therapy that therapists identify as being important, and those that clients identify as impactful. We also know that child therapy outcomes are influenced by parent's perceptions of the play therapy process. However, little is known about the lived experiences of both the child and the parent in play therapy. And even less is known about what parent and children might consider the elements for change to be. The aim of this study was to explore the perceptions of play therapy from the perspective of both child and parent, and to identify helpful elements of therapy from these perspectives. In order to do so, this study sought to answer the question, "What is the lived experience of play therapy from the perspective of both child and parent?"

Parent and child dyads who had previously, or were currently, attending play therapy were invited to participate in this study. Both the parent and child in the dyad were interviewed regarding their perceptions of play therapy. Interpretive Phenomenological Analysis was used for this study to explore both similarities and differences within parent and child experiences of the play therapy process.

Findings from this research study highlight that parents and children both identified important elements of play therapy as including three critical pieces: Support received, the role of the therapist, and the role of play in the therapeutic process. While some similarities were found between parent and child perceptions of each of these three themes, some subtle distinctions between child and parent perceptions were also discovered. In this discussion

section, key findings will be examined and discussed in relation to existing research and proposed theories. Implications and limitations of this research study will also be discussed as well as areas for future research.

Theme #1 Support Received

Parents and children in this study identified play therapy as being a circumstance where support was received. Three sub-themes were identified as key aspects of support: Child development, parent development, and a trusted relationship with the therapist. Parents also highlighted the impact administration and scheduling has in their experiences of play therapy. As well, parents also underscored the importance of crafted interventions that are tailor made for the particulars of their family as being necessary elements to feeling supported in the play therapy process. Children also specifically named play therapy as occurring in a novel and exciting environment, as well as feeling good at the end of a therapy session, as being necessary elements of feeling that they had received support in the play therapy process.

Child Development

Not surprisingly, parents and children both expected that child development would occur as a part of play therapy. For parents, this included an increase in their child's education/knowledge, an increase in child confidence, as well as some type of observable behaviour change on the part of the child. Interestingly, for parents to name that support for their child has been achieved, some type of observable change in their child's behaviour was a critical aspect to their assessment that support had indeed been provided for their child. From the children's perspective, they also felt that support for themselves included some type of education/knowledge, and an increase in confidence. However, from the perspective of the child,

there was no consideration of any type of child behaviour change needing to be achieved or associated with support received.

These findings of both parents and children having some expectations of child development occurring due to therapy, suggests the importance of addressing client expectation that is included as an element of the Contextual Model which ascertains that change occurs via three pathways of: 1) the real relationship, 2) expectation created by explaining the problem and treatment, and 3) engagement in health-promoting activities (Wampold & Imel, 2015). One can see that these findings highlight the importance of addressing the second pathway, expectation, and the importance of fully explaining the problem and treatment to parents in order to help create appropriate and informed expectations regarding the process of play therapy for their child.

Looking more specifically into the findings related to observable change as a parental expectation for their child having received support, and considering this is not a perspective shared with children, raises an interesting situation. Children had no expectation of change in their behaviour as needing to occur as part of the support they receive. In the process of play therapy, it may be that both the parent's and child's expectations of support are subtly different, and thus should be addressed differentially. For example, if parents have an expectation that they must notice changes in child behaviour for them to feel that support has been provided, and that for the child support means feeling more confidence, then these differing expectations can be understood and addressed by therapists. Recognition of these expectations by therapists may allow for more informed conversations with parents or choices in engagement with the child so that parents and children both feel supported throughout the play therapy process.

When specifically looking at the theme of confidence that arose in the children's view of their own personal support, we can understand this result as supporting the elements of the transtheoretical model of play therapy (Drewes & Schaefer, 2016). One of the elements of this model is a change in the child's personal strengths (e.g., problem solving, resiliency, self-regulation, self-esteem). Children in the current study identified elements of support as education and confidence, and these elements do correspond with Drewes and Schaefer's transtheoretical model's category of increased personal strengths.

Parent Development

Both parents and children expected that play therapy would also include some development for the parent. From the perspective of the parent, this included sub-themes of education/knowledge, feeling more agency/control in addressing their child's challenges, and an overall feeling of greater confidence in their ability to manage the situation. This finding also seems to address the element of expectation in the Contextual Model (Wampold & Imel, 2015). When specifically considering the element of expectation, it is surprising that although play therapy is typically considered to be therapy for the child, both children and parents held an expectation that some type of parental development would also be occurring within the play therapy process. Both children and parents expected that the parents would be involved in some types of learning to support the child's growth, and when this did not occur it was notable (i.e., parents naming they just dropped their child off for therapy, children naming that their parents didn't try anything new when interacting with the child). Given that the Contextual Model posits that change occurs via any of the paths and that use of multiple paths is more likely to aid client change, it seems that a greater understanding of expectation from both the child as well as the parent would be necessary to provide the opportunity for optimal client outcomes to occur. This

finding seems to highlight the critical need for clinicians to be addressing client expectations, and highlights that in the case of play therapy there may be multiple expectations of therapy that may be beneficial to explore and formalize.

Relationship with a Liked Therapist

Both parents and children identified the component of liking the therapist as being a critically important part of successful play therapy and for a perception of support having been received. This finding supports elements of the youth and family common factors model hypothesized by Karver and colleagues (2005) that highlights the importance of the building of the therapist-client relationship. Karver and colleagues' model also highlights a need to more clearly define and understand the terms therapeutic relationship and therapeutic alliance given that at least three different aspects may be involved: emotional connection (the affective bond with the therapist), cognitive connection (hopefulness about treatment or a willingness to participate), and behavioral participation in sessions (Karver et al., 2005). The authors recommend that these aspects, their relationships with one another, and their unique impact on outcomes need to be clarified before the therapeutic relationship/alliance common factor can be fully understood (Karver et al., 2005).

In the current research study, the vast majority of children spoke of liking the therapist, with even the youngest research participant at three years old clearly naming how she liked the therapist and that she knew the therapist liked her too. Parents also named the relationship with a liked therapist as being important, however parents also identified the additional role of trusting the therapist as being critical to developing a strong relationship with the therapist. This trusted relationship was described by parents as being generated from having a professional on their side, and one where the parents experience relief. All parents spoke of the relief to have

validation that their concerns about their child were legitimate, and relief to have another set of eyes on the situation to help figure out the challenges. Interestingly these particular parent findings are contrary to those of Nalavany and colleagues (2005) exploration of qualities and competencies that make up a "good" play therapist. Interviewing experienced play therapists, Nalavany and colleagues collected and ranked seven therapist qualities therapists identified as being the most important for effective play therapy. The least important skill/quality the therapists ranked was "skills with the family." In the current study parents repeatedly named the therapist's ability to create a trusted relationship with them and engage with the family as being one of the most important aspects of effective therapy. This discrepancy suggests that therapists may be under-estimating the need to connect and work with the parents as part of fostering positive child outcomes.

Administration and Scheduling

Parents all named various helpful administrative policies as beneficial, such as online booking, multiple methods of payment, free parking, as well as thoughtful considerations such as mini play rooms that allow for parents to attend parent sessions without needing to schedule childcare. These findings support the writings of Landreth and Bratton (2006) who highlight the parental workload involved in the practical endeavour of physically getting children to and from play therapy sessions, and the role of the parent to prioritize their child attending play therapy. In the current study, parents identified and named this burden of responsibility of getting children to therapy. An exploratory concept mapping study (Paulson, Truscott & Stuart, 1999) noted that from the perspective of the client, accessibility was named to be impactful to the client's experiences of counselling, with accessibility including administrative aspects of availability and affordability. While there has been limited research exploring the impact of administrative

practices on client's counselling experiences or outcomes, perhaps research that considers attunement in therapy might also be relevant. Attunement is one piece of the multidimensional construct of empathy. Attunement is a process that includes two parts: (1) an ability to connect with another individual's experience; and (2) the communication of that connection back to the individual (Erksine, 1998). When a therapist is attuned to the work the parents have already undergone to get their child to therapy and makes convenient booking or payment options available to relieve some of that work, this may help a parent prioritize play therapy. Parents certainly noticed and appreciated when therapists were sensitive to their burden and provided easy access to a variety of helpful administrative components.

Tailor-Made Interventions

When parents spoke about key aspects of the support they received, the vast majority named the importance of thoughtful and applicable interventions. Most parents spoke of therapy as not being the first thing they tried to get help for their child. Many had previously tried self-help strategies from the internet, Podcasts, or books and articles in an attempt to help their child. In this study, parents identified that when therapists took time to understand specific dynamics of families and then suggested and provided support around refining and tweaking applicable interventions, that this was a critical piece in parents feeling supported. This finding corroborates the research by Holcomb-McCoy and Bryan (2010) which identified the need for therapists to create a collaborative relationship with parents. It further corroborates the research by Bratton and colleagues (2005) which highlighted the successful involvement of parents in the play-therapy process. The engagement of parents through this collaborative process of tailor-made interventions was specifically identified by parents to be one of the key elements to their child

having successful therapeutic outcomes and was named as an important focal point for allowing parents to feel fully engaged in their child's therapeutic process.

Exciting Environment

Children all named an exciting and novel play therapy environment as being impactful to the child's perception of support. When talking about an exciting environment, children spoke extensively about the toys that were available at play therapy, as well as the storage of toys. Bins and cupboards where toys were tucked away and hiding for children to explore and discover were all identified as important elements in helping make the play therapy environment exciting for the child. Children also spoke of time spent playing with the therapist, and receiving little toys or treats at the end of the sessions as contributing to the excitement. Karver and colleagues (2005) defined the construct of the therapeutic relationship/alliance with youth as including three elements: an emotional connection with the therapist, a cognitive connection with the therapist, specifically manifested by a willingness of the child to participate in session, and finally the child's behavioral participation in sessions (Karver et al., 2005). The current study suggests that it is the sense of excitement experienced by the children that may help to foster the behavioural participation element suggested by Karver and colleagues (2005). Regarding the treat at the end of sessions that children also spoke of as contributing to excitement, it may be hypothesized that perhaps the treat or the toy after a session may be impactful in developing the second element Karver and colleagues hypothesized, cognitive willingness to engage in sessions. Specifically, for the children in this study, the exciting environment impacted their desire to actively participate in therapy sessions and was achieved in multiple ways. Considering research implicating the importance of the therapeutic relationship and the working alliance, this

understanding that play therapy is expected to be exciting from the perspective of the child, is an important piece of knowledge for therapists to keep in mind.

Child Felt Good

Most children named that after a play therapy session they felt different or good. This assessment of temporary change in how they felt typically was named as feeling relaxed or good after sessions due to the engagement and interaction they had with the therapist. While some children were additionally able to note some longer-term changes (for example, bad dreams that went away or getting along better with peers), which they also felt positive about, the majority did not notice or identify longer-type changes. As noted previously, parents in this study highlighted how effective play therapy must include some type of longer-term child behavioural change. However, from the perspective of the children, change in therapy is named to be a shorter term, state-change. These current findings support research by Scott, Burlingame, Starling, Porter and Lilly (2003) on Child Centered Play Therapy (CCPT) with sexually abused children, in which they found that children reported change and progress prior to parents reporting significant changes. Scott and colleagues (2003) hypothesize that this mismatch occurs due to children beginning to feel different sooner than longer-term change was observable by parents. The current research study supports the differing perspective of how children and parents interpret change, and further highlights how change in children is an in the moment experience of "feeling different" versus a goal-oriented longer-term expectation of change by parents.

Theme #2 Role of the Therapist

Parents and children in this study identified the important role the therapist plays within the play therapy process. Parents and children identified four sub-themes which they highlighted

as being key components regarding the role of the therapist: a neutral third party, modelling by the therapist, a therapist who is non-judgemental and kind, and a therapist who teaches. In addition, parents also highlighted two other critical roles that the therapist engage in: the therapist being a flexible professional, as well as the therapist being a decoder of information.

Neutral Third Party

Both parents and children identified that one of the most important roles the therapist holds, is to be someone engaged and committed to helping. However, this must be undertaken by someone who is not the parent. From the perspective of parents, they identified that having a neutral party involved allowed for a preservation of the relationship with their child during these very challenging times. As well, parents also identified that the therapist played a significant role in preserving the spousal relationship between parents through the teaching that occurs during parent sessions. Parents reported that their spouse was typically more willing to listen and be open to knowledge if it came from the therapist rather than them. Additionally, children named and identified that it was more positive and helpful to them when information came to them through a therapist rather than a parent. Children identified that simply because the therapist is not their parent, they were more receptive to listening, as well as recognizing that the therapist is differently qualified than their parents. For example, one child described their therapist as "a doctor of feelings." In the current study, many parents were actually trained and qualified to provide a variety of mental health supports to their own children. However, children did not seem to recognize the abilities or professional training of their parents, and only one child reported that if the therapist had not been able to help them that they were confident their mom would have helped. These findings by both parent and children suggest a recognition regarding the role of the therapist and the impact that perceived expertise has in play therapy. This

perception of expertise seems to support the findings of Locati, Rossi, Lang & Parolin (2020), in which the role of therapist expertise was specifically identified as a key element in the therapeutic process. While Locati and colleagues only considered adult perceptions, it did highlight that therapist expertise significantly affects the interpersonal dynamics occurring in therapy sessions. The results of the present study similarly highlight that all parties, both parents and children who are involved in play therapy, notice and are affected by their own perceptions of therapist expertise.

Modelling

Parents and children both named the modelling that occurred as being a helpful element of play therapy. Parents identified specifically that modelling communication, with the therapist acting as a conduit for communication between multiple parties, as being a critical piece. This communication guided by the therapist allowed for communication between parent and child, as well as communication between parents, and in some cases between the family and the school, or family and extended family members. This role of the therapist facilitating communication and transmitting appropriate information was identified as being essential. It allowed for complete information gathering and distributing as well as getting parents on a similar level of understanding regarding what is occurring and required in the treatment of their child.

Similarly, children named the therapist modelling both behaviours and emotions to the child as being helpful and important parts of play therapy. Children described how the therapists taught them greater understanding about their own emotions as well as their behaviours through modelling. Both parent and child findings seem to correspond with literature regarding the use of behavioural social skills training (SST), which although is not typically utilized in adult therapy, is often utilized in therapy in children. SST can include a series of non-verbal responses (i.e., use

of eye contact and facial expression), and verbal skills (i.e., tone, rate, volume of speech, word choice) as well as emotion conveyed (i.e., anger, fear, happiness) which impacts how others respond (Spence, 2003). Understanding and refining the use of these basic skills has important consequences over and above what an individual actually says or does in an interaction (Spence, 2003). The current study highlights that the therapist training and engaging in this type of communicative, emotional, and behavioural modelling is noticed by both parents and children and is considered to be an important role of the therapist from the perspectives of both parents and children.

Trusted, Non-Judgemental, Kind

Parents identified that being able to trust the therapist and to perceive the therapist as non-judgemental were both important pieces to helpful therapy. Parents identified that it was these two components being present that allowed them to open up and be vulnerable with information they were sharing with the therapist. Parents highlighted this critical step as being imperative for the therapist to be able to receive an accurate and full understanding of how individuals in the family are functioning, which fundamentally impacts how the family is operating as a whole. While no research literature has currently explored the role of parental vulnerability or parental disclosure in play therapy outcomes for children, Timulak and McElvaney (2012) explored the context that best creates an insightful client event in therapy. Their research highlights how a reasonably strong therapeutic alliance in addition to client vulnerability and a desire for client self-understanding provides a foundation upon which clients are able to create insight events in therapy. The current study highlights from the perspective of the parents that vulnerable disclosures regarding how they are feeling and how the family is

doing is an imperative piece fostering change and parental insight to occur within the play therapy process.

Children in the current study did not name their own vulnerability as being important, but instead named the kindness of the therapist and them liking the therapist as necessary pieces of helpful therapy. This liking of the therapist was named through a variety of descriptors of the therapist including nice, calm, helpful, and recognizing that the therapist was connected and interested in them. Children then named how this liking of the therapist helps to facilitate the play and the child engaging with the therapist in therapy. These findings support the findings of Carroll (2002) that children named their therapist as kind and helpful. Even the youngest research participant in this study (3 years old) recognized this connection stating, "I used to play in sand boxes with [the therapist], and she likes to play with me too." Both parent and child findings suggest support for the foundational perspectives of Virginia Axline (1947), where she hypothesizes that successful play therapists possess qualities including: 1) an attitude of respect and acceptance toward the client, and, 2) an ability to connect and be alert to the feelings of the client. Although parents named their experiences slightly different from the children, the tenets of trusted, non-judgemental, and kind do all seem to support Axline's (1947) necessary therapist traits hypothesis.

Teaches Parental Awareness, Teacher/Guide

Both parents and children named an important role of the therapist to be a teacher to them. Parents talked about the therapist helping to teach them awareness, specifically regarding changes that might be occurring in their child. This concept of "cueing" the parents was highlighted to be one of the overall most important pieces of the therapeutic process and one that relies on the role the therapist takes in this parental education. These findings may support

historical literature which looks at the role of self-monitoring and specifically the element of cueing may have in change. Johnson and White (1971) as well Kazdin (1974) view cueing as a necessary element for initiating change. These authors propose that the act of watching one's own actions can actively remind the individual of the observed behavior in question, which can then allow them to choose to alter their behaviour. The current study similarly supports this importance of cueing, however less so from the perspective of cueing awareness of the parent's own behaviour, instead focusing on the parent being cued to their child's behaviour changes. This cueing or noticing of children's attempts to do things differently, or use new skills, then was identified as bridging a sense of hope in parents that change might be possible. This cueing identified by parents could also be related to Timulak and McElvaney's (2012) research around insight. The cueing of parents could perhaps be understood as a parental insight event which impacts the overall therapeutic process.

Children spoke of the role of the therapist as a teacher or guide, where the therapist teaches the child new things about themselves or new things about a situation (such as their parents divorcing, or a child being bullied at school). As previously discussed, the teaching that occurs in the role of the therapist for children seems to be related to social skills training and modeling. Children identified the therapist as being in a teaching role where the therapist is providing important knowledge to the children, and where there can be didactic practice and modelling of the new information (e.g., role plays of what to say to a bully).

Flexible Professional

Parents spoke of the importance of flexibility in the role of the therapist. This flexibility was specifically identified regarding communication with multiple parties, such as parents, the child, and schools. Parents highlighted how the therapist has to be responsive and flexible in

their interactions with all of these parties and that communication with each may be quite different. For example, in the case of a parent who is reluctant to explore the impacts of their behaviour on their child, the other parent might expect an open and frank conversation. With children, parents expect gentle and caring communication, while with schools parents expect a confident professional who is advocating for the best interests of the child. The therapist is expected to take on multiple roles depending on who they are engaging with. One of the key elements that Landreth (2012), a leader in play therapy, identifies as an essential play therapy trait leading to successful client outcomes is that of flexibility. While one can intuitively expect that a play therapist must be flexible in their play therapy with the child, it is interesting that this key trait was specifically named by the parents as being essential to helpful therapy and it was specific to the realm of communication.

Decoder Interpreter

Parents unanimously named an important role of the therapist as being someone who acts as an interpreter of child behaviours as well as a decoder of what those behaviours mean in the context of the family. Parents identified that while they were easily able to identify challenging child behaviours, the play therapists provided an additional interpretive step of clarifying what the behaviours may mean, and also providing information as to how the parents may best navigate the behaviours. An example is Sally who spoke of the play therapist interpreting and sharing the pictures that her daughter drew of the family which suggested that the child had not yet fully processed the impending divorce of her parents. This role of interpreter and decoder again highlights a filling-in of information by the play therapist for the family. This naming of the therapist as a decoder/interpreter to help fill in of gaps in both information and communication corresponds with a psychodynamic perspective. It is interesting to note this

connection back of play therapy to its psychodynamic roots via the parents' perspective of the role of therapist. Parents named tremendous value in the therapist engaging in this decoding and interpretation of information that the therapist is getting from the child, and relaying it in practical and informed terms back to the parents.

Theme #3 Role of Play

Somewhat obviously perhaps, parents and children in this study all identified the important role of play during the play therapy process. Parents and children highlighted two shared sub-themes which they identified to be key aspects to the role of play: connection, and the funness of play. In addition, parents also highlighted two other critical pieces that play has in therapy: it is trusted by parents as a way for their child to engage with another adult, and the magical quality that play has to draw children into engagement. Finally, children also highlighted how play allows the child to feel control within the play therapy process and that play helps shift the power imbalance that is present between therapist and child.

Connection

Parents and children in this study all identified the significant role that play has in connecting with the play therapy process. Parents identified play being essential as a non-threatening way to access information that otherwise therapists may not be able to make contact with. Children also identified that play is a way to be fully engaged and connected with the therapist that also does not require talking. Both children and parents identified that it is easy for a child to feel overwhelmed and refuse invitations to speak in novel situations, while it is difficult to resist an invitation to play. These findings on play and the role it has in connection from both the perspective of the parents and the child corresponds to foundational literature on play therapy highlighting the need for therapist connection with the child. The writings of

O'Connor (2000), identify the importance of the therapist being actively engaged at all times with the child through play, while balancing both an integration of theoretical knowledge and the needs of the child in all interactions. O'Connor (2000) further highlights the critical need to develop a strong therapeutic relationship through engaging in activities with the child that are satisfying, flexible, and respect the child's natural way of being in the world (O'Connor, 2000). Kottman (2011) similarly makes the bold statement that regardless of the theoretical orientation of the therapist, it is the relationship between child and therapist that is a necessary requirement for successful therapy. Parents and children in the current study highlighted that this natural way of being in the world does seem to be through the act of play and that it is through play that therapist and child connection can be developed.

Fun

Parents and children both named the importance of play as contributing to the 'funness' of the play therapy session. Parents highlighted that if elements of the session were fun, or if the session finished on a positive note, for instance when the child is given a small treat or toy, these fun events make it far easier for a child to be excited and engaged about coming back for another session, even if they had worked on challenging topics in the session. Children named that it was how fun the session was that impacted their interest in returning, and children astutely noticed and named when there was an imbalance of too much talking and not enough fun in a session. Children were all clear that they were in play therapy to play, and they noticed when the therapy took precedent over the play. These findings corroborate research by Deboys, Holttum, and Wright (2017) in using art therapy with children that highlights the importance of therapy sessions being fun, playful and enjoyable from the perspective of the child. Deboys and colleagues (2017) further hypothesized that the fun in art therapy was an equally important

component of the change process, and hypothesized that fun was likely as important as the therapeutic relationship. Deboys and colleagues (2017) also identified that the role of fun in therapy is an important element to balance out and contain the more challenging elements of therapy that a child engages in. The current study highlighted both the parent perspective of funness being important for a child returning to do the work of therapy, and the child perspective of funness being intrinsically tied to the connectedness they feel with therapist in the process of play therapy.

Trusted

Parents spoke of how play is a trusted and developmentally appropriate activity for their child to engage in, and parents felt more comfortable accessing help that used play as a modality. Parents spoke of not wanting to further overwhelm their struggling child, and they trusted that treatment through play would not cause their child feel overburdened. The accessibility and understanding of the role of play was reported by parents to reduce parental worry regarding their child not being able to manage or handle treatment. While there is currently no research literature in the field of play therapy exploring parents' perceptions of trusting play as a healing mechanism for their child, these parental views do corroborate with Child Centered Play Therapy's broad underpinnings. Ray (2019) highlights how a humanistic play therapist supports the self-direction of children by being provided both an environment and relationship of safety, empathic understanding, and unconditional positive regard where a child's play can be trusted. In the current study, parents already identified this belief of trusting play as a medium for providing care for their child. One might speculate that perhaps due to the vast majority of parents in this study having careers in the health care field, the parents in this study may have already held an appreciation of what Ray (2019) calls relational humanism. Ray (2019) hypothesizes that

relational humanism is a perspective that fundamentally trusts the self-direction of children and trusts that play can be part of the treatment needed. Ray (2019) further argues that this philosophy of relational humanism is a key to a child's care continuing outside the realm of the play therapy room. It would be interesting to explore if this subtheme of trust in the role of play would still have been present if the sample in the current study did not contain an overwhelming abundance of health care workers.

Magical

Parents in addition also spoke about how children were engaged almost magically by play. The majority of parents spoke about how shy or nervous their child was and then, through engagement in play with the therapist, would be captivated by the play therapy. Many parents noted an aspect of this success was the rapport that the therapist was able to build, however parents also name this magical quality that the behavioural action of play has for child engagement. These findings support the research identifying how different play therapy is from adult therapy, and how play therapy requires expertise and skill not found in other therapeutic modalities (Landreth, 2012; Van Velsor, 2004). Deboys and colleagues (2017) also wrote about this magical quality of play and hypothesized that this ethereal quality came from a place of non-participation in the activity by parents, and so parents conceptualize this mysterious and unknown entity as having a magical quality. The current study seems to refute Deboys and colleagues' (2017) results slightly in that some of the parents in the current study did participate and observe the play that occurred with their children, and these participating parents still named the magical quality of play and also named a respect and reverence toward the play therapist to be able to so fully engage in this play with their child.

Control

A theme that arose from the child interviews was one regarding the control that children feel when they engaged in play. Similar to matching the pace of a walking companion, children felt significant control within the play therapy process regarding play being used, regardless if it was child-directed or therapist-directed. The fact that play was occurring at all afforded the perception by children that they held power within that interaction of play. These findings corroborate the foundational writings of O'Connor (2000) identifying play as being a natural state for children, and the act of play being a language via which the challenges a child is struggling with are represented and addressed. It is interesting that for the children participating in this current study, little preference was given for child-directed versus therapist-directed play. Rather than needing the play to be directed by the child to feel in control, the children instead spoke of feeling in control simply because the act of play occurred.

Implications for Practice

This study aimed to answer the question, "What is the lived experience of play therapy from the perspective of both child and parent?" Kazdin and Nock (2003) highlight the crucial need to identify the mechanisms of change in child and adolescent therapy to help better discern how therapy works, and understand the impact of treatment on children. In exploring the state of change mechanisms in play therapy, Kazdin and Nock (2003) argue that the topic of change mechanisms with children has been, and remains to be, neglected in current research. The current study aimed to begin to fill this gap in the literature by closely exploring the underrepresented perspectives of both the parent and child within the play therapy process. This study provided a beginning upon which to discern what makes up helpful play therapy. For clinicians, these findings highlight the duality of the client in play therapy (i.e., parent and child) and may help to

address specific factors to pay attention to when working with children or the parents of child clients. For example, considering the significant impact that cueing has which parents spoke about as being a key component to helpful therapy. It is the cueing of the parents by the therapist then helps orient parents to change that is occurring in their child. This noticing of change in the child, then helps the parent to feel that therapy is successful/helpful. This noticing of change in their child can also help increase hopefulness and agency in the parents, and may very likely impact their day-to-day interactions with their child. Similarly, hearing from children that play therapy must be fun and have an element of excitement is an interesting piece of data for clinicians to make note of. Children were quite quick to recognize when therapy sessions involved too much talking and did not focus on play, and this deeper understanding of children's astuteness to how time is spent in play therapy sessions may be an important consideration. This information may help guide therapists who question or understate the importance of play within the therapy sessions or even parents who may not understand the role that play has in play therapy sessions. Kazdin and Nock (2003) identify the critical need to help understand these key features that promote change, and the need for this understanding to be implemented into general practice. This study may help to refine clinician understanding regarding the various clients' values and perceptions guiding change that occurs within in the play therapy process.

Study Limitation Considerations

The current study focuses on the lived idiographic experiences of a small number of individuals who have engaged in a similar event: the experience of play therapy. However, one must consider that counselling is not a homogenous event in which individual therapists engage all clients in a similar manner. One of the limitations of the current study is that while two parent child dyads did coincidently share the same therapist, the remaining dyads all had experiences

with different therapists. Therefore, it must be considered that individual therapist factors will impact results and any generalizability of these results to all play therapists may be limited.

While a diverse range of individuals was sought to participate in this study, and indeed people with diverse experiences of play therapy (positive, negative and neutral experiences of play therapy) did occur, an interesting subset of participants that came about must be recognized. The vast majority of parent participants in this study were health care workers, or they worked with families or children in an educational or community support role. While this subsection of participants was not anticipated, it must be noted and one may also question if parental results may consist of a more sophisticated baseline of information than that of a typical parent. While generalizability of the individual's experience to the general population is not an objective for qualitative research, understanding that the parental education and views of this particular subset of the population may be quite unique in their perspective, must be acknowledged.

Another limitation recognized in this study is that while there was an unexpected homogeneity in the parent group, there was a lack of homogeneity in the child participants in two key areas. The first is that the age range of child participants which ranged from 3-9 years of age spans a variety of different developmental stages, thereby making the opportunity for child perceptions of their experiences and the reporting of their perceptions, to be challenging. The second factor lacking homogeneity is the reasons behind parents seeking out therapy for their children. The impetus for starting play therapy was wide ranging consisting of struggles with anxiety, challenges with aggressive behaviours, to more abstract concepts such as helping children understand and cope with their parent's divorce. This significant disparity of reasons for seeking therapy may also assuage any homogeneity of experiences within the child group due to the focus of each child's play therapy sessions potentially being quite dissimilar.

Finally, due to the restrictions in response to COVID-19, only one parent child dyad was actively engaged in the play therapy process while the interview took place. All other parent child dyads had ceased therapy, with some stating that they hoped to begin therapy again in the future with the lifting of COVID-19 restrictions. Caution must be applied when recognizing that the vast majority of all participant accounts of play therapy are retrospective accounts, and subsequently all recollection and client understanding of their experiences may be impacted by this delayed retrospective account.

Future Research

The current research study identified that while some children were able to identify longer term change as having occurred, the majority of children named change as being a temporary state change where they felt different. Future research exploring change from the perspective of children specifically considering that much of the change occurs in body sensation may be helpful. The use of some form of measure to help assess the body changes children are noticing within a play therapy session might be useful. For instance, having a child colour a figure of how their body feels at the beginning of a session, versus having a child colour a figure of how their body feels at the end of session, and having the child explain any differences may provide tremendous guidance to therapists regarding the more elusive change process that children seem to experience in play therapy.

Future process research further exploring both parent and child experiences of therapy may also be helpful. This study was largely an exploratory study to better begin to understand parent and child experiences of therapy and to attempt to understand how parent and child experiences may have similarities and differences. Further research perhaps utilizing longitudinal process research may help provide additional needed perspectives. Longitudinal research that

explores parent and child perceptions of play therapy throughout the process of therapy would bring significant refinement and recollection to in-the-moment events that may have been missed by the retrospective accounts collected in the current study.

Although research previously has found that non-directive play therapy provides more effective outcomes than directive play therapy, this was not a fully shared sentiment among children in this study. Curiously in the current study, children described how even when the therapist chose the toys to play with, from the perspective of the child, the play was still being led by the child. Future research better refining and understanding from the perspective of the child what constitutes child-centered, non-directive therapy would be helpful. Additionally, future research more fully exploring how the child's perceived sense of control manifests within the therapy process may also be advantageous.

References

Abidin, R. R., & Robinson, L. L. (2002). Stress, biases, or professionalism: What drives teachers' referral judgments of students with challenging behaviors? *Journal of Emotional and Behavioral Disorders*, 10, 204– 212.

Athanasiou, M. S. (2001). Using consultation with a grandmother as an adjunct to play therapy. *The Family Journal*, *9*(4), 445-449.

Association for Play Therapy. (1997). A definition of play therapy. *The Association for Play Therapy Newsletter, 16*(1), 7.

Axline, V. (1947). *Play therapy.* Ballantine Books.

Axline, V. (1950). Entering the child's world via play experiences. *Progressive Education*, *27*, 68-75.

Axline, V. M. (1964). *Dibs: In search of self*. Ballantine Books.

Axline, V. & Rogers, C. (1945). A therapist-teacher deals with a handicapped child. *Journal of Abnormal and Social Psychology, April,* 119-142.

Bach, K. (2017). *A Qualitative Investigation of Parental Experiences with Play Therapy*. [Master's thesis, St. Catherine University]. https://sophia.stkate.edu/msw_papers/708

Bedi, R. P., Haverkamp, B. E., Beatch, R., Cave, D. G., Domene, J. F., Harris, G. E., & Mikhail, A. M. (2011). Counselling psychology in a Canadian context: Definition and description. *Canadian Psychology*, *52*(2), 128-138.

Binder, P. E., Holgersen, H., & Nielsen, G. H. (2009). Why did I change when I went to therapy? A qualitative analysis of former patients' conceptions of successful psychotherapy. *Counselling and Psychotherapy Research*, *9*(4), 250-256.

Bogdan, R., & Biklen, S. (2007). *Qualitative research for education: An introduction to theory and practice* (5th ed.). Pearson.

Bratton, S., & Ray, D. (2000). What the research shows about play therapy. *International Journal of Play Therapy, 9*(1), 47-88.

Bratton, S., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytical review of treatment outcomes. *Professional Psychology: Research and Practice, 36*(4), 376-390.

Brewer, J., & Hunter, A. (1989). *Multimethod research: A synthesis of styles*. Sage.

Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health*, *21*(1), 87-108.

Canadian Psychological Association (CPA) (2017) *Definition of Counselling Psychology*. Retrieved from: http://www.cpa.ca/aboutcpa/cpasections/counsellingpsychology/

Carey, T. A., Carey, M., Stalker, K., Mullan, R. J., Murray, L. K., & Spratt, M. B. (2007). Psychological change from the inside looking out: A qualitative investigation. *Counselling and Psychotherapy Research*, *7*(3), 178-187.

Carroll, J. (2000). Evaluation of therapeutic play: A challenge for research. *Child and Family Social Work*, *5*(1), 11-22.

Carroll, J. (2002). Play therapy: The children's views. *Child & Family Social Work*, *7*(3), 177-187.

Casey, D., & Murphy, K. (2009). Issues in using methodological triangulation in research. *Nurse Researcher. 16*, 4, 40-55.

Chambless, D. L., Baker, M. J., Baucom, D. H., Beutler, L. E., Calhoun, K. S., Crits-Christoph, P., & Daiuto, A., et al. (1998). Update on empirically validated therapies, II. *The Clinical Psychologist, 51*, 3-16.

Creswell, J. W., Plano Clark, V. L., Gutmann, M. L., & Hanson, W. E. (2003). Advanced mixed methods research designs. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of Mixed Methods in Social and Behavioral Research* (pp. 209-240). Sage.

Creswell, J. W. (2012). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Sage.

Crotty, M. (1998). *The foundations of social research meaning and perspective in the research process*. Sage.

Deboys, R., Holttum, S., & Wright, K. (2017). Processes of change in school-based art therapy with children: A systematic qualitative study. *International Journal of Art Therapy*, *22*(3), 118-131.

Drewes, A. A., Bratton, S. C., & Schaefer, C. E. (2011). *Integrative play therapy*. Wiley.

Drewes, A. A., & Schaefer, C. E. (2016). The therapeutic powers of play. In K. J. O'Connor, C. E. Schaefer, & L. D. Braverman (Eds.), *Handbook of Play Therapy* (pp. 35-60). Wiley.

Drisko, J., Corvino, P., Kelly, L., & Nielson, J. (2020). Is Individual Child Play Therapy Effective? *Research on Social Work Practice*, *30*(7), 715-723.

Eagleton, T. (1983). *Literary theory: An introduction.* Basil Blackwell.

Erksine, R. G. (1998). Attunement and involvement: Therapeutic responses to relational needs. *International Journal of Psychotherapy, 3*(3), 235–244.

Freud, S. (1909). Analysis of a phobia in a five-year-old boy. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume X* (1955): *Two Case Histories ('Little Hans' and the 'Rat Man')* (pp. 1-150). Hogarth Press.

Garza, Y., & Bratton, S. C. (2005). School-based child-centered play therapy with Hispanic children: Outcomes and cultural consideration. *International Journal of Play Therapy*, *14*(1), 51-80.

Glazer, H. R., & Stein, D. S. (2010). Qualitative research and its role in play therapy research. *International Journal of Play Therapy*, *19*(1), 54-61.

Green, E. J., & Christensen, T. M. (2006). Elementary school children's perceptions of play therapy in school settings. *International Journal of Play Therapy*, *15*(1), 65-85.

Hardy, G. E., & Llewelyn, S. (2015). Introduction to psychotherapy process research. In O. C. G. Gelo, A. Pritz, & A. B. Rieken, (Eds), *Psychotherapy research: Foundations, process, and outcome* (pp. 183–194). Springer.

Health Canada. (2002). *A report on mental illness in Canada*. Ottawa.

Higgins, J. & Green, S. (Eds.). (2011). Cochrane handbook for systematic reviews of interventions Version 5.1.0 [updated March 2011]. *The Cochrane Collaboration*.

Higginson, S., & Mansell, W. (2008). What is the mechanism of psychological change? A qualitative analysis of six individuals who experienced personal change and recovery. *Psychology and Psychotherapy: Theory, Research and Practice*, *81*(3), 309-328.

Holcomb-McCoy, C., & Bryan, J. (2010). Advocacy and empowerment in parent consultation: Implications for theory and practice. *Journal of Counseling & Development, 88*(3), 259-268.

Hollon, S. D., Stewart, M. O., & Strunk, D. (2006). Enduring effects for cognitive behavior therapy in the treatment of depression and anxiety. *Annual Review of Psychology, 57*, 285-315.

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapists' contributions and responsiveness of patients* (pp. 37–69). Oxford University Press.

Hug-Hellmuth, H. (1921). On the technique of child-analysis. *The International Journal of Psycho-Analysis*, *2*, 287-305.

Hurlburt, M. S., Garland, A. F., Nguyen, K., & Brookman-Frazee, L. (2010). Child and family therapy process: Concordance of therapist and observational perspectives. *Administration and Policy in Mental Health and Mental Health Services Research*, *37*(3), 230-244.

Imel, Z. E., Malterer, M. B., McKay, K. M., & Wampold, B. E. (2008). A meta-analysis of psychotherapy and medication in unipolar depression and dysthymia. *Journal of Affective Disorders*, *110*(3), 197-206.

Jensen, S. A., Biesen, J. N., & Graham, E. R. (2017). A meta-analytic review of play therapy with emphasis on outcomes measures. *Professional Psychology: Research and Practice,* 48(5), 390–400.

Johnson, J. (2016). The history of play therapy. In K. J. O'Connor, C. E. Schaefer & L. D. Braverman (Eds.), *Handbook of Play Therapy* (pp.17-34). Wiley.

Johnson, R. B., & Christensen, L. B. (2012). *Educational research: Quantitative, qualitative and mixed methods* (4th ed.). Sage.

Karver, M. S., Handelsman, J. B., Fields, S., & Bickman, L. (2005). A theoretical model of common process factors in youth and family therapy. *Mental Health Services Research*, *7*(1), 35-51.

Kazdin, A. E., & Nock, M. K. (2003). Delineating mechanisms of change in child and adolescent therapy: Methodological issues and research recommendations. *Journal of Child Psychology and Psychiatry*, *44*(8), 1116-1129.

Klein, M. (1932). *The psycho-analysis of children*. Hogarth Press.

Kortesluoma, R. L., Hentinen, M., & Nikkonen, M. (2003). Conducting a qualitative child interview: methodological considerations. *Journal of Advanced Nursing*, *42*(5), 434-441.

Kottman, T. (2011). *Play therapy: Basics and beyond*. American Counseling Association.

Lambert, M. J. (2013). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.). *Bergin and Garfield's handbook of psychotherapy and behavior change* (pp. 169-218). Wiley.

Lambert M. J., & Hill C. E. (1994). Assessing psychotherapy outcomes and processes. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (pp. 72–113). Wiley.

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (pp. 139–193). Wiley.

Landreth, G. (2012). *Play therapy: The art of the relationship* (3rd ed.). Accelerated Development.

Landreth, G., & Bratton, S. (2006). *Child parent relationship therapy (CPRT): A 10-session filial therapy model.* Routledge.

LeBlanc, M., & Ritchie, M. (2001). A meta-analysis of play therapy outcomes. *Counseling Psychology Quarterly, 14*, 149-163.

Lipsey, M. W., & Wilson, D. B. (1993). The efficacy of psychological, educational, and behavioral treatment: Confirmation from meta-analysis. *American Psychologist*, *48*(12), 1181-1209.

Locati, F., Rossi, G., Lang, M., & Parolin, L. (2020). In-session interactive dynamics of the psychotherapy process between therapeutic alliance, therapist expertise, therapist technical intervention, patient metacognition and functioning. *Clinical Psychology & Psychotherapy*, *27*(6), 902-914.

Maione, P. V., & Chenail, R. J. (1999). Qualitative inquiry in psychotherapy: Research on the common factors. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The Heart and Soul of Change: What Works in Therapy* (pp. 57-88). American Psychological Association.

Maynard, M. (1994). Methods, practice and epistemology: The debate about feminism and research. In M. Maynard & J. Purvis (Eds.), *Researching Women's Lives from a Feminist Perspective* (pp.10-26). Taylor & Francis.

McConnell-Henry, T., Chapman, Y., & Francis, K. (2009). Husserl and Heidegger: Exploring the disparity. *International Journal of Nursing Practice*, *15*(1), 7-15.

Meany-Walen, K. K., Kottman, T., Bullis, Q., & Dillman Taylor, D. (2014). Effects of Adlerian play therapy on children's externalizing behavior. *Journal of Counseling & Development*, *93*(4), 418-428.

Miller, S. D., Duncan, B. L., & Hubble, M. A. (1997). *Escape from Babel: Toward a unifying language for psychotherapy practice*. Norton.

Morse, J. M. (Ed.). (1994). *Critical issues in qualitative research methods*. Sage.

Naderi, F., Heidarie, A., Bouron, L., & Asgari, P. (2010). The efficacy of play therapy on ADHD, anxiety, and social maturity in 8 to 12 years aged clientele children of Ahwaz metropolitan counseling clinics. *Journal of Applied Sciences,* 19, 189–195.

Nalavany, B. A., Ryan, S. D., Gomory, T., & Lacasse, J. R. (2005). Mapping the characteristics of a "good" play therapist. *International Journal of Play Therapy, 14*, 27–50.

Norcross, J. C., & Newman, C. F. (1992). Psychotherapy integration: Setting the context. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of Psychotherapy Integration* (pp. 3-45). Basic Books.

O'Connor, K. J. (2000). *The play therapy primer* (2nd ed.). Wiley.

Olfson, M., Marcus, S. C., Druss, B., Elinson, L., Tanielian, T., & Rincus, H. A. (2002). National trends in the outpatient treatment of depression. *Journal of the American Medical Association, 287*, 203-209.

Patton, M.Q. (2002). *Qualitative Research and Evaluation Methods* (3rd Ed.). Sage.

Patten, S. B., Williams, J. V., Lavorato, D. H., Wang, J. L., McDonald, K., & Bulloch, A. G. (2016). Major depression in Canada: What has changed over the past 10 years? *The Canadian Journal of Psychiatry*, *61*(2), 80-85.

Paulson, B. L., Truscott, D., & Stuart, J. (1999). Clients' perceptions of helpful experiences in counseling. *Journal of Counseling Psychology*, *46*(3), 317-324.

Piaget, J. (1962). *Play, dreams and imitation in childhood.* Norton.

Prochaska, J. O. (1995). An eclectic and integrative approach: Transtheoretical therapy. In A. S. Gurman & S. B. Messer (Eds.), *Essential Psychotherapies: Theory and Practice* (pp. 403-440). Guilford.

Ray, D. C. (2019). The child and the counselor: Relational humanism in the playroom and beyond. *The Journal of Humanistic Counseling*, *58*(1), 68-82.

Ray, D. C., Armstrong, S. A., Balkin, R. S., & Jayne, K. M. (2015). Child-centered play therapy in the schools: Review and meta-analysis. *Psychology in the Schools*, *52*(2), 107-123.

Ray, D. C., & Bratton, S. C. (2010). What the research shows about play therapy: 21st century update. In J. N. Baggerly, D. C. Ray, & S. C. Bratton (Eds.), *Child-centered play therapy research: The evidence base for effective practice* (pp. 3–33). Wiley.

Ray, D., Schottelkorb, A., & Tsai, M. (2007). Play therapy with children exhibiting symptoms of attention deficit hyperactivity disorder. *International Journal of Play Therapy, 16*, 95-111.

Ritzi, R., Ray, D., & Schumann, B. (2017). Intensive short-term child centered play therapy and externalizing behaviors in children. *International Journal of Play Therapy*, 26, 33–46.

Rogers, C. (1951). *Client-centered therapy: Its current practice, implications, and theory*. Houghton, Mifflin.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American journal of Orthopsychiatry*, *6*(3), 412.

Schaefer, C. E., & Drewes, A. A. (2011). The therapeutic powers of play and play therapy. In A. A. Drewes (Ed.), *Foundations of Play Therapy* (pp. 15-25). Wiley.

Schottelkorb, A. A., Doumas, D. M., & Garcia, R. (2012). Treatment for childhood refugee trauma: A randomized, controlled trial. *International Journal of Play Therapy*, *21*(2), 57-73.

Schottelkorb, A. A., Swan, K. L., Garcia, R., Gale, B., & Bradley, B. M. (2014). Therapist perceptions of relationship conditions in child-centered play therapy. *International Journal of Play Therapy*, *23*(1), 1-17.

Schumann, B. (2004). Effects of child-centered play therapy and curriculum-based small group guidance on behaviors of children referred for aggression in an elementary school setting. Dissertation from the University of North Texas. Retrieved from https:// digital.library.unt.edu/ark:/67531/metadc4684/m2/1/high_res_d/ dissertation.pdf

Scott, T. A., Burlingame, G., Starling, M., Porter, C., & Lilly, J. P. (2003). Effects of individual client-centered play therapy on sexually abused children's mood, self-concept, and social competence. *International Journal of Play Therapy*, *12*(1), 7-30.

Sezici, E., Ocakci, A., & Kadioglu, H. (2017). Use of play therapy in nursing process: A prospective randomized controlled study. *Journal of Nursing Scholarship*, 49, 162–169.

Shelby, J., Ellingsen, R., & Schaefer, C. E. (2015). Play therapy research: Issues for 21st century progress. In K. O'Connor, C.E. Schaefer & L.D. Braverman (Eds.), *Handbook of Play Therapy* (561-581). Wiley.

Shen, Y. (2002). Short-term group play therapy with Chinese earthquake victims: Effects on anxiety, depression, and adjustment. *International Journal of Play Therapy,11*, 43– 63.

Shirk, S., & Karver, M. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: A meta-analytic review. *Journal of Consulting & Clinical Psychology, 71*, 452–464.

Smetanin, P., Stiff, D., Briante, C., Adair, C. E., Ahmad, S., & Khan, M. (2011). *The life and economic impact of major mental illnesses in Canada: 2011-2041*. Prepared for the Mental Health Commission of Canada. RiskAnalytica.

Smith, J. A., Flowers, P., & Osborn, M. (1997). Interpretative phenomenological analysis and the psychology of health and illness. In L. Yardley (Ed.), *Material discourses of Health and Illness* (pp. 68-91). Routledge.

Smith, M. L., Glass, G. V., & Miller, T. I. (1980). *The benefits of psychotherapy.* John Hopkins University Press.

Smith, J.A., Flowers, P., & Larkin, M. (2012). *Interpretative phenomenological analysis: Theory method and research*. Sage.

Smith, J.A., Jarman, M. & Osborn, M. (1999). Doing interpretative phenomenological analysis. In M. Murray & K. Chamberlain (Eds.), *Qualitative Health Psychology: Theories and Methods* (pp. 218-240). Sage.

Smith, J. A., & Osborn, M. (2004). Interpretative phenomenological analysis. In G. M. Breakwell (Ed.), *Doing Social Psychology Research* (pp. 229-254). Blackwell.

Smith, J. A., & Osborn, M. (2007). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods* (pp. 53–80). Sage.

Spence, S. H. (2003). Social skills training with children and young people: Theory, evidence and practice. *Child and Adolescent Mental Health*, *8*(2), 84-96.

Stephenson, W. (1980). Newton's fifth rule and Q methodology: Application to educational psychology. *American Psychologist, 35*, 882-889.

Stulmaker, H., & Ray, D. (2015). Child-centered play therapy with young children who are anxious: A controlled trial. *Children and Youth Services Review*, 57, 127–133.

Taylor, S. J., Bogdan, R., & DeVault, M. (2015). *Introduction to Qualitative Research Methods: A Guidebook and Resource*. Wiley.

Timulak, L., & McElvaney, R. (2013). Qualitative meta-analysis of insight events in psychotherapy. *Counselling Psychology Quarterly*, *26*(2), 131-150.

Tyndall-Lind, A., Landreth, G., & Giordano, M. (2001). Intensive group play therapy with child witnesses of domestic violence. *International Journal of Play Therapy, 10*(1), 53-83.

U.S. Public Health Service (2000). *Report of the Surgeon General's Conference on Children's Mental Health: A national action agenda.* U.S. Department of Health and Human Services.

Van Manen, M. (1997). From meaning to method. *Qualitative Health Research, 7,* 345-369.

Van Velsor, P. (2004). Revisiting basic counseling skills with children. *Journal of Counseling and Development 82*(3), 313-318.

Wampold, B. E. (2011). *Qualities and actions of effective therapists.* American Psychological Association Education Directorate.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Erlbaum.

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, *14*(3), 270-277.

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work*. Routledge.

Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 629-640.

Watson, J. B., & Rayner, R. (1920). Conditioned emotional reactions. *Journal of Experimental Psychology, 3,* 1-14.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, *15*(2), 215-228.

Yee, T., Ceballos, P., & Swan, A. (2019). Examining the trends of play therapy articles: A 10-year content analysis. *International Journal of Play Therapy*, *28*(4), 250-260.

Yin, R. K. (2013). *Case study research: Design and methods*. Sage.

Appendix A

Therapist E-mail

Dear [Insert name],

My name is Michelle Hoover and I am a doctoral student at the University of Alberta. I am contacting you in regards to research I am conducting as part of my doctoral thesis, and I hope you might be willing to help.

The research I will be conducting is an exploration of child and parent experiences of play therapy. My goal is to better understand what both the child and parent each perceive to be important and necessary components for change to occur within the play therapy process.

This study has been approved by the University of Alberta research ethics board.

I would ask that you please consider putting the poster of my research study on display in your waiting room so that interested child/parent dyads might become aware of the study. Any interested participants would then contact me directly.

Thank you for your help and support in providing your clients access to information regarding this study. If you would like any additional information about this study, feel free to contact me with any questions or concerns at mway@ualberta.ca or my supervisor, Dr. Derek Truscott at truscott@ualberta.ca.

Sincerely,

Michelle Hoover

Appendix B

Research Poster

Play Therapy?

Has your child attended Play Therapy? If so, I would love to talk to you and your child!

I am a doctoral student in the Counselling Psychology program at the University of Alberta conducting a study: *Child and Parent Perceptions of Play Therapy*. If you are interested in participating or would like more information about this study, please contact Michelle by email: researchplaytherapy@gmail.com. Participation will consist of answering some questions via phone or video call; individuals who live in North America are eligible to participate. You and your child will each receive a $25 gift certificate as thanks for your participation in this study!

This study has been approved by the University of Alberta's Research Ethics Board
Updated: February 14, 2020
Ethics ID: Pro00080805

Appendix C

Information Letter and Consent Form

Study Title: Child and Parent Perceptions of Play Therapy

Research Investigator:	**Supervisor:**
Michelle Hoover	Dr. Derek Truscott
6-102 Education North	6-102 Education North
University of Alberta	University of Alberta
Edmonton, AB, T6G-2G5	Edmonton, AB, T6G-2G5
mway@ualberta.ca	truscott@ualberta.ca
780-222-****	780-492-****

Background

- You are being asked to participate in this research study because your child has engaged in play therapy.
- The results of this study will be used in support of my dissertation as part of the requirements for my PhD in Counselling Psychology.

Purpose

- The purpose of this study is to explore child and parent perceptions of play therapy and better understand what aspects of play therapy are perceived to be most helpful.
- It is hoped that this research will add to the current literature regarding what helps make therapy effective which may inform both clinical practice in the use of play therapy and potentially the training of future play therapists.

Study Procedures

- This study will include a 1 hour interview of semi-structured questions regarding your perceptions of play therapy. In addition your child will participate in a 1 hour interview of semi-structured questions regarding their perceptions of play therapy. These interviews may take place in person, or via telephone, or via online video platform.
- Participants will be a maximum 8 children and 8 parents of children who have undertaken play therapy (all interviews conducted separately).
- If additional information is needed after the initial interview, a supplementary interview may be requested.
- Interviews will be audio recorded using the primary researchers recorder and later transcribed. Recorded interviews will be removed from the device and stored on a password protected computer, these files will be encrypted.

Benefits

- There may be no personal benefits to participants, but it is hoped that through reflecting on their experience of play therapy that it could highlight and potentially enhance therapeutic benefits they received via play therapy.
- We hope that the information we get from doing this study will help us better understand play therapy and what makes it effective.

Risk

- There is minimal potential harm to participants in this study. It is expected that the benefits outweigh the risks in that information from this study may help individuals recollect and highlight aspects of play therapy that they found to be meaningful and helpful.

Renumeration

- Both you and your child will receive a $25 gift certificate to a business of your choice as a token of gratitude for your participation.

Voluntary Participation

- You are under no obligation to participate in this study. Your child is under no obligation to participate in this study. Any participation is completely voluntary. You or your child are under no obligation to answer any specific questions even if participating in the study
- Even if you agree to be in the study, or agree for your child to be in the study, you can change your mind and withdraw yourself and/or your child at any time. If you or your child withdraw from this study within 30 days from the interview, the data will be removed from the study. After this time the data will be included in the study but will be completely anonymized.

Confidentiality & Anonymity

- This research will be used in support of my dissertation as part of the requirements for my PhD in Counselling Psychology. All client information will anonymized and no personal identifiers will be used.
- All data collected will be kept confidential with only the researcher and the supervisor having access to the materials.
- All interviews will be done privately, therefore anonymity will be maintained and participants will not be able to be identified in the dissemination of the research.
- Only pseudonyms will be used to connect participants to their data. All information will be kept on a password safe computer, and files with identifying information will be encrypted. Any paper information will be stored in a double locked cabinet that only the primary researcher has access to for a minimum of five years after the completion of this project.
- Raw data, with pseudonym only, consent and assent forms will be destroyed 5 years following completion of the study. Paper information will be shredded and disposed, and electronic files will be wiped from the systems database. The master list that contains participant identifiers such as first and last name will be destroyed once a pseudonym has been connected to the raw data (e.g., transcribed interviews) which will be approximately one month after the interview occurs.

Further Information

- If you have any further questions regarding this study, please do not hesitate to contact: Michelle Hoover at 780-222-**** or Dr. Derek Truscott at 780-492-****.
- If you are interested in a copy of the completed dissertation, please provide the researcher with an email address where the document may be emailed.

- The plan for this study has been reviewed by a Research Ethics Board at the University of Alberta. If you have questions about your rights or how research should be conducted, you can call (780) 492-2615. This office is independent of the researchers.

Consent Statement

I have read this form and the research study has been explained to me. I have been given the opportunity to ask questions and my questions have been answered. If I have additional questions, I have been told whom to contact. I agree to participate in the research study described above and will receive a copy of this consent form. I will receive a copy of this consent form after I sign it.

_____ _____

Participant's Name (printed) and Signature Date

_____ _____

Name (printed) and Signature of Person Obtaining Consent Date

Consent Statement for Child's Participation

I have read this form. The research study and my child's participation in this study has been explained to me. I have been given the opportunity to ask questions about my child's participation in this study and my questions have been answered. If I have additional questions, I have been told whom to contact. I agree to provide consent for my child to participate in the research study described above and will receive a copy of this consent form. I will receive a copy of this consent form after I sign it.

_____ _____

Parent's Name (printed) and Signature Date

_____ _____

Name (printed) and Signature of Person Obtaining Consent Date

The University of Alberta Research Ethics Board has approved this research study.

Ethics ID: Pro00080805

Appendix D

Child Assent Form

Title of Study: Child and Parent Perceptions of Play Therapy

Principal Investigator(s): Dr. Derek Truscott **Phone Number(s):** 780-492-****

Michelle Hoover **Phone Number(s):** 780-222-****

I would like to tell you about a research study I am doing. A research study is a way to learn more about something. I would like to learn more about play therapy and your thoughts about play therapy. You are being asked to join the study because you have gone to play therapy and have experience with it.

If you agree to join this study, you will be asked a few questions that I have about play therapy, for example, what you liked about your therapist, or liked about the toys or games you played. If you would like to draw a picture about play therapy and then talk to me about it you can do this as well. We would have a video meeting, and I expect it would take about 1 hour. As a thank you I will send you a $25 gift certificate to a store of your choice (Mastermind Toys, Toys R Us, Dairy Queen, etc.) for being a part of this study.

This research study will help me learn more about play therapy and specifically what children and parents think about the process of play therapy. This is a chance for you to teach me!

You do not have to join this study. It is up to you. You can say okay now and change your mind later. All you have to do is tell me you want to stop. No one will be mad at you if you don't want to be in the study or if you join the study and change your mind later and stop.

I'm happy to answer any questions you have before you say yes or no to being in this study. If you do join the study, you can ask questions at any time. Just tell me that you have a question.

Please feel free to call Michelle Hoover at (780)222-**** if you have any questions about the study.

☐Yes, I will be in this research study. ☐No, I don't want to do this.

Child's name Signature Date

Person obtaining Assent Signature Date

The University of Alberta Research Ethics Board has approved this research study.
Ethics ID: Pro00080805

Appendix E

Parent Interview

Introduction: Thank you very much for taking the time to talk to me and participate in my research study. My name is Michelle Hoover and I am a doctoral student studying Counselling Psychology at the University of Alberta. My area of research is in the area of play therapy, and I am specifically interested in exploring both your unique lived experience of the play therapy and your child's experience of play therapy that you have engaged in. I really appreciate your participation in this study and all the information you share with me.

Please take a moment to read over the consent form, and feel free to ask questions. [After participant is completed signing.] The interview will take approximately one hour, and the information you provide is confidential and anonymous as indicated in the consent form. Please know that at any point you may feel free to withdraw from this study without any consequence. This is a semi-structured interview, so I will have some questions I'm following, but a lot of it will be lead by what you wish to share. Do you have any questions so far?

Demographic Information

Before we start I'm going to ask you some basic demographic information:

Age:

Gender:

Ethnicity:

Nationality:

Profession:

How many sessions did your child attend play therapy:

Approximate time-frame attending play therapy:

Name of therapist your child saw for play therapy (therapist will not be contacted):

Parent Interview Questions:

1) Can you tell me about how you decided to seek out play therapy for your child?

2) Can you tell me about the experience of taking your child to play therapy?

3) What does play therapy mean to you?

4) How do you think your life would be if your child had not gone to play therapy?

5) What would you tell parents who are thinking about taking their child to play therapy about the play therapy process?

6) What do you feel is an essential element in the process of play therapy?

7) Is there anything else you want to make sure I know about your experience of play therapy?

Child Interview:

Introduction: Thank you very much for taking the time to talk to me and participate in my research study. My name is Michelle Hoover and I am a doctoral student studying Counselling Psychology at the University of Alberta. My area of research is in the area of play therapy and I am specifically interested in your experience of play therapy. I really appreciate your participation in this study and all the information you share with me.

Let's take a minute together to go over this assent form together before you sign it. Your parent has also signed a consent form that says it's ok for me to talk to you. Please feel free to ask any questions you might have. [After participant is completed signing.] We will talk together for about an hour, and just so you know everything you say here is private. That means no one else like your parent or your therapist will know what you say in here unless you choose to share it with them. Please know that you can stop this interview at any time.

This is an interview where I'll have a few specific questions to ask you but I will create some as we go along. Do you have any questions for me so far?

Demographic Information

Age:

Gender:

Nationality:

What grade are you in:

Child Interview Questions:

1) When you think about going to play therapy, what do you remember?

2) Can you describe what a play therapy session was like for you?

3) What do you think your life would be if you had not gone to play therapy?

4) What would you tell a friend about play therapy if they were going to start going to play therapy but they didn't know anything about it?

5) What was the most important part of play therapy for you?

6) Why do you think you went to play therapy?

7) Is there anything else you want to make sure I know about your experience of play therapy?

Appendix F

Ethics Notification of Approval

Date:	April 23, 2018
Study ID:	Pro00080805
Principal Investigator:	Michelle Hoover
Study Supervisor:	Derek Truscott
Study Title:	Child and Parent Perceptions of Play Therapy
Approval Expiry Date:	Monday, April 22, 2019
Approved Consent Form:	Approval Date 4/23/2018 Approved Document AdultConsentFormUpdated.doc

Thank you for submitting the above study to the Research Ethics Board 1. Your application has been reviewed and approved on behalf of the committee.

A renewal report must be submitted next year prior to the expiry of this approval if your study still requires ethics approval. If you do not renew on or before the renewal expiry date, you will have to re-submit an ethics application.

Approval by the Research Ethics Board does not encompass authorization to access the staff, students, facilities or resources of local institutions for the purposes of the research.

Sincerely,
Anne Malena, PhD
Chair, Research Ethics Board 1
Note: This correspondence includes an electronic signature (validation and approval via an online system).