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What is the Experience of Trained Non-directive Play Therapists using the Western Model of Non-directive Play Therapy on a Kenyan Child?

A thesis submitted to the University of Manchester for the degree of Professional Doctorate in Counselling

2018

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Manchester Institute for Education, School of Environment, Education and Design
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<tbody>
<tr>
<td>ACU</td>
<td>Aids Control Unit</td>
</tr>
<tr>
<td>ANPPCAN</td>
<td>African Network for the Prevention and Protection Against Child Abuse and Neglect</td>
</tr>
<tr>
<td>ARVs</td>
<td>Anti-Retro Viral Drugs</td>
</tr>
<tr>
<td>CRECHE</td>
<td>Centre for Research Communication and Gender in early childhood education</td>
</tr>
<tr>
<td>ECD</td>
<td>Early Childhood Development</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/ Acquired</td>
</tr>
<tr>
<td>IPA</td>
<td>Interpretation Phenomenological Analysis</td>
</tr>
<tr>
<td>KAPC</td>
<td>Kenya Association of Professional Counsellors</td>
</tr>
<tr>
<td>NACC NASCOP</td>
<td>National Aids Control Unit</td>
</tr>
<tr>
<td>NACC</td>
<td>National Aids STI Control Programme National</td>
</tr>
<tr>
<td>NDPT</td>
<td>AIDS Control Council</td>
</tr>
<tr>
<td>NGO's</td>
<td>Non-governmental Organizations</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNEP</td>
<td>United Nations Environment Programme</td>
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<td>UNESCO</td>
<td>United Nations Educational Scientific and Cultural Organisation</td>
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<tr>
<td>UK</td>
<td>United Kingdom</td>
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<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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Abstract

In order to establish the appropriateness of the western model of non-directive play therapy within the Kenyan context, the study explored the experiences of trained play therapists using the western model of non-directive play therapy in their therapeutic work with a Kenyan child. The study used qualitative methodology with thematic analysis where six trained non-directive play therapists with more than two years’ practical experience participated. The participants comprised of five females and one male aged between 40 to mid-50 years were interviewed using semi-structured interviews while the interviews were tape recorded prior to their transcription. Data analysis was done using thematic analysis guidelines and the findings generated two main overarching themes stating that the Western model of Non-directive play therapy used in a therapeutic setting with a Kenyan child is in a large scale ‘appropriate’ (effective) while in some cases the same participants found the model ‘inappropriate’ (not effective) based on the Kenyan cultural beliefs and practices.

Within the two main overarching themes, emanated seven candidate themes perceived by my participants to be indicators of the appropriateness of the western model of non-directive play therapy within the Kenyan context, in which the therapists’ experiences revealed that in their therapeutic work with a Kenyan child using this model, the child developed a sense of ‘empowerment’; ‘freedom’ and at the same time became ‘expressive’ through the use of play. Meanwhile the inappropriateness of western model of non-directive play therapy in the Kenyan context were mainly perceived to be caused by ‘lack of awareness’ of the model’s existence and/or importance by most Kenyan communities, ‘cultural barriers’ particularly with regard to the use of ‘play’ and ‘non-direction’ in this model, Kenya’s ‘directive education system’ as opposed to the western non-direction and ‘social economic status’ of most Kenyans leading to access issues were also experienced as contributors to the models in appropriateness within the Kenyan context.
Declaration

No portion of the work referred to in this thesis has been submitted in support of any other degree or qualification of this or any other University or other institute of learning.

Signature ........................................Date...........................................
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I dedicate this study to...

all my grand-children, Peter, Enrique, Marie, Wanda, Zara, Clare and Regina, my late husband Peter who did not live to read this thesis and to my late parents for introducing me to formal education at a time when girl child’s education was not given prominence within the Luo community to which I belong.
Acknowledgements

I commence this acknowledgement by thanking The Almighty God for all the support that He accorded to me during this study.

Secondly I would like to acknowledge and appreciate the following people for their direction, and support without whom this study would not have been a success:

To my supervisors Prof. William West, Dr. Elizabeth Ballinger and Dr. Don Balmer for their patience, academic expertise, and support and for giving me an opportunity to grow and achieve my dream, thank you all. To all my classmates in this study, Cecilia, Anastasia, Tabitha and Lilian, thank you all for your support during this study.

To my children Kevin, Fiona, Jude, Timothy and Francis including their spouses, Christine, Catherine, Beatrice and Caro, not forgetting my sister Rev. Sr. Victoria and my brother Rev. Fr. Francis, thank you all for your support and encouragement. Your persistent prayers and belief on me, gave me strength to carry on even when my confidence and my ability was failing.

To my dear grandchildren, I thank you for your sense of humour as we played together, I felt lifted up in spirit even when things were overwhelming for me. I regret the times I had to keep you out of my life in order to concentrate on my studies.

To my study participants, thank you for your time and generous contributions to this study.
Author

Currently the author is a holder of master’s degree in counselling studies, from The University of Manchester, in United Kingdom, and is currently working as a counsellor, counsellor supervisor and play therapist consultant with the Kenya Association of Professional Counsellors (KAPC), a non-governmental counselling institution in Nairobi, Kenya. She has passion for children and is concerned about children’s welfare, hence her investigation into the experiences of play therapists using the western model of non-directive play therapy in their therapeutic work with a Kenyan child.
CHAPTER ONE: INTRODUCTION

Introduction

Kenya, a country located on the East Coast of Africa, (Communications Commission of Kenya, 2014), covers an area of approximately 582,646 square kilometres with a population of 38.6 million (2009 Census) spread across 43 different ethnic groups. The 43 Kenyan ethnic communities observe diverse cultural beliefs and practices, as evident in chapter five (5) of the constitution of Kenyan Review Act (2008, Article 26) which “recognizes culture as the foundation of the nation and cumulative civilization of the Kenyan people and communities and in particular, Clause ‘a’ of the Kenyan constitution affirms the value and principles of the communities of Kenya, their traditions...” Similarly, clause ‘b’ of the same article “recognizes and protects the fundamental goals and values of culture and appreciates culture as the basis for nurturing national pride and identity.”

All the forty three (43) ethnic communities of Kenya are from two main tribes, the Bantus and Nilotic. However, each of the forty three communities speaks different indigenous languages (their mother tongue). Meanwhile, the main languages spoken by Kenyans in general are English and Kiswahili. While English is the official language used for business and for education, Kiswahili is used as a national language. Having been born and raised within the Luo community residing along Lake Victoria in the western Kenya region, I belong to the Nilotic tribe and speak ‘Dholuo’ as my indigenous language (mother tongue) spoken by Luos. Throughout the Kenyan formal education system English language as a subject is compulsory for all students from primary level to secondary education. As such I learnt and used English during my formal education and have also used English throughout my professional work in Kenya. This explains why I have used English for this research study.

Why professional counselling for Kenyans?

Kenya like the rest of the countries in Sub-Saharan Africa has seen her citizens experience a number of challenges in their lives such as the impact of terror attacks, HIV pandemic infection, loss and grief, poverty, substance abuse and other natural calamities that warranted psychological support. For example, in 2000, the level of HIV infection among pregnant women in Kenya was estimated
at 13% in women aged between 15-49 years, the reproductive age group (DeCock, 2002). Coupled with high birth rates, this translated into an estimated 50,000 to 60,000 children under five years of age becoming infected with HIV per annum.

Subsequently, when Kenya declared AIDS a national disaster in 1999 (DeCock, 2002; NASCOP, 2001), the Ministry of Health/AIDS Control Unit (MOH/ACU) in coordination with the National AIDS Control Council (NACC) included in their National Strategic Framework the establishment of voluntary counselling and testing (VCT) facilities, both to aid in the prevention of HIV and AIDS in Kenya and as an essential component of an effective response to the AIDS epidemic.

The emergence of VCT services in Kenya, in my observation, heightened the development of ‘professional’ counselling in Kenya through the establishment of many counselling training institutions and VCT Centres in the region. According to Sweat et al. (2000), one such institution was the Kenya Association of Professional Counsellors (KAPC), a NGO based in Nairobi which developed a youth-friendly VCT facility with a focus on promoting positive behavioural change in those with HIV positive results.

Even though the counselling profession in Kenya is in its formative years (Okech & Kimemia, 2012), one of the phenomena that has heightened its growth and development has been a recent growth in migration from rural to urban areas stimulated by the search for employment opportunities (World Bank, 2010). According to Okech & Kimemia (2012), this migration has led to a systematic disruption of families and communities alongside a disintegration of traditional support systems, thereby creating a need for professional mental health services both in urban and rural areas. This therefore implies that the development and growth of professional counselling in Kenya is associated with changing societal structures associated with social, economic and political change over the past two decades.

**Rationale for this Research Study**

Having worked with children as a professional counsellor using verbal communication before training as a non-directive play therapist more than ten (10) years ago, the idea for this research study developed from my own practical experience and my personal curiosity in terms of wanting to know what other trained non-directive play therapists’ experiences/perceptions were of working
with Kenyan children using the western model of non-directive play therapy.

A second motivation was my awareness of the fundamental importance of the goals and values of the Kenyan collective culture both to Kenyan national pride and the identity of its communities (Constitution of Kenya, 2008); in contrast to the individualistic western culture that forms the basis of non-directive play therapy philosophy (Ma & Schoeneman, 1997; Moodley, 2007). This cultural difference potentially leads to conflicts and challenges in terms of its use and applicability for the Kenyan community. This awareness also triggered my desire to investigate the experience of a few trained non-directive play therapists using the western model of play therapy in their work with a Kenyan child in order to establish the model’s appropriateness for use within the Kenyan context.

Even though this research study investigates the experiences of trained Kenyan play therapists using the western model of ‘non-directive play therapy’, I consider it important to inform my readers of the various play therapy models developed within different counselling orientations for therapy with children in the west before narrowing my study to ‘non-directive’ play therapy.

**Major theoretical approaches to Play Therapy**

Some of the major theoretical approaches to play therapy are described as follows:

- **Psychoanalytic Play Therapy** is based on Freud’s work and was developed by Anna Freud. This therapy model aims at making unconscious process conscious and containing a child’s emotions through interpretation (Bromfield, 2003).

- **Jungian Analytic Play Therapy** is based on Carl Jung’s work. In this model using play, a therapist supports the child in finding strength and meaning from the collective unconscious patterns of images, thoughts, ideas that we collectively inherit and are always present in individual psyches (Jung, 1954), in order to organise new and distressing materials (Peery, 2003).

- **Adlerian Play Therapy** is a directed approach which is based on Alfred Adler’s work. Through the establishment of an equal relationship with the child and important people in a child’s life, a therapist uses this model to help a child develop greater understanding of the inter/intra-personal dynamics and make
new decisions about their world and learn new skills (Kottman, 2003).

- **Child-Centred (Non-directive) Play Therapy** based on Carl Roger’s work was developed by Virginia Axline. Therapy is non-directive and focuses on a belief that an individual has the capacity to understand and heal oneself through the process of self-expression and exploration, given a growth-enhancing environment within a significant relationship (Sweeney & Landreth, 2003).

- **Filial Play Therapy** is an approach based on Guerney’s work. It aims to train, support and supervise parents in their parenting role, based on the belief that parents are the most appropriate people to offer child-centred play therapy to their children (Guerney, 2003).

- **Gestalt Play Therapy** is based on Fritz and Laura Perls’ work. The approach is based on the belief that healthy development is rooted in the integration of a person’s senses, bodily, emotional and intellectual. The therapist provides experiences and activities that allow a child to fully experience oneself wholesomely (Oaklander, 2003).

- **Theraplay: Attachment-Enhancing Play Therapy** is based on the works of Jernberg who incorporated part of Austin Des Laurier’s work with children with autism and schizophrenia and Brody’s work on nurturing. Therapy is concerned with playful interactions between the child and therapist and later the child and parent. Therapy based on attachment theory, uses no toys and aims to strengthen the child’s sense of worth and security and help parents understand the child’s needs and to be more responsive to them (Munns, 2003).

- **Cognitive Behavioural Play Therapy** is based on Beck’s original work of Cognitive Behavioural theory and adapts cognitive theoretical understanding of emotional disorders and the cognitive therapeutic principles in an appropriate developmental way through play therapy. This therapy is directive, though considered inappropriate for use with very young children. Therapy aims to ‘help the child make connections between worlds and behaviours’ and to correct unhelpful beliefs and encourage adaptive beliefs’ (Knell, 2003, p.180).

- **Family Play Therapy** combines family system theory with therapeutic play. It does not focus on an individual’s difficulties but upon the interactions that may be maintaining the situation. Play is used to understand the issue and to
promote change. According to Gil (2003), therapy is experienced as pleasurable and rewarding and provides metaphoric and symbolic communication.

- **Group Play Therapy** is used by therapists from a variety of orientations. It creates an environment for children to learn, support and encourage each other; to share pain and joy; and to learn that they are capable of providing and receiving help (Sweeney, 2003).

- **Ecosystemic Play Therapy** considers that all the systems that may affect the child such as parental unemployment, sibling’s illness, a change in government and alike may impact on the child. Therapy’s focus is to understand the most distressing issues from the child’s point of view; develop and implement treatment that minimises distress and maximises enjoyment in life (O’Connor & New, 2003).

- **Phenomenological Play Therapy** is based on humanistic and existential philosophies. It was developed by Langeveld (1955), Vermeer (1955) and Lubbers (1971) and further enhanced by the work of Mook (1987, 1991, 1994, 1998, and 1999). This therapy encourages the child to take the lead in expressing self, using images, symbols and words, while the therapist brackets assumption and theoretical knowledge and tries to understand the phenomenological meanings of the play. The therapist offers tentative interpretations whose validity is endorsed by the child as congruent with her own experiential reality. Within the play, both therapist and child construct a shared interpretation of the meanings for the child (Mook, 2003).

- **Object Relations/Thematic Play Therapy** was developed by Melanie Klein from the psychoanalytic approach. This therapy incorporates both directive and non-directive strategies and is integrated with attachment theory. It is a relationship therapy based on the establishment of a secure base, with an emphasis on the mother-child relationship. This is based on the belief that the relationship between a child and others are internalised and used as a filter to perceptions, attitudes and responses. By identifying common themes in the play, the therapist can build up an understanding of the child’s inner world (Benedict, 2003).

- **Prescriptive Play Therapy** may be described as eclectic. The approach advocates combining useful tools of all the theories to meet client’s needs. Therapists attempt to fit therapeutic interventions to individual children in treating a wide range of disorders (Schaefer, 2003a).
The development of the different play therapy approaches can be viewed as providing opportunities for offering therapists and their clients a wide range of therapeutic strategies to help them respond effectively to the differing needs of their clients. However, based on research evidence, Schaefer (2003) argues that while all play therapy approaches seem to have some limitations, in terms of efficacy some approaches are stronger than others.

While acknowledging similarities and differences in play therapy models, Robson (2010) observes that approaches such as child-centred, phenomenological, psychoanalytic and objective relations/thematic described above share some common roots and beliefs about the nature of the person. At the same time, Robson (2010) argues that the various descriptions of play therapy models quoted above only apply to the United Kingdom (UK) approaches to therapeutic work with children. Other countries’ approaches may differ because there is the need for therapeutic work with children to reflect the values and belief of their own communities. Timimi (2009:16) supports this argument saying that ‘cultural beliefs are influenced by our value system and these in turn influence the meaning we give to a problem and what we do about it’.

The Study

This research study aimed to:

i) ascertain the appropriateness of the western model of non-directive play therapy within the Kenyan context;
ii) establish the challenges experienced by play therapists using the western model of non-directive play therapy in their work with a Kenyan child and
iii) seek the therapists’ recommendations for the improvement of the western model of non-directive play therapy in the Kenyan context.

The study was carried out within Nairobi City, Kenya, and adopted a qualitative methodological approach in order to explore the play therapists’ ‘lived experiences’ (Schwandt, 2001), which was the objective of my study. To ensure information richness (Polkinghorne, 2005), a purposive sample of six trained non-directive play therapists with more than two years’ practical experience of working with Kenyan children using the western model of non-directive play therapy was recruited. I collected data using individual face-to-face semi-structured interviews, which were recorded and subsequently transcribed. The transcripts were then

**My background**

I approached this research study as a Kenyan woman, born and raised within the Luo community in the rural area of Western Kenya prior to my settling in the urban city of Nairobi in my mid-adulthood. I am a widow, a mother and a grandmother. All my children live in Nairobi City independently, but we frequently meet for a meal in any of our residential houses. I am also a Christian guided by the teachings of the Roman Catholic Church and find my Christian beliefs and practice a source of consolation when faced with a challenge, including psychological challenges.

By profession, I am a trained and practicing counsellor, counsellor supervisor and counsellor trainer, working from a person-centred perspective. In addition to that, I am a trained and practicing non-directive play therapist and play therapists’ supervisor, having benefitted from a brief training in play therapy offered to a number of Kenyan counsellors by two western non-directive play therapists between 2004 and 2007.

Prior to joining the counselling profession, I had trained in human resource management and worked as an administrator in several organizations in Kenya, including a government parastatal firm which I left in 2000 in order to undertake a professional counselling training. My desire to do so developed in the course of my practice as a human resource manager. In this role I was frequently approached by staff members who sought my support in dealing with their personal challenges. Much as I would try to be helpful, I realised that I lacked counselling skills and knowledge. Hence I became interested in pursuing a course on counselling in order to gain competence.

**Key Terms**

These preliminary definitions are offered for key terms used in this thesis:

**Play**

From a Kenyan perspective, Makau (2010) defines play as a range of voluntary intrinsically motivated activities normally associated with pleasure and enjoyment, including activities not controlled by adults and which do not
necessarily conform to any rules. Play implies having leisure time and freedom to do as one pleases; having recreation which includes activities undertaken by choice for pleasure.

**Play Therapy**

Play therapy is referred to as an approach to counselling children and adolescents in which the counsellor uses toys, sand trays, games, creative/expressive arts techniques, storytelling, and other forms of play to communicate with clients (Kottman, 2001; Landreth, 2002).

**Play Therapist**

In my view, a ‘play therapist’ is an individual who has undergone a training course in play therapy and is qualified to offer counselling services using play as a technique during the counselling process, preferably to young adults and children.

**Kenyan Child**

In using the term ‘Kenyan Child’ in this paper, I refer to an indigenous Kenyan child, that is, a child born and raised in Kenya within the Kenyan traditional culture.

**Non-directive play therapy**

Non-directive play therapy is defined as a form of therapy or counselling approach that is facilitated through the use of play in a non-directive process (Association of Play Therapy, 2003). This definition of ‘non-directive play therapy’ emphasises how the nature of the ‘therapy/counselling’ approach is facilitated by ‘play’ in a ‘non-directive’ manner. In essence, the definition of non-directive play therapy characterises it as a form of counselling approach which is non-directed and is facilitated by the use of play. It is within these key concepts, namely, ‘play’ and ‘non-direction’ that I wish to investigate the experience of trained non-directive play therapists working with Kenyan children. Do the play therapists find ‘non-direction’ and ‘play’ used in a therapy context appropriate for a Kenyan child? What makes it appropriate or inappropriate for a Kenyan child?

In the non-directive play therapy approach to counselling children and adolescents, the counsellor uses toys, games, creative/expressive arts techniques, storytelling, and other forms of play materials to communicate with clients (Kottman, 2001; Landreth, 2002). By making available to their client a good selection of play materials (appropriate to the child’s age, gender and sometimes to a child’s presented issue), a play therapist ensures that play materials in the
Rogers (1942) developed a non-directive approach to therapy which became the foundation of the person-centred approach with adults using verbal communication. Later, Axline (1947) incorporated play as the principal means of communication in working with children and adolescents within the person-centred approach, terming it ‘non-directive play therapy’. Subsequently, the non-directive approach at various times has been called ‘client-centred’, ‘person-centred’ or ‘Rogerian’. Therefore, in this thesis, I intend to use these terms interchangeably.

**Structure of the thesis**

Apart from this introductory chapter one, this thesis comprises of four more chapters including a conclusion chapter. Chapter two, provides a review of relevant literature. Chapter three on methodology outlines the philosophy behind the methodological approach that I adopted for this research study and my choice of a thematic analysis approach for my data analysis. Chapter four presents the findings in sections featuring major themes that emerged from the research study and discusses them in the light of relevant literature. Chapter five provides a conclusion to the research study, considers limitations of this study and the study’s contribution to knowledge. It includes a section on recommendations based on research findings. Finally the chapter provided a researcher’s reflexivity that discusses my influence and impact on the whole research process and, conversely, its impact on me as researcher.
CHAPTER TWO: LITERATURE REVIEW

Introduction

This chapter reviews the literature on play therapists’ experience of working with children using the western model of non-directive play therapy. My objective is to hear the perceptions of trained non-directive play therapists working with children in Kenya and to establish what their experiences have been like.

The Literature Review starts by highlighting my aims in the review and outlining the strategies that I used to identify and source the relevant literature for this research study. I introduce the inclusion and exclusion criteria used in the construction of this review and briefly discuss the timing of the literature review during this study and its possible implications. Thereafter, I introduce the sequence that I used to write up this chapter as follows: Firstly, I review the origin of the western model of non-directive play therapy in the west before reviewing how and why the model was introduced to Kenya. Thereafter I look at the use of ‘non-direction’ and ‘play’ as key concepts used in this model, and how the two are viewed within western and Kenyan culture. I also review the therapist’s role in this approach and what is seen as contributing to therapeutic movement in this model. At the same time, this review also explores the efficacy of non-directive play therapy and the impact of culture on the practice of counselling. I look at Kenyan play therapists’ experiences of working with children in Kenya using play therapy. Finally I review the role of spirituality within Kenyan culture and the position of spirituality within the western model of non-directive play therapy before concluding this chapter.

The aims of the review

McLeod (2003) asserts that any piece of research exists in relation to other investigative studies, adding that:

“no matter how original a new research question or technique might appear to be, it can only be asked or constructed on the back of all the questions or techniques that have gone before it” (P.10).

In line with McLeod’s afore-quoted remarks, I initiated a comprehensive search of the academic literature for work already undertaken in the area. My aim here
is to present a critical appraisal of the published work relevant to my research topic, presenting the arguments put forward. I also aim to contextualise my study within others already undertaken in the area, as recommended by Boote and Beile (2005). As McLeod (2003) recommends, I aim to map a context within which the research study can be located and understood and bring the reader up to date with the current literature on my research topic.

At the same time, my purpose in reviewing the literature was to be able to acquire knowledge on the experiences of play therapists using the western model of non-directive play therapy. As Hart (1998) and McLeod (2003) argue, in reviewing literature the researcher is enabled to comprehend the significance of work already done in the field. Hence an aim was to familiarise myself with other relevant research in the area of my study.

**Sourcing the literature**

Because the term ‘literature’ in an academic or research context refers to information in the public domain (Sander & Wilkins, 2009), this literature review was sourced from a range of sources.

To be able to establish what had been studied and to source current information in the area of my research topic, I used electronic search engines, entering some of the common terminologies used within my research study such as ‘non-directive play therapy practice in Kenya’; ‘child’s play in Kenya’; ‘counselling in Kenya’; ‘Kenyan culture’; ‘western culture’; ‘the impact of the colonial legacy on the Kenyan culture’; ‘play therapists’ experience of using non-directive play therapy’ and so forth.

My electronic search was mainly undertaken through the University of Manchester Library where I was able to access the Psycho Info database. I also used Google Scholar. I searched books, mainly those held at The Kenya Association of Professional Counsellors’ library, which is a local counselling training institute in Kenya that collaborated with the University of Manchester in offering this doctorate study. I also looked at grey literature at some of the Kenyan local universities’ libraries. I perused the contents pages of recent editions of academic journals and examined the reference sections of articles with the aim of identifying and making comparisons of relevant literature to my research study, as outlined by McLeod (2003).
My experience of this exercise was that research on “play therapy” within the Kenyan context is scarce. Even where studies have been carried out in Kenya, they tend to have been undertaken by western researchers. The small number of Kenyan play therapists who have shared their experience of working with Kenyan children in journal articles that I accessed neither specified their orientations nor identified the models used in their practice. The majority simply talked of having used ‘play therapy’. This also posed a challenge to my literature review as my focus was specifically on ‘non-directive play therapy’ otherwise known as ‘person-centred play therapy’ and not just play therapy.

**Inclusion and Exclusion criteria**

According to O’Leary (2004), the literature review coverage need to be broad enough to inform readers of the nature of discourse and current debates on the research topic, while the level of the thesis also determines what is suitable and required for a literature review. Similarly, Bruce (2001) looks at the issue of the scope of the literature to be reviewed and suggests that a researcher reviewing literature on a topic about which very little has been written may need to broaden their search. This was the case for my topic. As there has been a lack of research into play therapy within the Kenyan context, I chose to initiate a relatively broad literature review in order for myself and my readers to gain more awareness, knowledge and understanding of my research topic.

McLeod (2001) asserts that an effective review of literature requires the construction of inclusion and exclusion criteria in order to help support the development of a researcher’s focus within the literature review. Putting McLeod’s views into action, I developed a list of inclusion and exclusion criteria to help provide a focus for my literature review. As this study investigated the appropriateness of using the western model of non-directive play therapy within the Kenyan context, my review included literature on the non-directive play therapy model in order to contextualize the potential impact of ‘non-directive play therapy’ within the Kenyan context and excluded other models of play therapy. Secondly, because the model was developed within the west, the cultural difference between western communities and Kenyan communities took a centre stage in a bid to establish the cultural implications experienced by trained non-directive play therapists’ use of a western model within a Kenyan context. Therefore the review sought to establish the impact of cultural beliefs associated
to ‘play’ and ‘non-direction, as well as the impact of the socioeconomic status of Kenyan trying to gain access to this therapeutic model.

At the same time, I mainly focused on reviewing qualitative research studies on my research topic. This was because qualitative data gathered primarily in the form of spoken or written language aims to describe and clarify human experience as it appears in individual’s lives (Polkinghorne, 2005). This complements the focus of this study. The exception to this was where quantitative data helped to contextualize my study, for instance, in looking at the impact of socioeconomic factors on access to therapy in Kenya.

However, despite my broad literature coverage, my review was limited to literature relevant to my research topic written only in English within western countries and from Kenya. My preference for literature written in English was based on the fact that English was the official language used in my studies, and as an international student, English was the only language that I was familiar with that I could use to communicate with both my supervisors and my school as well.

**Review Timing**

Debate on the timing of the literature review in a research study takes in different dimensions. McGhee et al. (2007) state that the timing of a literature review is often influenced by a researcher’s epistemological perspective. Hart (1998) similarly relates its timing to the ontological and epistemological view of reality that a researcher is committed to. According to Taylor et al. (2011), quantitative researchers undertake the literature review prior to data collection in order to guide the development of the research question and methods. Conversely, guidelines on the use of the literature review in qualitative research differ, with some approaches such as grounded theory recommending a delaying of the review until after data collection to ensure that emergent theory is grounded in the data and not forced to fit into a preconceived theory. Hutchinson (1993) on the other hand believes that a literature review should precede data collection in order to identify current gaps in knowledge and help provide a rationale for the proposed research.

In this study, while chapter two provides a dedicated review of the literature in the area, the reviewing of literature has been an on-going process throughout all stages of the research process from deciding on my topic through to writing up
this thesis. While recognising the argument for refraining from reviewing literature until after data collection, pragmatic considerations disallowed this. Some of the literature presented in this chapter was necessarily reviewed in order to construct the research proposal required by the university in order to be allowed to commence the research. This initial review was necessary in order to introduce and describe my specific research question, establish its importance, provide an overview of the relevant literature, and show how the current study would advance knowledge in the area of my study in the introductory chapter.

As such, my early engagement with the literature in this study placed an extra importance on me trying to set aside any presuppositions concerning my findings. It also meant I needed to ensure that the data collection process as far as possible was not shaped by the findings of prior research in the area.

Meanwhile other literature included here arose out of the findings. I introduce literature in this chapter which I accessed as a result of themes I identified within the data. Such literature is used in the discussion chapter to aid the exploration of these themes. Generally the literature referred to in the discussion is used to both contextualise and expand on my findings. As Mudavanhu (2017) argues, demonstrating the original contribution to knowledge requires a researcher to contextualise their findings in terms of what has and has not been done in the past. I therefore also support and criticise the available literature in the light of my new findings.

**Origin of Non-directive Play Therapy**

According to Bratton et al. (2005) and Schaefer (2003) a number of play therapy models were developed in the therapeutic arena within the west to substitute for verbalised therapeutic models. According to Axline (1947), Wilson (2000) and Landreth (2010), as play was assumed to be children’s natural mode of communication, play therapy was viewed as the most developmentally appropriate way to work therapeutically with children. Play therapy was seen as providing a safe, nurturing environment which would enable children and young people to play out what they have experienced, their reactions and feelings about those experiences, what they needed in their lives and how they felt about themselves.

Within the person centred approach, Axline (1947, 1964) applied Carl Rogers’ (1942) non-directive therapeutic principles in her work with children, viewing play
as children’s natural mode of expression of their feeling. Other therapists such as Ginott (1961), Moustakas (1953), Guerney (1983) and Landreth (1991) built on Axline’s work, contributing significantly to the widespread acceptance and practice of what is now referred to as child-centred (non-directive) play therapy. More recently the writings of Landreth (1993, 2001, 2002), have promoted child-centred play therapy in North America, together with the writings of West (1996) and Wilson and Ryan (2005) in Britain.

Axline’s work has been influential in the development of play therapy with many writers including those who do not adopt the non-directive approach, acknowledging the relevance of Axline’s ideas to their own work (Cattanach, 2002). However, while influential, until relatively recently Axline’s model is regarded as failing to establish itself as a fully developed approach in its own right (Wilson & Ryan, 2005). Reasons cited include: the lack of a coherent and developed theoretical foundation; the nature of Axline’s writing; the publication of accounts of practice potentially viewed as unacceptable; its foundations in Rogerian psychotherapy itself widely misunderstood and criticised; the lack of rigorous training and research base (Wilson & Ryan, 2005).

**Emergence of Non-directive Play therapy in Kenya**

The emergence of professional counselling and later play therapy in Kenya are connected to shifts in Kenyan societal structures. Okech & Kimemia (2012) associate the growth and development of professional counselling in Kenya with the erosion of traditional societal structures connected with social, economic and political developments over the past two to three decades. The two observe that although the ‘talking cure’ is not an unfamiliar concept, the contemporary western concept of a counsellor is a new one that the wider Kenyan community has been slow to embrace. According to Okech & Kimemia (2012), Kenyan children and young people were traditionally mentored and counselled by informal networks of relatives and family members. Hence the notion of consulting with a stranger about personal or family problems was an unusual concept and was even frowned upon, as families traditionally resolved their social challenges privately in order to safeguard their image and reputation.

However, despite the initial reluctance to embrace professional counselling, social, economic and political challenges experienced in Kenya in the past few decades have led to the growth and development of professional counselling in Kenya and
ultimately the development of play therapy there. According to Okech and Kimemia (2012), a number of developments stimulated change. One was the emergence of the HIV and AIDS epidemic in Kenya, with the Kenyan government declaring HIV and AIDS a national disaster in 1998. This led to the widespread establishment of Voluntary Counselling and Testing centres, concentrated mainly in urban areas, in order to provide psychological support to both infected and affected Kenyans (Kenya National AIDS Control Counsel, 2010). The August, 1998 bombing of the American Embassy in Nairobi is cited as another such development. An outbreak of student unrest involving the burning of some learning institutions and the killing of a number of students in those institutions is argued to have heightened the need for supplemental social services. The 2007 Kenyan post-election violence that witnessed the killings and displacement of many Kenyans including children led to substantial social disruption.

Elsewhere, Hunt (2009) points to the importance of economic growth and social change connected with increasing urbanisation and mobility in the development of professional counselling and play therapy. She argues that historically Kenyan tribal clan beliefs and customs combined with strong paternal powers to ensure that children’s physical and emotional support was a collective tribal responsibility provided either by individual parents or others within the child’s community. Social changes were eroding such traditional collective support systems within Kenya and out of necessity; counsellors trained only in ‘western’ adult counselling models were being called upon to offer therapeutic support to vulnerable children. As a result, in 2003 the Kenya Association of Professional Counsellors (KAPC), a non-governmental training institution which had introduced a masters’ degree programme in counselling studies in 1999 in collaboration with Durham University in UK, asked the university to provide further training in order to meet the needs of vulnerable adolescents and children in Kenya (Hunt, 2006, 2010). After exploring the therapeutic needs of vulnerable children in Kenya and the possible role of play therapy, between 2004 to 2007 two play therapists, Maggie Robson and Kathy Hunt, from Durham University delivered a number of brief certificate-level training courses in non-directive play therapy at KAPC training schools in Nairobi, Mombasa and Kisumu, based on Axline’s (1969) non-directive play therapy model (Hunt, 2006, 2010).

The pre-training evaluations according to Hunt (2006) revealed ‘professional crisis’ with trainees reporting that they were dealing with severely traumatised children on a daily basis but felt they had inadequate knowledge and skills to respond
effectively. As Hunt (2006, p.217) commented: “...even though trainees are trained as adult counsellors they lacked the necessary therapeutic knowledge and skills to offer support to children” (Hunt, 2006:p. 217). However, after attending the training which consisted of two teaching weeks and four months’ field work, the Post-Brief Training in Play Therapy Evaluation (Hunt, 2006) showed the participants reporting themselves as having gained skills in and understanding of non-directive play therapy. Their developed sense of competence brought them relief and a sense of optimism about working therapeutically with children. Many talked in favour of the use of play therapy in working with children as opposed to verbal counselling. They also had begun to identify their own particular skills’ gaps and future training needs. They carried a sense of responsibility for the future development of play therapy in Kenya and perceived the development of good local professional supervision as a priority in training play therapists in East Africa (Hunt, 2006).

While this points to the potential gains in skills and understanding from the brief training courses and paints an optimistic picture, a number of factors need to be born in mind. The evaluations only provide information on the short-term gains the counsellors felt they had made and give no sense of the longer-term impact of the training. Moreover, the data used to analyse play therapist trainees’ pre/post-training evaluations were only from very limited sources and one cohort across the many cohorts trained in Kenya. Generally there is a lack of published literature available on play therapists experiences within Kenya.

As a major concept in non-directive play therapy, my next section considers the impact of non-direction in a therapeutic context within Person-centred/Child-centred play therapy approaches as well as in the Kenyan context.

**Non-direction within Person-centred/Child-centred play therapy approach**

According to Wilson & Ryan (2005), the term ‘non-directive’ was used in this approach in an attempt to ‘distinguish this therapeutic approach from other approaches recognized by the British Association of Play Therapy, all of which are labelled ‘child-centred’ and where therapists may direct clients to subject matter (p.19)’. Hence ‘the distinctive feature of non-directive play therapy from other therapies is its non-directive nature’ (ibid: p.23). According to Rogers (1977), the basic assumption of the non-directive approach is that individuals have within themselves the ability to solve their problems satisfactorily without the therapist’s
direction on what to do, if given the opportunity within an environment that is conducive.

Wilson & Ryan (2005) argue that the use of the word ‘non-direction’ can be misleading, giving the incorrect impression that the therapist offers clients complete freedom. A related criticism levelled against the non-directive model of counselling cited by Hough (2002) is the possible danger of counsellors using this model becoming passive or laissez-faire. However Hough (2002) dismisses these criticisms, terming them misconceptions. She observes that the approach engages the counsellor in more difficult tasks of active listening, of acquiring the ability to enter the client’s frame of reference and convey deep understanding and acceptance in their responses.

Non-direction within a Kenyan context

According to Mwaniki (1973), traditional Kenyan society has a deep respect for the wisdom of the elderly. Kenyans value and rely on the directions of the elderly and respect for their elders is demanded of Kenyan children (Odongo & Onderi, 2014). Respect is also given to those in authority on matters relating to the welfare and development of her people. Teachers and parents in African traditional society (Kenya included) were directors of learning and not facilitators. Children were not allowed to pursue what they desired in a non-threatening climate: instead teachers ‘forced’ knowledge into the children through authoritarianism and through the use of corporal punishment. This experience of giving and/or receiving direction within the Kenyan context leads to the concept of non-direction being viewed as an alien western culture (Ma & Schoeneman, 1997).

Similarly, within the cultural context, the usual practice of giving direction to a traditional Kenyan child complicates the concept of non-direction for the same child. Non-direction and autonomy within Kenyan indigenous society is seen as reflecting individualism, equated with the placing of self before others and personal rights above collective responsibilities (Alexander, 2009). An emphasis on individual independence and freedom of thought and action runs contrary to the ‘Harambee Philosophy’ or the collectivist cultural norms which have traditionally characterised Kenya (Odongo & Onderi, 2014). In my experience as a Kenyan woman, individualistic norms may be equated negatively by indigenous Kenyans with self-love, self-centredness, failure to conform to one’s social, traditional and cultural values, indiscipline and lack of humility. Such Kenyan views on ‘non-
direction’ make it questionable whether the non-directive play therapy model would achieve therapeutic movement if used on an indigenous Kenyan child (Altrocchi & Altrocchi, 1995; Tudge & Odero Wanga, 2009).

However, it can be argued that such arguments are based on a somewhat simplified picture of modern Kenya. Rapid economic and social change has been accompanied by a level of cultural change, and the national picture is likely to be a more diversified and shifting one. As discussed more fully later in the chapter, within the growing urban areas urbanized, modernized, westernized and educated Kenyan families are assimilating western cultural ideas and hence may no longer adhere to traditionalist collectivist cultural norms (Hunt, 2009).

**Therapist’s Role in the Non-directive Approach**

The role of a therapist within the non-directive approach is rooted in her way of being and attitude, rather than in her knowledge, theories or techniques (Rogers, 1957). In this approach, the emphasis is placed on the importance of the therapist’s empathic understanding and acceptance of the client’s viewpoint in facilitating therapeutic movement and client change in this approach. The focus of empathy is not confined to the client’s cognitive world. Merry (2000) observes that the therapist’s concentration on empathic understanding of the client’s internal, subjective frame of reference and its subsequent communication involves feelings as well as other experiencing such as thoughts, bodily sensations, fantasies and memories. While Hough (2002) observes that clients who come for counselling often seek expertise and advice, the non-directive counsellor’s task is to encourage such clients to get in touch with their inner resources and to recognise their inherent ability/potential to solve their problems satisfactorily (Rogers, 1973; Wilson & Ryan, 2005). This is facilitated through the therapist’s commitment to the exploration of the subjective experience of the client in the world of feelings and relationships (Rogers, 1959). This is because, in developing non-directive therapy, Rogers believed that:

‘the individual has within him/herself vast resources for self-understanding, for altering his/her self-concept, attitudes and self-directed behaviour and that these resources can be tapped if only a specific climate of facilitative psychological attitudes can be provided’ (Rogers, 1980, p.115-116).

Consequently, based on Rogers’ (1973, 1977, 1980) assumptions, the person-
centred therapist trusts his/her client’s ability to solve their issues and refuses to assume the role of an expert or director. Instead, the therapist assumes the role of a listener, empathiser and authentic companion, who positively ‘prizes’ all dimensions of her client. As such, Haugh (2008) suggests that the sole intention of a non-directive therapist is to understand and experience the world of the client as they experience it. The therapist’s refusal to offer any advice, approval or disapproval to clients in this approach is assumed to increase clients’ sense of agency and potency which helps clients effect the desired change and take desired actions (Scott, 2013).

In non-directive play therapy, according to Landreth (2002) and Baggerly (2010), the therapist in a non-judgemental and non-directive way facilitates the development of a safe relationship within which the child is enabled to fully express and explore themselves through play with carefully selected toys. By reflecting on the content and feelings expressed by the child in the play (Baggerly, 2010), a play therapist encourages the child to solve his/her problem by returning responsibility to the child.

Even though techniques such as therapist reflections of the content of client’s words, their expressed thoughts and feelings are regarded as useful in this model, Merry (2000) argues that such reflections can only convey a partial picture of the client’s experiencing. He reaffirms the centrality of the therapeutic relationship in facilitating change. Such a relationship is characterised by an attitude of empathic understanding, together with personal congruence and unconditional positive regard (Rogers, 1957).

It is also characterised by a commitment to equality between therapist and client, with non-directivity at the heart of this commitment (Rogers, 1957). This commitment to equality has been a source of criticism of the approach. Mearns and Thorne (2000) argue that taking up such a role of powerlessness and vulnerability in their work has led to a critique of person centred therapists as anti-intellectual. Male therapists have also been depicted as unmanly as the therapists’ qualities lack the attributes of male dominance and reflect the maternal qualities of warmth and female sensitivity and sentimentality.

Equality between therapist and client is also argued to be unattainable. As Proctor (2006) argues, despite their intention not to influence or direct clients, therapists have a powerful role and will also bring to a therapeutic encounter their own
experiences of power and powerlessness. The commitment to equality is also questioned. Commenting on the issue of power, Pelham (2008:110) asserts that ‘power is an aspect of all relationships’ and is neither good nor bad. Because the therapeutic relationship is key in this approach, therapists need to understand when and how to explicitly exercise power for the benefit of the client. Pelham (2008) reflects on how ethical frameworks for all practising counsellors/therapists strongly suggest that therapists exercise power and influence in cautioning a client in a vulnerable state (such as children) about making major decisions that will significantly affect their life and lives of others. Elsewhere, Pitt-Aikens & Thomas Ellis (1990) postulate that the refusal to use power in a relationship can be just as damaging as the use of power, giving as evidence the lives of children whose caregivers have not set up appropriate boundaries.

The issue of non-directivity is seen as particularly problematic in terms of working with children. Rogers (1973, 1977) proposed that any autonomous choice freely made by an individual without external pressure would help that individual find their own solutions to whatever issues they might face if provided with sufficient support. This implies that the counsellor is to be led by the client in whatever issues the client wishes to discuss and to the conclusions the client chooses to make. While the autonomy offered in this approach is viewed as strength of non-directive play therapy (Ryan, 2004), there has been some criticism on the use of non-direction on children and the offer of autonomy to children.

Talking from a declared religious (catholic) perspective, Scott (2013) argues generally that unquestioned adherence to non-directivity may lead to the unhelpful withholding of relevant information or advice to clients. He argues in particular that children and young people need boundaries and that the avoidance of moral judgement on the part of the counsellor leads children to rely on their own resources and does them a disservice. A potential consequence is that the approach introduces ‘good kids to misconduct in the name of non-judgmentalism’. Scott (2013) acknowledges the influence of Coulson, a catholic and close colleague of Rogers, who similarly critiqued the approach. Coulson (1991) argued that the non-directive approach teaches the disregard of absolutes, rights and wrongs and a focus on individual wants and needs (Coulson, 1991). Scott (2013) talks pejoratively of the narcissism of the approach and its anti-religious bias. For him, the approach may only be considered appropriate when an individual’s autonomous choice is the primary value but not where serious moral considerations are involved. While the client-counsellor working relationship in the
non-directive approach is considered an important determinant of a successful counselling outcome (Haugh, 2008), Scott (2013) argues that counsellors adopting a neutral stance in practice can be unattainable as well as undesirable. This can lead to a level of incongruence evident in the counsellor’s non-verbal behaviour, which would be likely to undermine the client counsellor’s working relationship.

Within the approach itself, questions have begun to be raised over the non-directive stance of the counsellor. Classically, person-centred therapy relies upon clients’ resources for the generation of change, facilitated by the conditions provided by the counsellor, who responds primarily with empathic understanding directed at the client’s frame of reference (Cooper, Watson and Holldampf, 2010). However, according to Orlinsky et al. (2004), clients can prefer a more collaborative therapeutic relationship within which the therapist contributes their thoughts and advice, provides challenges and suggests useful exercises to their clients. For some clients this can be a means of mobilizing self-organising wisdom. As Wood (2008) argues that trust in the self-organising wisdom of the person is at the core of the person-centred approach, such strategies could be viewed as compatible with person-centred values.

Again from within the person-centred community, there have been calls for greater flexibility generally in how person-centred principles are translated into practice. Cooper et al. (2010) suggest that valuing the uniqueness of individual clients ought to be compatible with valuing and respecting both individual clients’ experience and their expressed wants and needs. To meet individual clients’ needs and wants in this approach, Cooper et al (2010:121) suggest:

‘a more integrative approach to person-centred practice within which therapists may suggest techniques and procedures that might be differentially useful to clients as long as that is done in collaborative consultation with client rather than in the form of the expert therapist telling the client what to do’.

Perhaps reflecting criticisms such as we have read in the previous paragraphs, Rogers (1987) warned that placing too much loyalty to a method, school of thought or technique could have a counterproductive effect on the counselling process. He suggested that:

‘There is one best school of therapy. It is the school of therapy you develop for
yourself based on continuing critical examination of the effects of your way of being in the relationship’ (p.185).

Supporting Rogers’ argument for the importance of reflexivity to the development of practice, Walshaw (2008) cautions practitioners over holding ‘internalised rigid conditions of worth about being Person-centred’ (p.4). She argues for practitioner’s ability to co-create relationships and the importance of them harnessing their spontaneity and creativity as opposed to rigidly applying ‘introjected’ rules from their person centred training. As a person-centred adult and child therapist, Walshaw observes that person-centred therapeutic work involves engaging one’s humanity, developing ones internal moral and ethical codes, questioning rules and recognise when these rules need to be upheld or challenged. It also involves substantial self-reflection. On a similar vein, Feltham (2007) recommends that practitioners working with children acquire high levels of discernment which would enable them to choose to hold a boundary because it is ethical rather than as a rule.

**What contributes to therapeutic movement in the Non-directive Approach?**

Rogers (1959, p.213) argued that six conditions were necessary and sufficient for change to take place. They were:

1. ‘That two persons are in contact.
2. That the first person ... the client, is in a state of incongruence, being vulnerable, or anxious.
3. That the second person ... the therapist, is congruent in the relationship.
4. That the therapist is experiencing unconditional positive regard toward the client.
5. That the therapist is experiencing an empathic understanding of the client’s internal frame of reference.
6. That the client perceives, at least to a minimal degree, conditions 4 and 5’.

Three of these conditions (3, 4, and 5) are commonly known as the ‘core conditions’ provided by the therapist. These involve a ‘way of being’ characterised by congruence, empathy and respect. Rogers’ assumption was that the manifestation of these conditions in the therapist’s behaviour would lead to the construction of a ‘facilitative psychological environment’ which enabled and
encouraged the client’s personality change (Rogers, 1961). For Rogers, directing the client was evidence of a lack of empathy and respect on the therapist’s part. Similarly Virginia Axline (1947) the renowned pioneer of non-directive play therapy, observed these attitudes to be equally applicable to work with children and valued the child as his/her own expert.

In characterising the approach Scott (2013) refers to the importance of the safe space created in helping the therapeutic process. Nash (2008:128) on the other hand argues that the success of this approach is due to the therapist’s engagement in a ‘dialogical relationship’ with the client; provision of a space for working and being with the client where the client is at the centre of this activity; and trying as much as possible to be non-directive in attitude and in being.

Nash’s (2008) highlighting of the importance of the dialogic relationship links potentially with three of the necessary conditions which have traditionally been neglected (Tudor, 2000). These conditions refer to qualities also brought by clients to the therapeutic process. For therapeutic change to occur, the client has, ‘in effect, to fulfill three conditions i.e., that they are in (psychological) contact, in some state of incongruence, and that they experience/perceive being received’ (Tudor, 2011, p.169).

From the above observations, what stands out as factors that contribute to therapeutic movement in the non-directive model of counselling are the therapist’s creation of a ‘safe or conducive environment’ for clients to express their concerns and the therapist’s ability to maintain particular ‘attitudes’ towards the client within this therapeutic relationship. They also point to the importance of the client being in psychological contact, of having a level of experienced incongruence and the ability to respond to the counsellor’s communications of the core conditions.

A potential critique of all these arguments is that they are theoretical rather than evidence-based. As Tudor (2017, p.283) remarks:

Research evidence that the therapeutic conditions are both necessary and sufficient is not unequivocal, though much of it suffers from inadequate methodology and the possibility of poorly reported and discussed result.

General research into the ingredients of effective talking therapy whatever its orientation, does point to the significance of a therapeutic relationship.
characterised by qualities that closely parallel the core conditions. Mirroring the six conditions, it also points to the significance of the client, which is indeed identified as the key factor. Successful therapy is most closely associated with clients whose attributes include: motivation; active engagement; realistic expectations; higher psycho-social functioning; strong social support (Cooper, 2008). What we cannot infer from such research is how transferable such findings are to play therapy with children.

My next section looks into ‘play’. It examines: play as an activity; the purpose of play; types of play; beneficial functions of play; the play therapy process; play therapists’ experience of using play for therapy.

**Play as an activity**

Roopnaire (2010) views play as an integral part of everyday childhood activities in most cultural communities around the world, Whitebread’s (2012) description of play highlights the different values that can be placed on it:

‘Play’ is sometimes contrasted with ‘work’ and characterised as a type of activity which is essentially unimportant..., trivial and lacking in any serious purpose...; something that children do because they are immature, and as something they will outgrow as they become adults... Surprisingly, play in its rich variety is one of the highest achievements of the human species alongside language, culture and technology... The value of play is increasingly recognised by researchers within the policy arena for adults as well as children, as evidence mounts of its relationship with intellectual achievements and emotional well-being’ (Whitebread, 2012:3).

A research study that investigated African American parents’ perceptions of play therapy revealed that parents identified “play as an activity that is not only essential to developmental learning, but as something that is transient and ideally perpetual” (Brumfield & Christensen, 2011, p.216). This finding indicates that such parents might agree with Timberlake and Cutler’s (2001) claim that ‘play’ is not only desirable but also a basic necessity and fundamental for the healthy development of children.

Within the Kenyan context, there are some indications of an increasing importance being accorded to play. In an interview reported in one of Kenya’s leading newspapers, ‘gender and development consultant’ Makau (2010) argued for the
importance of play in the development of children’s cognitive abilities, social skills and child’s emotions as well as in the preservation of cultures and communities. She also noted the rising acceptance of the importance of play, while also observing that play is frequently taken for granted and its significance at times neglected. Similarly, in the same issue, Kola (2010) acknowledges the interplay between work and leisure and describes play as a key factor in children’s wellbeing and holistic development. Despite the evidence of mixed views regarding the value of play for children and adolescents, Whitebread (2012) cites the worldwide manufacture of play materials as evidence of the widespread recognition of its value by adults.

The Purpose of Play

Play as an activity is undertaken for various purposes and the purpose of play activity determines its role and importance in the therapeutic field. West (1990) differentiates between play as a medium and play as a technique used in treatment for therapeutic purposes. As a medium, play is spontaneous and children undertake play activity for pleasure, fun, enjoyment, and satisfaction (Makau, 2010) while, as a technique, play is used in a focused manner for therapeutic ends.

In Kenya, the Early Childhood Development (ECD) policy programme is based on children’s play with the aim of providing opportunities for child’s holistic development before entry into a primary school (Kaga, 2006). According to Kaga, using play in ECD improves children’s educational performance; ensures holistic development; prepares young children for successful schooling; facilitates school performance; stimulates children’s social, emotional, physical and cognitive development.

In Article 31 of the UN Convention on the Rights of the Child (Office of the United Nations High Commissioner for Human Rights, 1989), play is enshrined as children’s right. Within the context of play, the literature provides examples of different types of play and its perceived beneficial functions, as reflected on in the following paragraphs.

Types of Play

Children’s engagement in play activities takes different forms ranging from physical play, play with objects, symbolic play, pretence/socio dramatic play and
games with rules, all of which are found in all cultures (Whitebread, 2012). However, the culture in which play takes place is important in shaping the type of play activities available to children and influences the activities in which participation is either encouraged or discouraged (Tudge & Odero-Wanga, 2009).

Children in traditional societies are more likely to engage in work related play activities and their play includes more work-associated themes than children in technologically developed societies (Morelli et al., 2003). Because a child’s play reflects adult cultural activities, Kamei (2005) observes that a traditional Kenyan child’s play is an imitation of adult activities such as hunting, fishing, housework, traditional songs and dances. Furthermore, traditionally Kenyan children would combine work and play by, for example, playing marbles on the way to the grocery or chase birds when going to fetch water for domestic use. Such were the experiences of the late Kenyan Nobel Peace Laureate, Wangari Mathai (2004) who during her Nobel Peace award ceremony in Oslo, fondly recalled her childhood experiences with her environment, stating how as a child on her way to a stream to fetch water for her mother she would play among the arrowroots’ leaves, trying in vain to pick up the strands of frogs’ eggs, believing they were beads. This personal account suggests that indigenous Kenyan children’s play may not only include work related themes but also playing with nature in the open fields around their environments. It also implies that the choice of play may be determined by the individual child without the involvement of their parents. This is contrasted with western and other technologically developed societies, where it is argued that play is embraced as central in enhancing the growth of specific cognitive and social skills in young children (Johnson et al., 2005). This lead parents to provide numerous objects to promote opportunities for children’s play and sometimes participate in children’s play.

A research project (Nuffield funded) into play within Kenya was carried out by Robson (2009), assisted by eight trained Kenyan play therapist observers including the author of this thesis. Descriptions were collected of eight Kenyan children’s play (i.e. four from Nairobi City and four from rural Kenya) both at school and at home. The findings revealed identifiable differences based on location and socioeconomic status. Rural children and those from poorer urban homes more frequently engaged in work-related play than children from affluent urban homes. At the same time, children from the poorer areas of Nairobi as well as from the rural areas tended to ‘make’ their toys and use their imagination to make up games from traditional sources. Children from more affluent areas in Nairobi
played with commercially produced toys and also accessed modern technology. While no claim was made for the transferability of these findings, they do indicate the potential for difference in the nature of play in rural and urban areas as well as between richer and poorer households. It is important to note that, even though the types of play and use of play materials observed showed difference, this should not be taken to imply inferiority or superiority (Robson, 2009).

**Functions of Play in Children’s development**

As Whitebread (2012, p.5) observes:

‘Psychological research has established that there are five fundamental types of human play, commonly referred to as physical play, play with objects, symbolic play, pretence or socio-dramatic play, and games with rules. Each supports a range of cognitive and emotional developments and a good balance of play experience is regarded as a healthy play diet for children’.

Play, as a pleasurable, spontaneous and voluntary activity (Schriver, 2001; Anderson-McNamee and Bailey, 2010; Schaefer, 2003), helps children in a number of important ways. It enables them to communicate emotions, to solve their problems and express their needs. It stimulates language growth; develop positive relationships; learn to take turns; understand others’ roles in their life; and master skills. According to Schaefer (2003), enjoying play is therapeutic as participation in pleasurable and fun activities helps neutralise stress and lift and restore the spirit.

Literature on children’s play overwhelmingly places its emphasis on the beneficial values and functions of play rather than on its disadvantages. For example, play involving counting and other basic mathematical operations is argued to support young children’s ability to engage confidently with formal mathematics (Whitebread, 2000; Carruthers & Worthington, 2006). Play is viewed as contributing to the development of language and production of private speech as children self-commentate on their play (Vygotsky, 1978; Whitebread, 2011; Vallaton & Ayoulo, 2011). Play is also seen as boosting children’s self-regulation and hence their academic achievements and well-being. Use of dolls, puppets, role-play, fun and games in learning captures children’s attention and increases their motivation to learn (Drewes & Schaefer, 2010). Exploration using miniature toys can help lessen children’s anticipatory anxiety linked to stressful life events.
such as the coming birth of a sibling or a scheduled visit to a doctor (Wohl & Hightower, 2001). Engaging in play with toys promotes children’s creativity and emotional expression, and enables limit testing and role-playing of reality (Landreth, 2002; Kottman, 2003). Similarly, children use a variety of toys and play materials to experience a cathartic release of tension (Homeyer & Morrison, 2008).

Despite the widely acknowledged beneficial functions of child’s play, the United Nations Educational Scientific and Cultural Organisation (UNESCO) in their policy review of early childhood care and education in Kenya observed that the significance of play to healthy development is not universally recognised and argued that without using concrete evidence, it will be difficult to convince parents and teachers that play is the best medium in which young children develop, learn and prepare for their future (UNESCO, 2005). As all theories of play are based upon observations of western children’s play, Hinman (2003) emphasises that applying western views of play to work with a child from a far Eastern culture where play is seen as inconsequential, may be inappropriate. As a consequence, Hinman cautions play therapists to fully understand the cultural context of play and avoid erroneous conclusions based on preconceived ideas of what play should be like.

**Play as a technique in therapy and the therapeutic process**

As Allan (1997) noted, one difference between play and play therapy lies in the role played by the therapist. Their therapeutic role requires them to be able to think analytically about the content of sessions, verbal, non-verbal and symbolical. Similarly, the play therapist’s orientation dictates whether a child’s play with toys or games is child-directed or directed by the professional (Homeyer & Morrison, 2008).

As Cattanach (2003) argues, within play therapy, children play imaginatively, creating a fictional world which can act to help them make sense of their real world. In this creative process, children have the power to construct, change and reconstruct events, thus enabling them to interpret or re-interpret their own experiences (Cattanach, 1995). Providing a child with real-life miniatures such as medical kits encourages self-expression and healing (Landreth, 2002). Playing with materials such as clay, crayons and blocks is argued to promote feelings of success, provide the child with the ability to complete a task independently and
According to O’Connor (2005), playrooms should ideally have culturally-neutral play materials and culture-specific items, to meet the needs of a diverse population. This is in contrast to the way that toys generally reflect the attitudes of the dominant group (Nelson, 2004) and can be used to perpetuate and legitimise the ideas, values and experiences of the dominant group at the expense of others. Alternatively, Walshaw (2008) argues that all play therapists need to do is use their imagination and creativity in collecting and using resources within their environment for play materials such as crayons, glitter, paper, clay, stones, furniture in the room, sand and miniatures. She cites Moustakas (1973) who considers a range of toys available as less important than the opportunity for each child to use materials of his/her choice.

While children’s play may take place outdoors or indoors according to the child’s choice, on the contrary, play therapy is generally carried out in a specifically designed and equipped playroom (Wilson & Ryan, 2005). Important criteria in the construction of such are privacy and lack of interruption in order to help the child client to feel safe and comfortable and encourage their self-expression (Wilson & Ryan, 2005). This is important as children commonly need to explore difficult material. However, their stage of development in expressive and receptive language skills and limited vocabulary repertoire make it difficult for them to use expressive language to communicate their feelings (Landreth, 2002; Drewes and Schaefer, 2010). Using play allows children to act out the circumstances that are bothersome, scary or confusing to them (Woltmann, 1952). Thus, it is argued, play therapy can help prevent or resolve psychosocial difficulties and help the client achieve optimal growth and development. The therapist, by watching for patterns and themes in children’s play, can make responses that help to produce therapeutic movement and ultimate catharsis (Landreth, 2002).

Safety for the child is also created by the centrality accorded to play within the therapeutic space. There is a general belief that when a child plays with toys or other play materials and dramatizes the play or narrates a story, the child is safely distanced from the real world. The use of metaphors by the child and the therapist’s focus on the metaphor (Grainger, 1990) creates what Grainger (1990) termed ‘aesthetic distancing’ between the child and the event in the child’s life. The distance provided by the metaphor provides safety and enables the child to look at painful and difficult emotions connected with their experience (Cattanach,
According to Hunt (2006), children in their play develop metaphoric expressions of their life situations. The therapist assists in the development of the play by ‘bathing’ the metaphor through questioning about the presented figure in the play or about the feelings reflected on in the play. This process enables the child to explore their metaphor in more depth and unconsciously develop a story of their life experience which in turn can help the therapist understand the child’s emotional feelings.

According to West (1990), Cooper et al. (2010) and Ryan (2004), it is important to keep in mind the distinction between play and play therapy. As they state, play in itself is neither a therapy nor a general panacea. It is a valuable medium of exchange in the treatment of children, especially when children’s problems are deeply rooted and emotional care is inadequate. Subsequently, Cooper et al. (2010) argue that it is the “relationship” that develops in a play therapy session that is the major therapeutic factor.

**Efficacy of non-direction in Play Therapy**

Despite a range of criticisms aimed at non-directive approaches, non-directive play therapy is considered effective because it allows the child to be responsible for treatment direction (Guerney, 2001). In this approach, the child is the driving force behind the therapeutic process; the context and direction of therapeutic process are determined by the child within an environment where they feel safe to do so (Sweeney & Landreth, 2003). Whereas Guerney (2001) argues the importance of providing a safe and nurturing environment that allows the child to heal from their traumas, gain insight and perspective into what they are feeling and experiencing, Carroll (2002) affirms that giving children the opportunity to make choices in the playroom makes them feel valued and appreciated and in control of the process.

The basic assumption of non-directive play therapy is that children and young people themselves have the potential to choose their own form of emotional expression for a wide variety of problems (Ryan, 2004). Non-direction allows children ‘choice’ and ‘autonomy’ also provides the ‘freedom’ to choose the type of play that suits them at a given time, regarded as particularly important for traumatised and maltreated children. Elsewhere, Ryan & Wilson (2000:267-283) talk of the appropriateness of non-directive play therapy for children and young people involved in court proceedings because ‘it is compatible with the court’s non-
leading or suggestive evidence from child witnesses; non-direction also functions as a strong means of assessment of children’s needs, wishes and feelings, as well as assessing children’s emotional worlds in a non-threatening way.’

It needs to be emphasised that most research on the efficacy of non-direction in play therapy has been carried out in the west with western children. Its transferability to the Kenyan context can thus not be assumed. However, during the launching of the first training in non-directive play therapy in Kenya in 2004 by western play therapy professionals at the Kenya Association of Professional Counsellors, the conviction was that play therapy could not only help children affected and infected with HIV and Aids but all children experiencing psychological challenges as highlighted by Hunt, 2006:

‘Vulnerable children in the care of counselling and other caring professionals in Africa have many varied needs that could be met with play therapy interventions. These include the psychosocial impact of: separation, loss, bereavement, illness and caring for ill relatives caused by HIV/AIDS, abuse including, sexual, physical and mental trauma; domestic violence; civil unrest; crime; poverty and for refugee children, the experience of war. (Hunt, 2006:216)

To establish the perceived potential efficacy of non-directive play therapy in working with Kenyan children, in the absence of case study outcome researches, the 2006 cohort undertaking brief training in Kisumu, Kenya completed an open-ended questionnaire regarding their motivation for undertaking the course and their perceptions of the usefulness of play therapy as a therapeutic tool for working with children (Hunt, 2006). The results indicated that they believed non-directive play therapy to be appropriate in helping Kenyan children. The capacity for play to help self-expression and self-control was cited by the counsellors. It was seen as facilitating the expression of feelings and exploration of issues. It was viewed as enabling children to understand and come to terms with their experiences and world, seen as particularly important in a time of rampant abuse and violation of children’s rights.

At the same time, the trainees cited possible challenges in establishing non-directive play therapy as a mode of counselling in Kenya. They pointed to a lack of awareness of the value and practice of professional counselling and play therapy (including non-directive play therapy) on the part of the majority of Kenyans. Professional play therapy centres and/or rooms and appropriate play materials
necessary for the establishment of this model in Kenya were also considered lacking. Whereas trainees considered it costly setting up and maintaining a play therapy centre, the lack of local training facilities for play therapy was considered to be a factor in the lack of trained play therapists in Kenya. Also the Kenyan-trained therapists pointed to their lack of opportunities to practice due to the general lack of awareness of the value and practice of play therapy, coupled with most Kenyans view of ‘play’ as lacking in seriousness.

As referred to previously, therapeutic work with children and young people is still in its infancy in Kenya and access to training and literature is scarce (Robson, 2010; Ochieng, 2010). However, there have been some examples of Kenyan play therapists sharing their experiences of therapeutic work with children and emphasising the usefulness of play therapy. For example, Ochieng (2010) shares her experience of therapeutic work with children who witnessed brutality during the 2007 post-election violence in Kenya. Ochieng describes how she offered both individual and group therapy to a traumatized girl in an attempt to help her make meaning of her experience and re-engage with her life. Using the limited tools and skills at her disposal, she offered various activities such as composing of songs, engagement in physical education, drama and dance. Through the use of such activities, she experienced the girl as gaining self-acceptance and emotional containment, self-expression by sharing out her story, and the possibility of making meaning from her experience.

Another Kenyan counsellor, Ramogo (2009) reports how she helped by engaging Kenyan child victims of post-election violence in playing, drawing and telling both good and bad stories about their experiences. According to Ramogo (2009), this process was therapeutic in enabling the children to express themselves in ways that enabled her to understand the children’s experiences and to facilitate the children’s expressions of feeling. In yet another incident, at a camp in Nakuru town in Rift Valley, Mwarangu (2009), a volunteer counsellor with the Kenya Red Cross shared her experience of working with children after the 2007 post-election violence by engaging them in a play programme. Through the programme, the children were able to tell their story by drawing pictures of houses on fire, people struck by arrows and other disturbing scenes, and acting out the scenes of violence that they had experienced using toys. Mwarangu (2009) observed that play therapy programme helped these children to express repressed feelings of bitterness, anger, fear, desire to revenge and other intense emotions.
According to Goldfinch (2009) traumatic experiences can impact physical functioning and can cause developmental delays. Therefore through play therapy programmes, the above-mentioned counsellors reported themselves as able to address these emotions in order to try and ensure long term mental and emotional health of those innocents caught up in the mayhem.

On a final note here, despite the arguments put forward for the effectiveness of non-directive play therapy by play therapists, Wilson and Ray (2005:18) observe that:

‘the links of non-directive play therapy with Rogerian psychotherapy are incompletely explored, and the function of play in therapeutic process and its relationship to mental and emotional development is barely analysed.’

My next paragraph views the relationship between culture and psychotherapy and the difference between western culture and Kenyan culture.

**The Impact of Culture on Counselling and Psychotherapy**

Richard (1997) describes culture as a socially transmitted concept that relates to the values, attitudes and behaviours common to a group. Tudge and Odero Wanga (2009) view cultures as groups of people sharing a general set of values, beliefs, practices, institutions and access to resources. Within the group, people may have a sense of shared identity, connection or belonging, and the adults of that group pass on the values, beliefs, practices of the group to the children. Tudge and Odero Wanga (ibid) further elaborate on culture, saying that within a given society’s politically defined borders, there may be many different cultural groups and people may be considered as members of more than a single cultural group. Different ethnic groups, socio-economic groups, regional groups and groups that are more locally constituted may be in existence. However, all may constitute cultural groups so long as they conform to the descriptions highlighted above.

Alongside such characteristics, culture is considered dynamic rather than static (Jenkins, 2002). Wangari Mathai (2004) acknowledges that culture evolves over time, consciously discarding retrogressive traditions and embracing aspects that are good and useful. In this respect, Kenya has experienced substantial societal change in the recent past connected to the increasing urbanisation and mobility of her population (Hunt, 2009). Change within the Kenyan education system and the
import of western culture and social practices principally through the media has undermined Kenyan cultural practices. During the pre-colonial era (Kinuthia, 2009) Kenyan education was localized, and relevant indigenous knowledge was considered important in the organization and transmission of knowledge. Within traditional Kenyan culture were:

‘social groups such as clans members, age mates and elders through which the youth acquired social education and ethics, strong extended family systems also reinforced whatever was taught by these social groups...’ (Koech, 1999:25).

With regard to play within the Kenyan culture, the Centre for Research Communication and Gender in Early Childhood Education (Creche) (2010) observes that in the past Kenyan children easily intermingled play, work and leisure? For example, girls fetched water using gourds but could also fill them with seeds or pebbles for play purposes. In the same way, Kenyan boys used catapults both for play and to kill birds for supper. Today, these traditional systems of culture have either weakened or been broken down with the adoption of a formal education system, foreign religions and foreign cultures (Koech, 1999).

The introduction of the formal education system in Kenya during the British Colonial era stirred ideological conflict in Kenya, due to its western nature and it being provided mainly by missionaries (Strayer, 1973; Bunyi, 1999; Ntarangwi, 2003). The missionaries spread the ‘belief among Kenyans that their traditional culture was backward and uncivilized and that they should aspire to be like the ‘civilized British’ (Coles, 2008:32). By the time Kenya gained independence, the colonial government had left a strong legacy but the paradox of living between traditional and modern culture persisted. While part of the Kenyan population craved for a western style of education and knowledge believing that it promoted economic development, acquirement of riches, indicated power and strength, others resisted and maintained their traditional life style.

The post-independence era has experienced rapid population growth in urban areas. This is partly due to rural-urban migration as people move in search of better living facilities (Hope, 2013). The attraction to urban life is contributed to by the British Colonial government’s concentration of administrative, cultural, economic and recreational activities within these communities. As Hope (2013:275) argues:
Following on from independence, Kenya sustained this urban community bias as the local elite began to gain entry into these formerly exclusive European settlements. The consequence was the continued development of commerce and industry, and the growth of transportation, communication, education, and other types of infrastructure in these urban communities.

Thus a good number of educated Kenyans living in urban areas, having acquired higher economic and social status, have become more westernised compared to those of lower socioeconomic status (Kiribati, 2014). This is reflected in the findings of a research study undertaken by Tudge and Odero-Wanga (2009) among twenty members of the Luo community living in Kisumu city, Kenya. The typical activities of children in ten middle-class families and ten working class families were observed and compared, with a particular focus on children’s play. The findings revealed that although children from the middle-class families lived in large houses with individual compounds providing sufficient room for play, the fencing between houses led to a lack of interaction with other children beyond their siblings or invited friends (Kiribati, 2014). Meanwhile, children from the working class families, living in smaller houses with shared compounds and shared facilities such as washrooms, freely mingled and played interchangeably around each other’s houses. Another noted difference was that children from middle-class families played with commercially-made play equipment and lived a modern lifestyle, while children from working class families used play equipment made from the locally available materials, for example, they used banana leaves to make dolls, or a can of juice to make a car with bottle tops for wheels. These findings point to the assimilation of western individualistic lifestyles by the Kenyan local elites that impact on children’s typical activities such as play.

In the practice of counselling and psychology, Mohammed (2000) argues that culture is key to the defining of different aspects of an individual’s social and psychological experiences. She argues that the concept of mental health is culturally constructed and is influenced by the way individuals develop a sense of themselves through the dynamic interaction of psychological and social circumstances. Such interaction can involve the interplay of spiritual factors, instincts, emotions and relationships. As Mohammed argues, achieving and maintaining a sense of wellbeing is dependent on the interplay between such factors, including the way individuals views themselves and are viewed and treated by others.
Mohamed (2000) argues that western psychotherapy and counselling has neglected non-western countries’ cultural systems. It thus rests on ethnocentric and culturally specific foundations, potentially leading clients accessing therapy from other cultures to feel alienated by its cultural norms. Mkhize (2000) observes that even counsellors working in NGO and Government programmes which aspire to be community based and culturally relevant, fall into the trap of adopting an individualistic model by assimilating the ideology of their training. As a result, Mkhize (ibid) calls for an authentic integration of traditional healing models. Similarly, Walker (2005) advocates for a culturally competent practice that would understand and support children and adolescents from a range of cultural backgrounds.

**Western Culture versus Kenyan Culture**

While the term western culture is often used to describe a culture or lifestyle lived by a group of people within a particular geographical area, such as, North America, Northern and Western Europe (Ma and Schoeneman, 1997), I consider the term ‘western’ to mean European civilization; western heritage, social norms, ethical values, customs, belief systems and so forth. As such, I consider the western world to include all cultures directly derived from and influenced by European cultures such as Western Europe, Central Europe, Northern Europe, South Eastern Europe and Southern Europe, Eastern Europe, South Africa and Oceania.

From a cultural perspective, the concept of client autonomy is seen as essentially reflecting western views which recognise the self as independent and autonomous (Holdstock, 1993, 1996; Ma & Schoenema, 1997). This western emphasis on individualism and on individual freedom conflicts with Kenya’s tradition of collectivism and thus potentially raises questions over the fit between the person-centred approach and Kenyan culture. In the practice of counselling and psychotherapy, the non-directive/person centred approach places the individual’s self-concept at the centre of its hypothesis (Haugh, 2008). The assumption is that individual self-concept is formed within the individual's environment. In parallel, there is recognition that cultural norms and practices which influence the individual’s self-concept also influence psychological process (Lehman, Chiu & Schaller, 2004). However, there is a failure on the part of many western psychologists to recognise that cultural difference produces different types of self-concepts (Ma and Schoeneman, 1997). As such western psychologists’ assumption
that their cultural view of the individual as autonomous bounded entity is universal inevitably raises the question of the appropriateness of the western model of non-directive play therapy in the Kenyan context.

Haugh (2008) argues that person-centred theory, as a western model, is the product of an individualistic view and thus less concerned with cultural difference. On the same note, person-centred theory is criticised for separating and isolating an individual from society, based on the model’s assumption that psychological disturbances are the result of an individual’s personal history rather than being connected with their social context (Waterhouse, 1993; Hill, 2004). Similar views on cultural implications are reflected by Moodley (1998; 2007), who argues that counselling and psychotherapy have been developed in ways that preserve a particular western cultural origin, where black and ethnic minorities appear to be absent.

The debate on the appropriateness of western model of counselling in the African context takes on another dimension with the writing of Solomon et al. (2004). They observe that the appropriateness of western model of counselling in the African context rests on two foundations: the question of the appropriateness of an individualistic or community paradigm and a bio-medical or indigenous paradigm for counselling. They put forward a number of arguments. They argue that, since the individualistic orientation of the western psychology contradicts the community orientations of Africans, the model’s goals of increased insight and self-actualisation could be culturally inappropriate within the African context. They also observe that the human rights’ principles of confidentiality and informed consent are wrongly assumed to be globally appropriate. Within the context of HIV and AIDS Voluntary Testing and Counselling (where play therapy is also used to provide psychological support to HIV infected and affected children), they contend that the psychological model used lacks the religious and spiritual conceptualisations which underpin African interpretations of sickness and disease. They also point out that western perceptions of sexuality, sexual risk and sexual health are not compatible with African cultural reality. Finally Solomon et al. (ibid) observe that the Western bio-medical of/and explanation of HIV and AIDS does not incorporate the African model of sickness and disease.

Elsewhere, Ma and Schoeneman, (1997:262) describe the individualistic western culture’s self-concept as ‘egocentric, separate, autonomous, self-contained and independent’. Within individualist ideologies, they argue that control belongs to
the individual and childrearing methods encourage children to ‘be themselves’ and ‘to find themselves’: concern is focused on instilling the values of self-reliance, independence, creativity and autonomy. In contrast, Kenyan collectivist culture emphasises the importance of social control with limited emphasis on individual freedom (Mwaniki, 1973). Individuals act according to the expectations of family and friends and strive to maintain a demeanour in aid of group harmony, even if there is a strong disagreement. Childrearing practices of collectivist cultures teach obedience, reliability, proper behaviour and support to each other. Jomo Kenyatta (1938) in his book Facing Mt. Kenya emphasizes collectivism as an essential aspect of Kenyan Kikuyu society and the suspicion attached to anyone regarded as an individualist.

While criticising the western model of non-directive therapy, Laungani (1999) and Leach (1997) point out that many counselling approaches and psychotherapies may at times be confusing and irrelevant to black and ethnic minority clients’ needs. From inside the approach, Brodley (2004) defends the person-centred approach saying that:

‘Client centred therapy in contrast to other therapies, is inherently multicultural in the best sense... when practiced by an experienced therapist, and is simply free of the defect of generalising about individual on the basis of their race’ (p.47).

Wilkins (2003) similarly argues that client-centred therapy ‘when properly conducted is “culture free”’ (p.59). However Dalal (2006), counters Wilkins’ views saying that a:

‘culture-free position is not only untenable, it is in fact completely culture bound, and that what is actually taking place is that a particular model of the psyche..., is taken to be normative, universal and then applied to all people and contexts’ (p.39).

Finally, Solomon et al. (2004) point to the deficiency of discussion around cultural issues within the field. They talk of a marked discrepancy in the literature in terms of the extent to which cultural issues in counselling are discussed and the extent to which they are addressed through research. They highlight the lack of local research to examine and identify culturally acceptable counselling models. Meanwhile a Kenyan counsellor, Ochieng (2010), while sharing her experience of counselling work with child victims of post-election violence, suggests that Kenya
needs a more specialised counselling that is culturally sensitive to the needs of her people. Elsewhere, McGuiness et al (2001) stress the importance of recognizing the western models of therapy called for in Kenya, but urged the Kenyan therapists to consider the appropriateness of these approaches and adapt them in the light of their own cultural values. In terms of cultural values, Gaskins, (2006) and Gaskins, Haight and Lancy (2006) observe that because of cultural beliefs and practices, family structural arrangements and modes of production have a vast influence on play in terms of its expression, the choice of play partners; its setting and the time allocated to it. As a consequence, therefore, they suggest that play is culturally situated in the familial and that social experiences of young children often reflect what is valued within the cultural community. Tudge & Odero-Wanga (2009) and Whitebread (2009) argue similarly for the importance of culture in play. Cultural attitudes to children’s play based on cultural values, economic conditions, religious beliefs and social structures may also affect how much play is encouraged and supported by parents in any society (Whitebread, 2012). At the same time, there is a greater pressure on children to accept their parents’ ways (Tudge & Odero-Wanga, 2009) in cultures where tradition is highly considered important than in cultures in which creativity and independence are more valued and one is expected to find a rapid change.

**Spirituality within the Kenyan culture and the western model of non-directive therapy**

From a spiritual perspective, Rogers’ philosophy of non-directive therapy is perceived to be based on ‘a secular humanistic assumption of the perfectibility of man, which took no account of Original Sin’ (Scott, 2013), this philosophy contradicts the spiritual beliefs of the majority of Kenyans (Gifford, 2009). 80% of Kenyans are argued to have adapted to Christian teachings, and would often prefer to seek spiritual guidance rather than psychological support when faced with emotional/psychological challenges (Brumfield & Christensen, 2011).

Judged by western standards, Kenya, a predominantly Christian society, exposed their children to extremely strict discipline both at home and at school, based on their interpretation of Christian teachings and on a commonly held belief ‘Spare the rod and spoil the child’ (Hunt, 2009:1065). Accordingly the focus on non-direction and lack of recognition of the importance of religion and spirituality within the approach conflicts with Kenyan values. This lack of focus on religion and spirituality is not confined to the approach. The western model of psychology is
argued to ignore the religious or spiritual aspect of cultures in which it is integrated (Fernando, 2002). However, critics contend that spirituality and religion should not be underestimated as they are part of the overt belief systems of children and young people (e.g. Walker, 2005; West, 2008). As such, they can form critical components of a child’s well-being, acting as a source of strength and hope in adverse circumstances (Walker, 2005). West (2008) considers therapists’ inability to work with clients’ on religion and spirituality issues as unethical, implying therapist’s incompetence.

**Conclusion**

This chapter highlights the range of literature that I reviewed, starting with the origin of the western model of Non-directive play therapy through to its emergence and subsequent practice in Kenya. My initial effort to focus this literature review within the Kenyan context revealed that much of research on this topic has been carried out elsewhere, overwhelmingly in the west by western researchers. Literature written from a Kenyan perspective is scarce and in some cases written by western writers. The lack of published research within Kenya suggests an urgent need for more research into the applicability of the western model of non-directive play therapy practice to the Kenyan context.

Literature from the west focuses on the positive impact of non-directive play therapy. A review of the literature also highlighted an acknowledgment of the relative neglect of cultural issues within the approach and therapy in general. This indicates the potential negative impact of the western cultural beliefs and norms that underpin the approach on its appropriateness for therapeutic work in Kenya. A few case studies emphasise the authors’ experience of the value of play therapy in their work with Kenyan children, although the theoretical orientation is unclear. The limited number of Kenyan non-directive therapist trainees whose views have been published subsequent to training (Hunt, 2006) voiced a preference for the use of non-directive play therapy in working with Kenyan children. However, this needs to be treated cautiously as reflecting the influence of the theoretical orientation of their initial counsellor training as well as an absence of training opportunities within different play therapy approaches. However the same trainees also cited challenges that are likely to derail the development of this model in Kenya unless action is taken. For example, a lack of awareness of the model’s existence and value; lack of professional support in terms of support and supervision as well as lack of play therapy training and play therapy facilities in
Kenya.

The review demonstrates the importance of research into the experiences of Kenyan play therapists following on from their lived experience of applying the non-directive play therapy model within the Kenyan context.
CHAPTER 3: RESEARCH METHODOLOGY

Introduction

As I conceived the idea of investigating the experiences of trained non-directive play therapists using the western model of non-directive play therapy on a Kenyan child, a major challenge was to devise a research question which reflected the questions I wished to explore. Having developed my research question ‘What is the experience of trained non-directive play therapist using the western model of non-directive play therapy on a Kenyan child’, I had a number of essential methodological considerations to address. These included: the methodological approach that would best answer my research question; the data collection techniques to employ; the type of data to collect; how to analyse the data; who will be my research samples/participants; the number of research participants required to gather the required data; where and how to access participants.

According to O’Leary (2004:28), ‘a well-informed research question is crucial because it gives focus, sets boundaries and provides direction’. Knowing what I wanted to know and being able to articulate it as a well-formed question allowed me to assess whether the question was appropriate for the research study. However, O’Leary (2004:28) further observes that ‘research questions can change, shift and evolve during the early stages of a research project so that they can most appropriately accomplish the research tasks’. This was the case with my research question, whose evolution included a change from investigating the ‘relevance’ of the western model to investigating its ‘appropriateness’ before reaching its final more open form of investigating ‘experience’.

For this research study, I chose for my methodology a qualitative thematic analysis approach. Braun and Clarke (2006) are the authors who made the case for thematic analysis to be recognised as a methodology in its own right rather than as just an analytic method. McLeod (2011) argues that for some researchers, being able to identify themes and show how these themes are linked to each other “is the primary goal of qualitative inquiry” (McLeod, 2011: 145). I chose thematic analysis as it allowed me both the means of analysing and reporting the data and facilitated me “staying close to the experience of my participants” (McLeod, 2011:145).

In view of the current debates on decolonising research methods (Khupe & Keane, 2017; Keane & Malcolm, 2004; Ndimande, 2012), I was mindful of how my chosen
methodology sits with African cultures. McLeod (2011:15) postulates that ‘qualitative research represents a form of narrative knowing, grounded in everyday experience...’ Growing up as an African child, I experienced the importance of story-telling as a means of transmitting knowledge from generation to generation. This transmitted knowledge included ‘knowledge of the other’, ‘knowledge of phenomena’ and ‘reflexive knowing’, the same areas of knowledge that, according to Willig (2008), qualitative research seeks to develop and illuminate. As such, I found my childhood experience of story-telling/oral culture based on individuals’ life experiences congruent with the ideologies of qualitative methodology. I agree with Merchant and Dupuy’s (1996) assertion that qualitative methodology aligns with African world-views and may be more appropriate for research exploring non-European culture/s.

Defining key words

The Oxford English Dictionary (2002) defines research as ‘the systematic study of materials and sources in order to establish facts and reach new conclusions’. Meanwhile, McLeod’s (2003:4) definition of research is: ‘a systematic process of critical inquiry leading to valid propositions and conclusions that are communicated to interested others’. For me, the term refers to the searching again or the re-investigating of a particular subject of interest in order to be able to develop a better understanding, which can lead on to new discoveries.

O’Leary (2004) defines a ‘methodology’ as a framework associated with a particular set of paradigmatic assumptions that a researcher uses to conduct research, e.g., scientific method, ethnography, action research. At the same time, O’Leary (ibid) defines ‘methods’ as the techniques a researcher uses to collect data, such as interviewing, surveying and/or participative observation. I would define methodology as a theoretical framework used by a researcher to guide a research study, whereas method refers to the way or style of doing something or carrying out research in this respect.

Methodology Determinant

McLeod (2011) argues that the choice of methodology is influenced by the research question, the phenomenon under investigation, and the objectives of the researcher. O’Leary (2004) and Patton (1990) similarly observe that the nature of a research question is a key determining factor in an exploration of potential
methodologies. In making methodological choices, Bell (1999) points to the importance of the methodology’s ability to provide data that is both appropriate and likely to produce a complete piece of research.

My methodological decision-making reflected such considerations. My choice of methodology was influenced by my research question, the phenomenon I wished to research and the specific objective of my research study, which was for me and my readers to develop a greater understanding of how the western model of non-directive play therapy is experienced within the Kenyan context. Asking myself what I needed to know and how I wished to know it, enabled me to determine the type of data I required, how, where and from whom to collect data, and what to do with the data collected in order to be able to answer my research question.

**Qualitative verses Quantitative methodology**

Based on Bell (1999), O’Leary (2004) and Patton’s (1990) views, I decided to peruse both qualitative and quantitative methodologies in order to gain a better understanding of their nature and facilitate my decision-making. Aware that different methodologies use different methods of collecting data, my immediate priority was to identify what each research methodology could bring to a research study.

According to O’Leary (2004:99) quantitative research is generally understood as reflecting ‘an objective search for singular truths that relies on hypotheses and variables, and is large-scale’. Quantitative researchers collect factual data and study the relationship of one set of data to another, using techniques that are likely to produce quantified and if possible, generalizable conclusions. This contrasts with researchers adopting a qualitative perspective. In brief, qualitative enquiry (Schwandt, 2001:84) deals with human experience ‘as it is lived, felt, undergone, made sense of and accomplished by human beings’. Researchers are more concerned with understanding individuals’ perception of the world, with a search for insight rather than statistical analysis. ‘They doubt whether social ‘facts’ exist and question whether a ‘scientific’ approach can be used when dealing with human beings’ (Bell & Waters, 2014:9). O’Leary (2004:99) describes perceptions of qualitative research as ‘a subjective, value-laden, biased, and ad hoc process that accepts multiple realities through the study of a small number of cases’.

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Qualitative inquiry is also concerned with language. As McLeod (2011:3) argues, a primary aim of qualitative research is 'to develop an understanding of how the social world is constructed through talk and language'. Polkinghorne (2005) argues that qualitative research values the collection of language data which helps illuminate the experience or context that the researcher is investigating. Researchers conducting qualitative descriptive studies seek descriptive validity or accurate accounting of events (Sandelowski, 2000).

The descriptions of quantitative and qualitative methodologies highlighted above gave me an insight into which approach would most appropriately answer my research question, concerned as it was with the quality of play therapists’ experiences. I decided against a quantitative approach based on measurements and statistics. Instead, I chose a qualitative approach which, as Willig (2008) argues, is concerned with the quality and texture of experience and the meanings attributed to events by the research participants. As a practitioner-researcher, I was interested in researching play therapists’ lived experiences of practice using the western model of non-directive play therapy. I wanted to capture their meaning-making and the precise way they talked about their experiences. A qualitative approach seemed best suited to providing the rich individual descriptive accounts I sought.

My choice of a qualitative approach does not imply that I believed it somehow ‘better’ than a quantitative approach. Methodological design is about informed decision making that involves weighing up pros and cons and deciding what is most appropriate, given one’s specific context. As O’Leary (2004) strongly argues, all researchers need to move towards reflexive awareness and informed choice in their decision-making. O’Leary points to three key prerequisites for credible design. These are that the design addresses the question, suits the researcher, and leads to a research project that meets ethical requirements and reflects the resources, time and access available. These three pre-requisites guided me in my research design.

**Qualitative Methodology**

According to Fossey et al. (2002: 717):

‘Qualitative research is a broad umbrella term for research methodologies that
describe and explain persons’ experiences, behaviours, interactions and social contexts without the use of statistical procedures or quantification’.

As Brantlinger et al. (2005) note, qualitative research encompasses a large number of methodological approaches. Among qualitative approaches are grounded theory, interpretative phenomenological analysis (IPA), phenomenology, heuristics and narrative research, just to mention a few.

My adoption of a qualitative methodology reflected my aim of developing an understanding of the experiences of non-directive play therapists and the meanings they attached to them. A central feature of qualitative research according to Fossey et al. (2002:717) is that ‘the research participants’ subjective meanings, actions and social contexts of participants, as understood by them are illuminated’. This reflects my aim in this study. As McLeod (1999, 2003) argues, qualitative research describes in words rather than in numbers and is concerned with gathering and analysing attitudes, thoughts and feelings. He describes it as based on a process of systematic enquiry which is built around the collection and analysis of accounts given by people regarding their experience. Such processes and characteristics gave me confidence that its application would provide the data I sought, which was the subjective description of non-directive play therapists’ experiences and the personal meanings that they attached to their lived experiences of working with children. Because qualitative research is more consistent with many of the values of counselling psychology, such as people’s feelings, experiences and beliefs (McLeod, 2001), I perceived it as credible and relevant to my study as a practitioner in this field.

As I have indicated, there are a large number of qualitative approaches and I considered a range of potential approaches. After much reading and discussion within academic supervision, I identified thematic analysis as my preferred methodological approach. A number of factors influenced my decision. Sanders and Wilkins (2009) describe it as a widely used qualitative analytic method appropriate for research beginners. While approaches such as IPA and grounded theory tend to be associated with particular theoretical and epistemological positions, thematic analysis is argued to be independent of theory or epistemology (Braun and Clarke, 2006). This theoretical freedom is argued to contribute to its flexibility and wide applicability and, as an approach, it is argued to facilitate the production of rich, detailed accounts of data (Braun & Clarke, 2006). I discuss such characteristics further in following sections.
Thematic Analysis


‘thematic analysis should be seen as a foundational method for qualitative analysis. It is the first qualitative method of analysis that researchers should learn, as it provides core skills that will be useful for conducting many other forms of qualitative analyses.’

Braun and Clarke point to how the thematic analysis has been identified as commonly practiced across approaches. It has been variously described as a skill (e.g. Holloway and Todres, 2003), tool (e.g. Boyatzis, 1998) or an analytic process (Ryan and Bernard, 2000). Braun and Clarke, however, argue that it should be regarded as a method in its own right. McLeod (2011:146), similarly described it as a ‘stand-alone method that fulfils most of the functions of grounded theory and other methods of analysing the meaning of interview transcripts’. McLeod echoes Braun and Clarke’s endorsement of its flexibility and accessibility.

I chose thematic analysis as a means of both analysing and reporting the data as well as a process that facilitated me “staying close to the experience of the informants” (McLeod, 2011:145) as an insider practitioner and also as an outside researcher. The approach enabled me, the researcher, to identify themes and show how these themes are linked to each other “which is the primary goal of qualitative inquiry” (McLeod, 2011:145). Themes can be identified in an inductive or ’bottom up’ way (Frith and Gleeson, 2004) or in a theoretical, deductive or ‘top down’ way (e.g. Boyatzis, 1998). My approach of choice was inductive. Inductive analysis is data driven and, as in grounded theory, involves coding the data without the application of a pre-existing coding frame or analytic preconceptions (Braun and Clarke, 2006). The aim is to ground the themes in the data themselves (Patton, 1990).

Braun and Clarke (2006: 82) argue that a theme conveys:

‘something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set’.

Mirroring Braun and Clarke’s arguments for its utility, thematic analysis facilitated my identification, analysis and reporting of patterns within the data, as well as its
organisation and rich detailed description. They argue that the researcher’s judgment plays a crucial role in the identification of themes. My objective in telling the story of the research participants was to arrive at an understanding of the data through seeking out ‘themes’ which collectively convey the significant and typifying elements of the stories told. For a rich description of the data set, it was important that I determined the type of analysis I wanted to do, and the claims I wanted to make, in relation to my data set. My aim was to construct themes which described the essence of the collected stories as a whole. Since I desired to provide a rich thematic description of my entire data set for my readers to get a sense of the predominant or important themes, this meant that the themes that I identified, coded and analysed were to be an accurate reflection of the content of the entire data set. In such an analysis, even though some depth and complexity is necessarily lost, a rich overall description is maintained.

Furthermore, thematic analysis according to Braun & Clarke (2006) is a useful method for investigating an under-researched area. This was relevant to my study as I was investigating the experience of non-directive play therapists within Kenya whose views are either not known or little researched. My choice of thematic analysis was also compatible with the underlying ontological and epistemological positioning of this study.

**Weaknesses of Thematic analysis**

Despite the benefits of thematic analysis highlighted above, it also has a number of potential weaknesses. This section highlights some of the acknowledged weaknesses of thematic analysis and how I sought to mitigate them.

Braun & Clarke (2006) describe thematic analysis as ‘a poorly branded’ method, in that it does not appear to exist as a ‘named’ analysis the way other methods do. As such it is often not explicitly claimed as a method of analysis. Lack of clarity regarding researcher’s data analysis and assumptions informing the analysis in this approach according to Attride-Stirling, (2001) implicates research evaluation. The fact that the approach is poorly demarcated and claimed, yet widely used, is likely to suggest that the approach is mainly applied by researchers without the knowledge or skills to perform supposedly more sophisticated ‘branded’ form of analysis. Furthermore Holloway & Todres,(2003) observes that thematic analysis is simply ignored in textbooks of qualitative methods, while Vaismoradi et al. (2013) argues that the availability of only a few papers introducing thematic
analysis can be concluded to mean that the approach has not been completely described, leaving a number of unanswered questions about the approach. At the same time, Braun & Clarke (2006) suggests the scarcity of information regarding the process of data analysis in qualitative methodology papers has resulted in a diversity of perspectives on how the approach is used in a research practice. To deal with these, Gbrich, (2007) recommends a unified and standard data analysis protocol to be implemented by all researchers. At the same time, Vaismoradi et al (ibid) recommends that the approach be clarified in relation to its epistemological roots and connections.

Lack of scientific vigour and credibility associated with quantitative methods, is another criticism level against all qualitative approaches where vigour in qualitative studies is most commonly achieved through credibility, dependability, conformability and transferability (Lincoln & Guba, 1985). However, due to the pure qualitative nature of thematic analysis, peer checking of intercoder’s reliability is not always possible due to the scepticism about the value of such testing (Loffe & Yardley, 2004). Subsequently, a practical way to improve vigour in a thematic approach according to Ballinger et al. (2004) was for me, a researcher to maintain a personal research diary. Another way of judging the quality of findings suggested by Krippendorff (2004) was for me the researcher to establish that new insights into the studied phenomenon provided increased understanding of the phenomena.

Due to its theoretical freedom, thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex account of data. However, Holloway & Todress (2003) foresees the possibility of flexibility provided for in this analytic approach leading to inconsistency and lack of coherence in data analysis. A way of ensuring consistency and coherence suggested by Polit & Beek, (2003) and Hoye & Severinson, (2007) was for me the researcher to produce evidence of quality data analysis of my study by evaluating the conceptual and methodology decisions I made.

**Epistemology and ontology**

Whether it is made clear or not, the researcher’s understanding of how knowledge is gained inevitably leads to the study having an epistemological and ontological positioning (Sanders & Wilkins, 2009). As Bonds (2004:9) asserts:

*what is considered to be good practice in data collection and analysis is highly*
dependent on the selected research design and its underpinning philosophy about
the nature of being (ontology), the theory of knowledge (epistemology) and the
systematic application of research design and methods (methodology).

In this research study, I was indeed guided by how I think knowledge is constructed,
my belief about the nature of human beings and the ethical and personal values
that I bring to my study.

Ontology relates to the nature of the world, asking ‘what is there to know?’ Willig
(2008:13) identified ontological positions as ‘realist’ and ‘relativist’. A realist
position is that the world is made of structures and objects which are connected
via cause-effect relationships. In contrast, a relativist position embraces multiple
realities and meanings and rejects the realist view of the world as a law-bound
place. Relativist ontological understandings guide this study.

In terms of epistemology, I identify with a constructivist position. In humanistic
terms, I understand knowledge as subjective. I believe individuals construct their
knowledge and understanding of the world by reflecting on their experiences and
that each individual constructs a personal framework to making sense of their
experience. This allies me with the philosophical position which underpins much
qualitative research, characterised by the belief that “meaning is socially constructed and
that ‘truth’ is subjective and depends upon individual’s point of view” (Sander &
Wilkins, 2009:14).

Having chosen thematic analysis as my ideal approach for researching the
experiences of non-directive play therapists, my concern shifted to deciding who,
how and where to recruit my research samples.

Research Sample and recruitment

Qualitative sampling is concerned with ensuring the adequacy and appropriateness
of the sample in terms of producing information-rich data (MacDugall and Fudge,
2001). As Fossy et al. (2002) state, this involves identifying participants who can
best inform the study. It also involves ensuring the sufficient sampling of
information sources in order to both address the research question and develop a
full description of the phenomenon under study (Popay et al., 1998). Hence, as
Polkinghorne (2005) observes, sampling is purposive in that participants are
deliberately selected to provide the optimum information-rich data. It is also
criterion based, in that the researcher applies specific criteria in recruiting the sample. Beyond purposive and criterion-based sampling, the specific sampling strategies according to Morrow (2005) depend on the purpose of the study as well as on the depth and breadth of information one wishes to obtain.

To ensure information-richness based on the appropriateness and adequacy of data collection, I employed a purposive and criterion-based sampling strategy. I selected participants who are professional counsellors and trained practising non-directive play therapists with more than two years’ practical experience of non-directive play therapy work with Kenyan children. It was my conviction that only practising trained non-directive play therapists with more than two years’ experience would be able to give rich descriptive accounts and sufficient depth of information on their work experiences.

No fixed minimum number of participants is necessary to conduct sound qualitative research; however, a sufficient depth of information needs to be gathered to provide a full description of the phenomenon being studied. As Fossy et al. (2002:726) argue: “qualitative sampling may involve a small number of participants, while the amount of data gathered can be large, with many hours of participant interviews (P.726)”. Patton (1990) similarly argues that “validity, meaningfulness and insights generated from qualitative inquiry have more to do with information-richness than with sample size (P.185)”. According to Morrow (2005), what is more important than sample size are the procedures applied, the quality, length and depth of interview data and the variety of evidence collected. For qualitative research using semi-structured interviews, the recommended sample size varies substantially. For example, Pollio, Henley and Thompson’s (1997) refer to sample sizes of between three and one hundred.

My choice of a sample size of six was based on my research methodology (i.e. qualitative with thematic analysis), data collection method (semi-structure interviews) and the availability of potential participants. I felt that six interviews had the potential to supply adequate data while recruiting more than six participants might provide me with an overwhelming amount of data. Secondly, owing to lack of practice opportunities due to the limited number of clients seeking play therapy in Kenya, only a small number of trained non-directive play therapists met the criterion for participation of having two years practical experience. My six research participants were trained non-directive play therapists from different ethnic and cultural
backgrounds who have worked with Kenyan children in Nairobi City. Among them were five female non-directive play therapists of Kenyan origin, all married and living with their nuclear families, and a non-Kenyan male church minister, working in Kenya. All participants were in their late 40s and mid-50s. All stated they had been in professional practice for more than two years and had experienced working with Kenyan children using the western model of non-directive play therapy. They were all counsellors trained within the person centred orientation.

Working in a person centred training institution that is also engaged in training non-directive play therapists; I was able to identify from the institution’s database my ideal sample and invited them for a briefing session. Assuming that not all of those invited would be available or willing to participate in the study, I invited more than the six I required. This conveniently left me with the required number when a number did not respond to my invitation. Because I work within the play therapy training organisation from which I recruited my participants, I needed to be aware of the issues of power and my dual role. I needed to pay attention to how I may be perceived by potential participants and how this might influence our interactions. As O’Leary (2004) argues, in order to ensure ethical treatment of participants and authenticity in data collection, any perceived power imbalance needed to be negotiated. As a person centred and qualitative researcher, my intention was to understand and experience as deeply as possible the world of my respondents as they experienced it. This intention, in person centred therapy, leads counsellors to pursue a position of non-directivity. However, it has been argued that non-directivity does not equate to a lack of influence. As Greenberg (2004:54) notes, ‘non-influence is impossible; however, the intention to try consciously not to influence what a person decides or chooses is possible’.

While having the intention not to influence my respondents, as a researcher, I needed to remember that I have a role of power. According to O’Leary (2004:43) a researcher has power and exercise power "derived from being in a position to conduct research, power that comes from being in a position of control and authority”.

As Feltham and Horton (2000) argue, power in itself is neither good nor bad: what is important is having awareness of holding power and paying attention to how it is used. Rather than ignore or misuse my power, I wanted to use whatever power in a responsible and ethical manner. I aimed to further the power of the participants, to enlighten rather than to mystify, to respect rather than exploit. I
also needed to focus on the obligations attached to my position rather than its advantages.

Negotiating power in the research relationship required me to maintain awareness of my subjectivities. I also needed to consider how my position might impact on the researched and the research process. I attempted to manage the research process in a manner characterised by integrity and authenticity that ensured the dignity and welfare of the participants. As O’Leary (2004) argues, this involves: showing respect for their cultural beliefs; treating them in a manner that is just and equitable; obtaining informed consent from all participants; ensuring the absence of harm; protecting the confidentiality of the participants. Aware of my position of power, I sought to ensure that prospective participants did not feel obliged to participate in my research study by sending invitations with information concerning the purpose and process of my research study via email, avoiding a face to face invitation. I also gave ample time for my invited participants to decide whether or not to participate in my research study. I indicated that participation was voluntary and that they could withdraw at any stage in the research process. I also made arrangements for psychological support should any participant need such support as a result of participating in the study.

I also kept in mind that ethical behaviour is more a way of being than a following of rules. As Bond (2002) comments, researchers should not rely uncritically on ethical codes and/or institutional bodies to guide their conduct. As he argues, such uncritical reliance might in itself be unethical and the researcher ultimately must take responsibility for ensuring the ethical nature of their research activity. Having recruited my research samples, I then moved to data collection exercise. However, before embarking on data collection exercise, I considered it important to identify a data collection mode that would be appropriate to my study based on my research methodology.

**Data Collection**

The common modes of qualitative data collection are interviews, focus groups and observations (Fossy et al., 2002). Qualitative research interviews aim at gathering participants’ social life experiences relating to their feeling through the use of unstructured or semi-structured interviews.

According to Fossy et al. (2002:727):
‘Unstructured interviews are usually conducted in an everyday conversational style, in which participants take the lead... in telling their story rather than the researcher directing the interview. Semi-structured interviews are used to facilitate more focused exploration of a specific topic, using an interview guide ... containing a list of questions and prompts designed to guide the interview in a focused, yet flexible and conversational manner. Semi-structured interviews offer sufficient, flexibility for follow-up questions to find out more about what the interviewee meant by the answers given to the main questions’.

I found a semi-structured approach advantageous in ensuring ‘sensitivity to participants’ language and privileging their knowledge’ (Fossey et al., 2002:727). However, a disadvantage of semi-structured interviews cited by Sander & Wilkins (2009) is their time-consuming nature both as a means of collecting data and analysing data, due to the length of interviews and the unpredictability and volume of data produced. My experiences echoed this.

In carrying out the research, my aim was to facilitate a more focused exploration of non-directive play therapists’ work experiences. This implied gathering descriptions of non-directive play therapists’ experiences in their work with children with respect to interpretation of the meaning of the described phenomena. I was convinced that using semi-structured interviews would facilitate the more focused exploration I sought. As Sanders & Wilkins (2009) argue, by using an interview guide containing a list of questions and prompts designed to guide the interview in a focused, yet flexible and conversational manner, semi-structured interviews are well-suited to the exploration of specific topics. Fossey et al. (2002) point to the danger of inadvertently asking leading questions, which can lead to the themes identified reflecting the questions asked. They also caution that it is impossible to eliminate leading questions entirely from a conversation or interview. The solution is not to try to eliminate such influences but to try to analyse the different types of leading questions and their influence upon the answers given. Such understandings guided the construction of my interview guide and the interviews were carried out following an interview guide focusing on certain themes.

Having chosen to use semi-structured interviews for my data collection, the interviews were conducted at a time and place convenient for both interviewee and interviewer, on a one to one basis. The interview length was between forty five minutes to one hour. In conducting the interviews, I began with a social
conversation aimed at creating a relaxed and trusting atmosphere. Following this opening, I gave the interviewee a few moments to focus on their experience of working with children using non-directive play therapy by focusing on moments of particular awareness and impact. I then encouraged them to describe the experience fully. In the position of an interviewer, I was responsible for creating a climate in which the research participant would feel comfortable and would respond honestly and comprehensively (Moustakas, 1994).

As a means of maintaining anonymity, participants were assigned pseudonyms and the interviews were audio-taped and transcribed word for word for the purposes of data analysis. The transcripts together with the tapes constituted the material for the subsequent interpretation of meaning. The main task in interviewing according to Kvale (2005) is to gain an understanding of the meaning of what is said and how it is said. The desired data is qualitative and descriptive. I sought descriptions of experiences in the therapists’ world. I aimed at gathering rich and presupposition less descriptions of the non-directive play therapists’ lived experience. As Kvale notes, the interviewing process possesses certain characteristics. It is focused on certain themes. It is dynamic, open to ambiguity and change. It is based on an interpersonal interaction and its quality is dependent on the sensitivity of the interviewer. It has the potential to be a positive experience.

According to Kvale, (2005;178):

‘The reciprocal influence of interviewer and interviewed on both the cognitive as well as an emotional level is, however, not primarily a source of error but a strong point of the qualitative research interview’ (178).

Rather than seek to reduce the importance of the interpersonal interaction in the situation, what matters is to recognize and apply the knowledge of this interaction in the interview. As an interviewer, I was conscious of the inter-personal dynamics within the interaction and took these into account both within the interview situation and in later analysis of the finished interview. Information gathering during data collection was recorded in a manner that enabled me to analyse the data, and to describe subjective meaning and social context from the data. The aim of the analysis was to understand the meanings given to a situation as expressed by interview participants (Fossey et al., 2002). However, prior to analysing my data, I recorded and transcribed the interviews.
Interviews’ recording and transcription

To be able to carry out a full analysis of the data, it was necessary for me to audio-record and transcribe the interviews as most qualitative methods of analysis requires verbatim transcription of the interview materials (Willing, 2008). Within the interviews, because participants may not be entirely comfortable and relaxed in the presence of a tape-recorder, I felt it important to explain why the recording was being made and how it was going to be used. Prior to commencing my interviews, I ensured that electricity was available in the recording room; that the recorder was in a working condition and placed the tape recorder on a table placed between the interviewee and myself, the interviewer. Such positioning allowed me the researcher to keep an eye on the recorder and to ensure that it was taping the interview, and also enabled me to change the tape when necessary. All these considerations were made to avoid the frustration of finding that an hour-long interview has not been recorded or are inaudible.

After the interviews, I repeatedly listened to the recorded interviews from the tapes prior to their transcription and then re-listened to them alongside reading the transcript when coding. Transcribing the data enabled me to get close and familiar with the data. However, it required a lot of attention to the details of punctuation and pauses to try and ensure I was effectively capturing the participants’ meanings.

Data Analysis

Bracketing off

Whilst conducting the analysis, I attempted to bracket off my assumptions. I paid attention to the potential impact of my position as an insider practitioner. I focused on my subjectivity or viewpoints and, as in therapeutic practice, remained mindful of considering alternative meanings or interpretations as stipulated by McLeod (2001). Reflecting on bracketing off, Willig (2008:25) suggests that ‘a good way to obtain detailed and comprehensive accounts from interviewees is to express ignorance...’ In line with this, I had attempted to conduct my research interviews as ‘a naïve interviewer’. I adopted a naïve stance in order to encourage my interviewees “to state the obvious’ and thus to give voice to otherwise implicit assumptions and expectations” (Willig, 2008:25). What was important to me was that the analysis retained the information I needed from their verbal accounts and in a way which was ‘truthful’ to its original nature (Braun and Clarke, 2006).
The Analytic process

I decided to analyse my data manually. I felt that analysing my data manually would offer me the opportunity to be sensitive to individual participants’ use of language, pause and non-verbal communication. At the same time, I considered that manual analysis of data would fully facilitate any in-depth meaning of what could be particularly poignant, interesting or relevant data that could be analysed in the process of re-reading constantly, cross referencing and comparing to other pieces of data.

Thematic analysis procedures

As stated previously, according to Holloway and Todres (2003), thematic analysis should be seen as a foundational method for qualitative analysis, and the first qualitative method of analysis that researchers should learn as it provides core skills that will be useful for conducting many other forms of qualitative analysis. It is considered ‘an essentialist method which reports experiences, meanings and the reality of participants’ (Braun and Clarke, 2006:81) and offers flexibility as one of its benefits. Its flexibility allowed me, the researcher, to determine themes in a number of ways. However I remained mindful throughout of the importance of consistency and transparency in the analytic methods applied.

Step by step guide to thematic analysis

In analysing data, I followed Braun and Clarke’s (2006) six phase step by step guide to doing thematic analysis as appended below:

Phase I: Familiarizing myself with my data

The process of familiarising myself with the data started during the data collection process, using 1:1 semi-structured interviews with my research participants. Therefore, I entered phase 1 of the data analysis with some familiarity with the data and some initial analytic interests or thoughts. However, in this phase, transcription of the interviews led me to more fully immerse myself into the data, moving backward and forward, actively listening to my participants’ tape-recorded interviews many times during the transcription process. The process of transcription was time consuming and at times difficult, especially where the interviewee’s voice became inaudible. Most times I listened to the tapes alone for confidentiality purposes and to aid concentration. However, under such
circumstances I found myself inviting the interviewee to join me as I listened to the taped interview to be able to make sense of what was said. For example, on one occasion, when a section of a tape was inaudible, I invited my interviewee to join me in listening and making sense of what had been said during the inaudible sections of the interview. On another occasion, I asked yet another participant if we could have a repeat interview because the entire recorded interview was completely inaudible, which my participant consented to, though it took considerable amount of time to reschedule the interview due to this participant’s other commitments. Despite all that, this phase of transcribing was an excellent way for me to start familiarising myself with the data as I noticed issues of particular interest in the data.

Phase 2: Generating initial codes

According to Sanders & Wilkins (2009), coding in its simplest form is the description of events in single words or prose. As they argue, there is no set method or procedure used for coding and a successful coding, ultimately, is a product of common sense and thoughtful planning. In this research study, I followed guidelines produced by Braun and Clarke (2006). I was also informed by Sanders & Wilkins (2009), who talk of the value of using single words to attach meaning to differing elements of participants’ experience and to reduce data to a manageable size. They also refer to the importance of comparing and cross-referencing the main themes within each account in order to consider what the difference and similarities were in the data set as a whole.

This phase began after I had read and familiarized myself with the data and generated an initial list of ideas about what the data contained and what was interesting about the content. The phase involved the production of initial codes within the individual transcripts. These initial codes identified features of the data that appeared interesting to me, the analyst, and referred to ‘the most basic element of the raw data that could be assessed in a meaningful way regarding the phenomenon’ (Boyatzis, 1998: 63). As I organised my data into such meaningful groups, I sought to ensure that the themes were transparently ‘data-driven’, i.e. rooted in the participants’ words. Working systematically through the entire data set, I gave full and equal attention to each data item, and began the process of tentatively noting interesting aspects within and across the data items that might potentially form the basis of repeated patterns (themes) across the data set.
See Table 1 below for an example of codes applied to a short segment of data in this study.

<table>
<thead>
<tr>
<th>Data Extract</th>
<th>Coded for</th>
</tr>
</thead>
</table>
| ... you know a child who has lost their parent..., they are processing the loss. But through the use of play therapy, the child can be able to express themselves, express their loss; mourn the loss of the parent; express anger... and at some point reach at some point of acceptance. (Abich - Appendix.3) | Therapeutic Outcome  
Expression of feelings |

Table 1: Data extract with codes applied (from Abich’s interview transcript – See Appendix 3).

**Phase 3: Searching for themes**

Phase three began when I had coded and collated all data and had a list of different codes that I had identified across the data set. Phase three involved sorting the different codes into potential themes and collating all the relevant coded data extracts within the identified themes. Here I started to analyse my codes and to consider how different codes could be combined to form an overarching theme. I did this using a thematic mind-map while writing the name of each code with a brief description on a separate piece of paper and organizing them into theme-piles. See a thematic map of my initial stage in ‘Diagram 1’ within my ‘Finding Chapter’.

**Phase 4: Reviewing themes**

Phase four involved the refinement of a set of candidate themes, i.e. ‘themes with enough data to support them’ (Braun and Clarke, 2006:91). At this stage, I read all the collated extracts and considered whether they appeared to form a coherent pattern. On being satisfied that my candidate themes formed a coherent pattern and adequately captured the contours of the coded data, I then moved on another level of this phase, that is, the second level where I considered the validity of
individual themes in relation to the data set. At the same time, I considered whether my candidate thematic map ‘accurately’ reflected the meanings evident in the data set as a whole. At this point, I re-read my entire data set to ascertain whether the themes ‘work’ in relation to the data set and to code any additional data within themes that could have been missed in earlier coding stages. The outcome of my refined thematic map can be seen in a thematic table (table 1), within my findings chapter and tells an overall story about my data.

**Phase 5: Defining and naming themes**

At this point, I defined and further refined the themes that I have presented for my analysis and analysed the data within them. Defining and refining meant (Braun and Clarke, 2006: 92) ‘identifying the essence of what each theme is about and determining what aspect of the data each theme captured’. I did this by going back to collated data extracts for each theme and organizing them into a coherent and internally consistent account, with accompanying narrative and identifying what is interesting about them and why. Part of the refinement was for me to identify whether or not a theme contained any sub-themes, (i.e. themes within a theme). I had identified two overarching themes in Non-directive play therapists’ experiences of using the western model of non-directive play therapy in the Kenyan context. Within each theme, three sub-themes were identified: under appropriateness: the sub-themes were Expressive, Empowerment and Freedom. Meanwhile themes indicating inappropriateness: were directive education system, cultural barriers, social economic status and lack of awareness. Phase five ended with clearly defined themes that could describe the scope and content of each theme in a couple of sentences.

**Phase 6: Producing the report**

Phase six began when I obtained a set of fully worked-out themes, and involved the final analysis and write-up report. My write-up report provided evidence of themes within the data and also made arguments in relation to my research question. Though Braun and Clarke’s (2006) step by step guide to thematic analysis provided a way of systematically making sense of coding the data, as Patton (1990) observed such guidelines are not rules and hence needed to be applied flexibly to fit my research question and data.
Validity & Reliability/Trustworthiness

The terms reliability and validity (Sanders & Wilkins, 2009:42) are ‘expressions of the desire to establish the trustworthiness of not only individual measurements but also hypotheses and theories’.

According to Sanders & Wilkins (2009:120):

‘validity is about knowing that measurements can be trusted’ while ‘reliability is about knowing that if the same procedure is conducted by a different person, a similar conclusion will be reached’.

The description of validity above clearly indicates that validity is a concept rooted in quantitative research where findings are based on figures. In qualitative research, the issue of validity according to Willig (2008) addresses the possibility of ensuring that data collected from research participants really addresses the question we want answered. This reflects a difference between qualitative and quantitative methods in terms of establishing validity. As Sanders & Wilkins (2009) argue, qualitative research relates to ‘stories and understanding the humanness of human beings’ (pg.121) and thus, it is inappropriate to seek validity in figures. Trustworthiness, however, remains an important feature of all research, whatever the approach. The question of the findings of a research study being trusted is a key issue. The trustworthiness of a qualitative research process and findings according to Sanders & Wilkins (2009:123) is related to a number of issues. It focuses on the research question and the procedures followed in responding to the research question (Sanders & Wilkins, ibid). It involves decisions concerning the researcher, who they are, their motivations and conduct within the research. It also involves decisions relating to those contributing the data. As Sanders and Wilkins (2009:123) argue, qualitative research is about ‘human encounter’. Key is the transparency on the part of the researcher concerning their positioning and decision-making. Therefore, by locating myself in this research study, the trustworthiness of this research results and findings may be enhanced (Sanders & Wilkins, 2009).

Locating myself

According to Sander & Wilkins (2009:123):

‘Whatever methods you adopt as a qualitative researcher, they will involve you as
a person in a way traditionally avoided in quantitative research. A quantitative approach does not acknowledge any reasons other than intellectual reasons for making decisions regarding research... Since qualitative research is about humans, by humans and of humans we would not seek to eliminate the human touch. We must mindfully include it in order to understand it better. As a starting point, you should reflect on why you want to do the particular piece of research, what you want to know from it; how and to whom you want to convey what you the findings and most importantly how, who, and what you are may influence what you do and what you say’. Therefore, guided by Sander & Wilkins’ views, as a person centred researcher researching the experience of Kenyan play therapists, I sought an approach that was congruent with my personality, values and research question. Whilst considering methodological choices, I was clear in choosing qualitative research because ‘it hopefully facilitates me as a researcher to generate data which give an authentic insight into people’s experience’ (Silverman, 1993:91).

As a person centred therapist and researcher, my personal and professional philosophy is holistic and humanistic. I believe in the humanistic principles of ‘trust, integrity and trust-seeking capacity of the person and in the sense making capacity of individuals and groups’ (McLeod, 2001:122). I consider that my choice of qualitative methodology and thematic analysis is congruent and consistent with my practical methods and with my belief in the importance of working in an atmosphere of trust, acceptance and collaboration.

Qualitative methodology enabled me to take the stance of naive inquirer which Morrow (2005) considers important when the interviewer is to some degree an insider. As a practicing play therapist, I am an insider by way of being familiar with the phenomenon of inquiry. However, taking a naïve stance as a qualitative researcher, helped me to be conscious about whose reality I was representing in the research (Denzin and Lincoln, 2000). For example, when on one occasion I was faced with the challenge of transcribing due to the audio tape being inaudible, I had to call my interviewee to come and listen to the taped interview in order to make sense of the un-audible recorded statement. This was helpful especially in retaining the accuracy of my interviewee’s intended meanings during the transcription process.

Aware of transference and counter-transference in my practice as a therapist, I am experienced in ‘bracketing’ and have found the ability to ‘bracket’ a useful transferable tool when conducting data analysis. In this process, I focused on
understanding my participants’ lived experience, as well as being authentic with them about my aims and stance with the hope of gaining an insight and understanding of their experiences. I need to acknowledge, however, that the data that emerged from the research was not independent of my involvement. In qualitative research, as a human encounter, my involvement in this research process inevitably influenced the outcomes. However, my hope is that my participation as researcher helped facilitate the process and bring relevant understanding, knowledge and experience to the researcher role.

Research Practice Ethical Considerations

Prior to commencing my data collection, ethical approval was granted by the University of Manchester’s Ethics Committee. The committee viewed a written application containing a copy of my information sheet and the participant consent form informing interested therapists about the purpose of my research, their rights as participants and the responsibilities of the researcher. There were no incentives for participants. However, the equivalent of £10 transport refund was given to participants together with a commitment that they would receive details of the findings once the study was completed.

McLeod (2003:167) asserts that:

‘it is necessary to give careful consideration to ethical issues at all stages of the research process...’  He further notes that ‘research in counselling is bound by a general set of ethical guidelines applicable to all types of investigations of human subjects, but also generate unique dilemmas and problems distinctive to the nature of the counselling process’ (pp.167).

In this study, I was interested in gathering thorough and detailed accounts of the experiences of the play therapists. This involved developing a close relationship with the participants, and encouraging them to talk openly and honestly about themselves and their experiences. As what emerges for the informant may be painful and distressing (West & Byrne, 2009), it was my responsibility as researcher to do everything possible to ensure the well-being of the person (McLeod, 2003).

Subsequently, in carrying out qualitative research on the experience of non-directive play therapists, I adhered to the basic ethical principles according to Beauchamp and Childress, (1979) and Kitchener (1984), cited in McLeod (2003:167) as:
1. ‘beneficence (acting to enhance research participants’ well-being),
2. non-maleficence (avoiding doing harm to my research participants),
3. autonomy (respecting the right of the participant to take responsibility for self), and
4. fidelity (treating everyone in a fair and just manner (i.e. equally’).

As a reflexive researcher, I was also aware and sensitive to, cultural difference and the gender of my participants (Cloke et al., 2000; Denzin, 1997). I also arranged for counselling services should one be emotionally overwhelmed during the interview process. Three fundamental points about the relationship between ethics and research design in counselling are according to McLeod, (2003):

“It is impossible to design ethically neutral research; Ethical decisions always have some bearing on the quality of results obtained in a study; Ethical issues that arise through the conduct of the research are the same as those that occur in the context of counselling practice” (pg.167).

As West (2002) argues, being ethical not only involves wrestling with the issues in a systematic and considered way, but also taking personal ownership of the responsibility for acting ethically. Bond (2000) invites individuals not to rely uncritically on any ethical code but to cultivate an attitude of ‘ethical mindfulness’ instead. Addressing moral and ethical dilemmas associated with qualitative researchers, McLeod (2011:66) considers it helpful for a researcher to distinguish procedural ethics from ethics in practice stating that:

...“procedural ethics refers to the ethical procedures that are required by institutional ethics committees and boards, in terms of participants’ information sheets, consent forms and the like. By contrast, ethics in practice refers to the moment-by-moment ethical procedures that take place in interaction with research participants”.

Subsequently, McLeod (2011) argues that these situations are similar to the kind of things that can happen in therapy, therefore as a researcher as well as a therapist, I was in a good position to know how best to respond. McLeod (2011) further, recommends having access to effective supervision from an experienced researcher or peer group, a key factor in management of ethics in practice for researchers.

Finally, a common theme across this set of issues concerns the abuse of power on the part of researchers. Though the issue has been discussed earlier on in this paper, I would add that, client and counsellor ideally engage in an alliance which is
primarily in the interests of the client. The participation of researchers in this relationship introduces a new source of power and control, and a new and different set of interests. Strategies for dealing with these issues fall into three main categories; appropriate research design, ensuring informed consent and maintaining confidentiality (McLeod, 2003) all of which I attempted to comply with during this research process. For instance, since good qualitative research data should be ‘thick data’ (Geertz, 1973), such richness of data risks breaching confidentiality. To avoid breaching confidentiality, among other things, I used fictitious names when referring to my research participants while transcribing my data.

However, being a practising therapist as well as a researcher, observing the same ethical procedures in my practice and having access to supervision, I did not encounter any major research ethical dilemmas during this research exercise that I can talk about. This was because being aware of my own researcher’s position of power, I indicated that participation was voluntary and one could withdraw at any stage should they wish to discontinue their participation and assured them of confidentiality. Hence I feel they made informed choice to participate in my data collection exercise. I also made arrangements for anyone who could have needed a psychological support as a result of his/her participation in my research data collection to access counselling elsewhere.

Conclusion

Qualitative research methodologies are oriented towards developing understanding of the meaning and experience dimensions of human lives and their social worlds. In non-directive play therapy, they are useful in developing knowledge in poorly understood and complex areas, such as understanding the subjective experiences of trained play therapists using the western model of non-directive play therapy in working with a Kenyan child, the meanings ascribed to these experiences, and interactions of participants with their child clients. Good qualitative research is characterized by congruence between the perspective (or paradigm) that informs the research questions and the research methods used. The quality of qualitative research and standards for ethics in qualitative research are also interconnected, so that central to both issues is whether the subjective meaning, actions and social context of those being researched is illuminated and represented faithfully. The principle of good practice in the conduct of qualitative research and the trustworthiness of the interpretation of information gathered are both essential to judgements about its quality (Fossey et al., 2002).
CHAPTER FOUR: FINDINGS AND DISCUSSIONS

Introduction

This chapter combines a presentation and discussion of the findings of the study which investigated the experiences of trained non-directive play therapists using the western model of non-directive play therapy on a Kenyan child. My research aimed to establish the appropriateness of the western model of non-directive play therapy in the Kenyan context. In this chapter, the term ‘appropriateness’ is used to communicate the therapy’s ability to achieve a therapeutic movement: ‘inappropriateness’ on the other hand communicates the model’s inability to produce a therapeutic movement when used on a Kenyan child.

Having adopted an inductive or ‘bottom up approach’, I applied thematic analysis as an independent and reliable qualitative descriptive approach to ‘identify, analyse and report patterns (themes)’ within my entire data set (Braun & Clarke, 2006:79). Even though thematic analysis offered me, the researcher, the flexibility of determining themes for my research findings, their ‘keyness’ was dependent on whether the identified themes captured something important in relation to the overall research question (Braun and Clarke, 2006:82). While employing a relatively low level of interpretation (Sandelowski & Barroso, 2003) in analysing my participants’ accounts of their experience, the use of thematic analysis enabled me to provide a rich thematic description and accurate reflection of the content of my entire data set, thus enabling my readers to get a sense of important themes (Braun & Clarke, 2006).

The chapter also discusses the results of this research study in the light of relevant literature and particularly through the theoretical lenses of the Western model of non-directive play therapy. The findings are summarised and contextualized within the literature. The implications and limitations of the study are considered and recommendations made for future research.

In my findings, I have randomly given fictitious identities to my research participants by labelling them Achiel, Ariyo, Adeck, Angwen, Abich and Auchiel simply to ensure anonymity. I have similarly considered the latent and manifest content of the participants’ accounts in analysing my data. Working from a constructivist perspective, my participants’ accounts of their experience as reflected in my findings focus on their sociocultural contexts. Having systematically
worked through the entire data set, giving full and equal attention to each data item, I was able to identify two main overarching themes which communicated the experience of my research participants, who in their narratives, all observed that the western model of non-directive play therapy was in a large scale ‘appropriate’ to the Kenyan context because it facilitated therapeutic movement when used in a counselling session with a Kenyan child. At the same time, most participants’ experiences revealed that there were times when the western model of non-directive play therapy was found to be inappropriate, in that it was not perceived as therapeutically effective. However this view is challenged by Adeck who felt the western model of non-directive play therapy is appropriate in the Kenyan context except that ‘it has not been embraced yet’. Adeck further observed that as a therapist, one has to prove the therapy’s effectiveness.

A thematic map below reflects the two main overarching themes indicating that:

i) The western model of non-directive play therapy is regarded as appropriate (effective) by the participating therapists for use within the Kenyan context.

ii) On the other hand, the same participants considered the western model of non-directive play therapy inappropriate (ineffective), in some situations within the Kenyan context.
Diagram 1: A thematic map showing two main overarching themes representing seven candidate themes
In a repeated search within my data, I identified a total of seven candidate themes captured within the main overarching themes of appropriateness and inappropriateness.

The candidate themes perceived to be indicators of the appropriateness of western model of non-directive play therapy’ in the Kenyan context indicated that in therapy:

1. Children developed the sense of **Empowerment**
2. Children experienced the ‘**Freedom**’ to be themselves and
3. Children became ‘**Expressive**’, the play therapy enabling them to express their emotions, issues and experiences.

In contrast, the inappropriateness of the western model of non-directive play therapy experienced by my participants was particularly reflected as:

1. ‘**Lack of awareness**’ – the majority of my participants’ experiences revealed that most Kenyans lacked awareness of the existence, knowledge and understanding of the western model of non-directive play therapy;
2. ‘**Cultural barriers**’ – my participants’ experiences also revealed that most Kenyans considered professional counselling including the western model of non-directive play therapy inappropriate due to cultural beliefs and practices upheld by the Kenyan traditional communities;
3. The Kenyan ‘**education system**’ was identified as based on values and assumptions contrasting those held by the western model of non-directive play therapy, causing confusion to children in therapy.
4. The ‘**economic and social status**’ of some Kenyans was seen as posing access issues to therapy.

As well as constructing the thematic map, reflecting the flexibility of method which characterises thematic analysis, I opted for the use of a thematic table as a visual representation within which I organise my themes into theme-piles and convey the relationships between the main overarching themes, candidate themes and sub themes that I have identified within the participants’ data. This is presented below. Following on from this, I present my analysis of the same themes supported by appropriate direct quotes from some of my participant’s narratives extracted from the data (Braun and Clarke, 2006).
<table>
<thead>
<tr>
<th>Main Overarching Themes</th>
<th>Candidate Themes</th>
<th>Sub-Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appropriateness of the Western Model of Non-directive Play Therapy in the Kenyan context</strong></td>
<td>Celebrate</td>
<td>-Self-trust -Self-confidence -Self-esteem</td>
</tr>
<tr>
<td></td>
<td>Expressive</td>
<td>Means of communication</td>
</tr>
<tr>
<td></td>
<td>Freedom</td>
<td>In play children create their own world</td>
</tr>
<tr>
<td><strong>Inappropriateness of the Western Model of Non-directive Play therapy within the Kenyan context</strong></td>
<td>Cultural barriers</td>
<td>Professional counselling:</td>
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<td></td>
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<td>Play unvalued</td>
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<td>Access issues</td>
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<td></td>
<td>Kenyan Education System</td>
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<td></td>
<td>Social Economic status</td>
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<td></td>
<td>Lack of awareness</td>
<td>Conditional awareness On-going Awareness</td>
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**TABLE 2: Visual representation of theme-piles**
Within the main overarching themes that communicated the appropriateness of the western model of non-directive play therapy in the Kenyan context, are the candidate themes that I analyse as follows:

**Themes reflecting the appropriateness of the approach**

1. **Empowerment**

Out of the six participants that I interviewed, five talked about their personal experience of therapy as engendering positive personal change to their clients. Some elements of these changes they saw in terms of empowerment of the child, others were more equated with acceptance of situations clients found themselves in. These experiences were manifested in the children’s ability to gain confidence, self-trust, and eventually develop raised self-esteem, making the children autonomous and even assertive as a consequence of using this model. According to the five participants, empowerment or clients’ positive personal change was displayed in the children’s behaviours, attitude, in their play and even in their drawings which began to show some life.

For example, Achiel experienced her client being more ‘*communicative*’ than he was when he started therapy and developing a changed attitude. She noted how the client’s ‘*demeanour*’ changed: ‘*... he used to come like ready to fight but ... after six sessions he...was more open*’.

A sign of empowerment experienced by my participant Ariyo was her seeing children in therapy develop autonomy, confidence and assertiveness as they moved onto the play-mat. In her own words Ariyo narrated that:

‘*they kind of change their identity..., they are more assertive, the voice changes ... and they will behave ...very mature, very composed even when they are out of play*’ ...

Abich shares the same sentiments saying that the non-directive play therapy: ‘*is not problem solving... but more ...empowering the child so that even after counselling has ended, the child can be able to ...deal with some challenges that they meet in life*’. Abich noted how the model helps bereaved children process their losses and reach acceptance. According to Abich, acceptance was displayed when in their play children showed signs of ‘*moving on..., relocating the deceased...and*'}
adjusting to the situation without the person they had lost’. Abich also noted that
the model enabled children who at first exhibited resistance, anxiety and fearfulness
to build trust, feel safe and gain some degree of confidence. In her own words, Abich
narrated this experience saying:

‘... a child who when they came for counselling could not even speak loudly... not
even look at me... standing in front there for thirty minutes or ... sitting in the car
talking to themselves and then after working with the child, the child is so
confident. Or a child who could not come into the play room unaccompanied by
the parent... crying... fearful or anxious, then...we are going to the play room, and
the child says to the parent 'wait down there.’

The play therapists’ attending and listening attitude portrayed in therapy sessions
with children were observed as helping to raise children’s self-esteem. Abich
commented on how unusual and empowering such an experience was for child
clients:

‘... because out there... they don’t experience things like that..., so they get
amazed and they think... what kind of a place is this? This place is not a school;
...not a hospital; this is actually a place where children come to be listened to, a
place where they can be themselves’.

Another positive change reflecting empowerment was reported by Auchiel who
found out that through the use of non-directive play in a therapeutic setting, a
child client who has autism learnt to swim and gained speech ‘slowly by slowly’.
Commenting on this experience, Auchiel states that ‘what I am seeing is that play
therapy works because for this young girl, it was all about play. It is one case that
has made me really appreciate play therapy’. According to Auchiel, from this
experience the girl’s mother also appreciated her daughter’s progress, saying the
girl had become really active in the way she did things. My participant Angwen’s
experience was that using play in a debriefing session, especially with traumatized
children, enabled them ‘gain confidence and share a lot of materials than if they
used other techniques because children love play and quickly opens up’.

The therapists’ experience of the empowering impact of therapy and its
manifestations is in line with literature in the area. Acknowledging children’s
empowerment as an indicator of therapeutic movement achieved through the use
of this model, Ray (2007) attests that children undertaking child-centred play
therapy sessions have shown improved self-confidence, increased sense of autonomy and developed positive interpersonal relationships. According to Oaklander (2006), most young children’s experiences of powerlessness and vulnerability contribute to their frustration and engagement in power struggle which manifest in children’s temper tantrums or outbursts of anger. As such empowerment gained in the safe environment of therapy (Oaklander, 2006) supports a child in dealing with internalised fears. In support, Landreth (2002), states that the unique relationship developed in the child-centred therapy playroom with the play therapist guarantees a child safety, thus providing empowerment and self-acceptance to a child in therapy. Subsequently, an empowered child according to Oaklander (ibid) develops a spirit of fun and playfulness and hence becomes calmer and easier to relate to. This is because, in that state, the child begins to experience some control and power in her/his life within safe boundaries.

Auchiel’s positive experience of working with a child with autism chimes with Bratton and Ray’s (2000) review of twentieth-century research into play therapy’s effectiveness, which revealed its positive effects on autism among other conditions. Similarly, Josefi and Ryan’s (2004) exploratory research on non-directive play therapy revealed that the model has the potential to increase the emotional and the social development of children with autism. In particular, their findings reported improved autonomy; increased empathy towards younger siblings and greater independence in self-care for a six year old boy with severe autism.

The importance of the listening and attending skills of the therapist has also been identified within the literature. Affirming this, Oaklander (2006) observes that ‘It is not a common experience for adults to listen to the child’s statements and they sometimes are surprised at the therapist’s interest’ (pg.62). Meanwhile Green (2010:262) in his article on children’s perception of play therapy attests to children’s attractions to a therapeutic play room experiences saying that ‘...along with the ability to make independent choices, children also valued a non-judgmental, attentive adult who acknowledge their creativity and promote individual, creative self-expression, as supported by the tenets of non-directive play therapy (Axline, 1950).’

Despite ‘empowerment’ being considered a positive contribution of this model, in few isolated cases some parents would develop negativity over the child’s
empowerment and consider some of the child’s actions disrespectful. While depicted as strength of the approach, there was acknowledgement that it was not necessarily seen as such by some parents. For example Abich observed that some parents would say that ‘they cannot control the child now; the child has become bad; the child is talking back to the parent’. Elsewhere Oaklander (2006) argues that children have difficulties feeling a sense of self without boundaries and limits for their own safety saying: ‘children are happy to give their parents the power and control in their lives as long as they feel heard, encouraged voicing their opinion, and know that the rules are fair’ (pg.59)

As discussed more fully later in the chapter, empowerment of children could be viewed as countercultural. Within the Kenyan context, a handbook of Luo customs (Luo Kitgi gi Timbegi, Mboy, 1997), explains the power/leadership structure within the Luo community of Kenya, stating that leadership in this community is patriarchal, where only male adults occupied leadership positions and made rules that governed the community members activities. Whereas women and children were expected to adhere to community norms submissively without questioning, their views were neither sought nor heard. From a personal experience, I have observed that most Kenyan traditional societies have maintained their cultural practices to date. In particular, most Kenyan rural communities observe their cultural practices except for those individuals who having migrated to the urban cities may choose to free themselves from such practices based on their exposure to other cultural practices that one may find more attracted to, as is witnessed today among the Kenyan urban dwellers.

Looking at the Kenyan traditional societies’ culture of children’s anticipated total submissiveness, I am prompted to question whether a Kenyan child’s empowerment achieved in therapy would work within the Kenyan traditional societies. How beneficial would empowerment be to a Kenyan child? And how would they sustain this empowerment in their relationship with their caregivers since children in Kenya are to be seen not to be heard?

2. Expressive

My participants’ experiences of using the western model of non-directive play therapy also revealed that they experienced the model encouraging expressivity when used by children in therapy. In various ways, all the research participants communicated having experienced play as an important means of communication for children, through which they expressed their emotions, narrated their
experiences and sometimes indirectly dealt with their issues using play materials. For example, Abich narrated her experience of how play therapy can facilitate the expression of experiences, issues and emotions of a child who is processing loss, and eventually lead to the child experiencing a therapeutic movement. Abich stated that providing a child with play materials gives the child the opportunity:

‘to express the loss, mourn the loss ..., express their anger and at some point reach acceptance by beginning to speak about the person they have lost in the past-tense..., ... mourn and... ask the person questions, and sometimes ...pick a doll and pretend it is the person who died or they are doing something in the sand-tray, but you can see where they are is not where they were when they came for therapy’.

In another instance, my research participant Ariyo’s experience revealed that the western model of non-directive play therapy expresses or brings out:

‘a lot of internalized emotional feelings through activities such as drawing, painting or playing, thus capturing feelings of the moment in one’s subconscious and revealing a lot of issues when explored’. Ariyo gave an example of how a ‘frown’ a client put on her face in a drawing could bring out a lot of issues when explored. Ariyo’s experience also revealed that non-directive play therapy could also be used in therapy with adult clients to help bring out a vivid picture of what the client is trying to express in a session:

‘just last week I used drawing on a lady client who is trying to transform her life and change herself and she says she feels she has grown and the old her is getting smaller. And I asked her to draw the two pictures of herself and when we started discussing, she was saying "I didn’t realise that this was like this" when she was drawing. But when we were discussing the two, I would highlight something...and she would say ooh, I didn’t realise at the time.... And when we are able to see it visually, they are able to change.’ Ariyo’s experience was that some adults also prefer using this model to express their emotions and feelings when they experienced difficulty in verbalising them:

‘...sometimes even for adults it is quite difficult to put some emotions and some feelings into words and even if they were, for you ... counsellor to perceive them with same intensity and you see words are said and are sometimes forgotten. A picture is there and it can be seen and it brings in a lot of dimensions for instance,
the size... the shape, the colour ..., the roughness, the neatness. It brings in a lot of what is internalised in a person. A person can just draw themselves on a piece of paper and may be that person is not standing on the ground, is raised, and exploring that alone will bring a lot of things, how secure, how grounded that person feels. It may be in the unconscious and it will not come out in the verbal sessions but when it is ... in a drawing you find that it comes out right away’.

Similarly, Abich’s experience also revealed that some adolescents preferred using non-directive play therapy to express themselves due to the intensity of the feelings associated with what they wanted to talk about:

‘...an adolescent would say that I don’t want to talk about this... Can I draw what I am talking about so that you can understand me?’ Affirming the model’s impact on expressiveness, Ariyo talked of how the experience of working with children had been transformed:

‘Before I did non-directive play therapy, dealing with children was almost impossible because they don’t have words to express what they are feeling... But when it comes to play therapy, magical... it is very spontaneous (voice raised), I mean everything comes out... and the child ceases to even be intimidated by your presence’.

Adeck talked of how engagement with play materials in a play therapy session enabled children to act out their experiences. Adeck used an example of how how non-directive play therapy helped a boy to express his issues and emotional inner feelings of loneliness and despair after he was taken for therapy for refusing to take his antiretroviral (ARVs) medications. According to Adeck, what came out from the therapy session was that the boy’s mother had died and the father re-married another wife. The boy had become very close to his stepmother but his father was physically abusing her to the point that she was now threatening to leave. Adack described the therapeutic process saying:

‘...using dolls... when... playing especially in the sand tray, he would place a small boy in a corner... while the parents are fighting and he would demonstrate like they are fighting.... And then the parents seemed to be on the other side and ... him ... in a corner somewhere, alone.... Then with time... this child was now not playing at all and was just in a corner completely forgotten.... Then...the step mother would actually leave.... Then the child would be left there in a corner, the dad is going to work ...but the child is in a corner.'
Elsewhere Angwen found that the use of play, art or painting revealed something the child may be going through. Angwen stated that:

‘...I came to realize that children, especially the ones who are traumatised, if you engaged them into play, they will be able to share a lot of material that you would not get otherwise if you were using other techniques...’.

Angwen’s sentiments were supported by my participant Auchiel who also revealed that play enabled children to express their frustrations or their trauma using play materials and/or drawings. Narrating her experience of working with traumatised children during the 2007 Post Election violence, Auchiel explained that:

‘...the affected children were withdrawn and some displayed symptoms such as bed wetting, others were not doing well at school. When the children came to me, the trauma was so much that ... they were not actually opening up and talking, they were just blocked. ...therefore I was ... in a confusion to be able to work with such children. But when I got play therapy, they would take a paper and start drawing and that helped them in debriefing. So there is much difference from when I did not have play therapy. It is much easier working with children, and made the children feels at ease, like they are at home’. Also Auchiel acknowledged play as an appropriate means children use to voice/express themselves universally saying:

‘...I don’t think the Kenyan child is any different from any other child anywhere in the world, because the voice of the child seems to be quiet inside them, especially when a child is in a particular distress..., it does not come out and therefore play therapy gives them a chance to voice themselves in play’.

The literature related to play therapy points to the key importance of encouraging expression and the potentially severe and long-lasting impact of failure to express. According to Oaklander (2006:50), ‘children need to be supported to express blocked emotions’ because of their lack of ego strength. They are egocentric, uncritically taking responsibility for any trauma that occurs and introjecting negative constructs about themselves. Such processes ‘cause fragmentation, inhibit healthy growth and integration, and are the roots of a self-deprecating attitude and low self-esteem’ (50).

Oaklander (2006) argues that, without support, a child will respond to the intensity
and weight of traumatic feelings by suppressing them into their unconscious. However, their behaviour and life process is likely to be greatly affected by these feelings. Oaklander therefore advocates helping a child to express the suppressed feelings in therapeutic work because in the process of expressing self, a child goes through some catharsis in the safety of the therapeutic setting. The use of techniques such as drawing, playing with clay, fantasy and imagery, creative dramatics, story-telling, and sand-tray work offered in play therapy help children unlock and express buried emotions. For example, if a child creates a sand-tray scene with varied miniatures that are available in the play room, the act of projecting this symbolic material is in itself therapeutic because something within the child has been expressed, while telling the story about their scene helps them to express more of themselves at a deeper level. As Homeyer & Morrison (2008:213) suggest: ‘children’s play is a symbolic expression of their world which allows children to express the unmanageable in manageable ways by providing the emotional distance necessary for communication’.

3. Freedom

According to four of my research participants’ experiences (Auchiel, Adeck, Ariyo and Abich), the freedom accorded to children in this therapy helps children to express their feelings and hence achieve a level of catharsis. It was mainly manifested in the therapeutic setting by giving children the autonomy to choose their own play, their own agenda and play materials. They also were given a freedom of action and expression. They saw the role of the non-directive play therapist as to attentively listen to their verbal expressions and feelings, accord them the autonomy just to be what they wished to be and also reflect back the client’s verbalised and non-verbalised feelings.

The use of the term ‘freedom’ to describe the experience of children in this therapy seems to reflect the significance the play therapists placed on the non-directive nature of this therapy, manifested in the child’s freedom to choose their own agenda and way of working during play therapy sessions. Working within a therapeutic setting with limited restrictions, my four participants, Ariyo, Adeck, Abich and Auchiel, all observed that the freedom they offered as therapists led children to experience the freedom to be themselves and to freely express their feelings and experiences in play, especially when left on their own.

Using different terminologies, the four participants identified areas in their experience that seemed to facilitate the ‘freedom’ for children using this model.
For example, Ariyo talked about the ‘play mat’ saying “When children get onto the 
‘play mat’ they are free to be who they are and they express it”, Adeck identified 
the ‘playing space’ as offering children the opportunity ‘to be themselves’. Abich 
and Auchiel both talked about the ‘non-directive’ setting facilitating children’s 
feelings of freedom in this therapy. Abich stated that ‘... in that non-directive 
setting the child gets to choose what they want to work with ... the agenda’. Abich 
talked of how the therapist would encourage clients to find out for themselves 
issues that they wish to work on, by asking the client questions like. ‘What would 
you like to do today? ’We have thirty ... forty minutes, and this is your special time. 
At the same time, Auchiel noted that ‘for children with different issues, the model 
of ‘non-directive play therapy’ gives them an opportunity to be themselves’. 

According to my research participants, a sense of ‘freedom’ developed within a 
non-directive environment offers a child a space to create own world and 
autonomy to independently determine own action. When the children experience 
such freedom within a therapeutic relationship, they are able to express 
themselves freely, experience their potential, gain confidence and develop self-
esteeem. These qualities are believed to promote therapeutic feelings according to 
Green (2010)

This theme chimes with the strengths of the approach reported from within the 
promotes self-direction, growth and integration, thus enabling clients to develop 
a more positive view of themselves, increase self-responsibility and self-
acceptance. Landreth, (2002) suggests that the model provides clients with the 
freedom to make choices and to take responsibility for their choices. Based on 
professional experience of working with children within a person centred 
perspective and in terms of psychotherapeutic practice, Nash (2008) observes that 
working in a person centred way means letting the client occupy the centre of 
activities by giving them a working space, and being with them wherever they are 
in a non-directive attitude. Green (2010;256) affirms that within a therapeutic 
relationship ‘freedom to choose promotes children’s creativity or self-expression’ 
which enables children to experience ‘the power of their unique potential and to 
experience less anxiety; change negative thoughts; feel more confident and gain 
Improved self-esteem’.

As founder of the person-centred approach, Rogers (1973, 1977) asserted that 
the non-directive approach was based on a profound respect for individuals
seeking help with the conviction that they will be able to find their own solutions to whatever issues they face if provided with sufficient support. The approach is based on the assumption that any autonomous choice freely made by an individual without external pressure will be the best choice for that individual. According to Nash (2008) this implies that the counsellor is to be led by the client in terms of issues discussed and conclusions reached.

In terms of the model’s basic assumptions, my participants’ experience of their clients gaining freedom would point to the effectiveness/appropriateness of the non-directive approach for therapeutic work with Kenyan children. However, this has cultural connotations, which will be further discussed in this chapter. Within the Kenyan context a child’s freedom may hold negative connotations and indeed it is not generally encouraged. Within collective cultural practice which is still highly influential within Kenya (Ma & Schoeneman, 1997; Odongo & Onderi, 2014), children are expected to rely on adults’ directions and to consult with adults prior to making any decisions or actions. Abich observed the difficulty which could be caused by the mismatch between children’s experience of adult’s behaviour at home and in therapy. Oaklander (2006:16) attests to this saying that ‘children learn from their particular cultural group what is expected of them… and that, difficulties often arise when a child finds herself in between two cultures’.

My participants’ experience of Kenyan children being surprised when offered non-direction during a therapeutic session is an indication that cultural difference can be a challenge if not accorded due consideration in a therapeutic setting.

Evidently the beliefs that underpin the nondirective play therapy reflect western psychologists’/writers’ ideologies and assumptions. Even though the gaining of autonomy is viewed by the play therapists in the study as the strength of non-directive play therapy, Feltham (2000) highlights its cultural overtones. He argues that autonomy as an ethical principle should be considered a guideline rather than an absolute rule, as a prioritising of autonomy can undermine social responsibility/social ethics. It can be culturally insensitive particularly within collectivist cultures to the extent of causing internal conflict for the client and leading to possible damaging consequences.

In the African context, Robson (2010), Odongo & Onderi (2014) and Mwaniki (1973) consider it rare for children to be autonomous in terms of freedom of action and choice. Power issues are argued to come into play since in childhood adult
carers and/or parents are usually the sole providers of basic needs and the child is dependent on the same adults for protection, care and love. There have been attempts, however, to ensure some basic rights for children. The Kenyan Government has committed itself under the Children’s Act to address the rights of children, calling for respect for the opinion of children as contained in the United Nations Convention on the Rights of the Child and the African Charter on the Right and Welfare of the child. At the same time ANPPCAN Kenya (2009) stresses the importance of allowing the child to air her views or opinions on an issue and ensuring that those views and opinion are respected and accorded due weight. However, in Kenya one wonders how much this will lead to change given the lack of a forum for children's voices.

**Themes reflecting non-directive play therapy approach’s inappropriateness within the Kenyan context**

- **Cultural Barriers**

  Cultural barriers were reflected mainly in terms of the attitudes of traditional Kenyans living within collective communities in rural Kenya. These were perceived as creating barriers to the acceptance of the value of both ‘non-direction’ and ‘play’, as well as the place of ‘professional counselling’ in its entirety. Also, issues were raised in terms of the nature of the play space and play materials available for children living within both urban and rural Kenya.

- **Non-Direction within the Kenyan Culture**

  While acknowledging the positive impact of non-direction, my participants’ acknowledged that the experience could be confusing for some children. For example, Ariyo’s experienced that:

  ‘because our Kenyan children comes from environments where there is a lot of direction, ... in the school, even at home you find the child is a passive receiver of adult’s directions and instructions..., but when they come to the play room, when you adopt the non-directive play therapy..., sometimes you find the child being a bit surprised because they come expecting the same experience with adults out there...’

  From a theoretical perspective, Rogers (1977) argued that individuals have the
capacity to be self-determining and thus have the potential to resolve their own issues if provided with the right conditions. Based on this assumption, non-directive play therapy founded on Roger’s philosophy trusts the child’s ability to deal with her issues undirected (Axline, 1947). As such the therapist’s key role in practicing this model is to:

‘develop a close and trusting relationship with the children, and to reflect and respond to their thoughts, feelings and activities in such a way as to facilitate the resolution of children’s emotional difficulties at their own pace and through the means they have chosen’ (Wilson & Ryan, 2005:23).

However, the use of this model with a Kenyan child raises concerns based on cultural differences between Kenyan communities and the western communities where this theory was developed. Triandis (2001) argues that a general criterion for evaluating the appropriateness of a theory to a new cultural context is the cultural distance between the culture/country in which the theory originated and the one where it is applied. As such, Triandis observes that the greater the distance in cultural values, language, politics and so forth, the less congruence/applicability the theory might hold.

Cultural differences between Kenya and the west, from where the theory underpinning both person-centred counselling and non-directive play therapy, are evident. For instance, as Mboya (1997) attests, within the Luo community of Kenya (one of the major tribal groupings) there has been a tradition of patriarchy. The appointed male elders created obligatory rules to guide, protect and maintain moral values among community members. Challenges and issues experienced within the community were handled by various committees who were given the responsibility to handle issues such as destruction of property, arson, theft, sexual assaults/harassments, land issues, domestic challenges and security. Women and children were excluded from the committees. Membership of the committees was confined to men. Women and children were excluded and their views were not sought even though they had to adhere to the norms. At the same time, male children born out of wedlock or to mothers from other ethnic groups or nationalities were not offered leadership positions within the community. From personal experience, these practices continue to be observed by the community’s indigenous rural population to date.

As reflected above, autonomy for children does not fit easily with cultural norms.
Elsewhere, Kenyatta (1937) in his book ‘Facing Mount Kenya’ gives a comprehensive account of how, within the Kikuyu community of Kenya, the community elders took responsibility for maintaining community cohesion by following a strategy of involving the young in communal activities. Though the book may appear out-dated for this research study, from my experience, the Kikuyu community of Kenya has maintained these practices to-date. At the same time, the arrival of Christianity in Kenya has witnessed many Kenyans adopt the Christian faith. Adherence to Christian teachings, values, and morals is seen as an obligation, scarcely leaving room for autonomy in decision making (Gifford, 2009). Looking at autonomy from a spirituality viewpoint, from within the person-centred school, Thorne (2000) has questioned the value accorded to it. He challenges the assumption that individual autonomy is good and promotes personal growth. He argues that religion plays a prominent part in many individuals’ lives and that therapists who consider religion damaging to human spirit may experience difficulties understanding and accompanying a client who believes that true freedom is found in one’s submission to God’s will and the teachings of the Gospel. As discussed earlier, from an ethical perspective Feltham (2000) also postulates that autonomy offered in non-direction is not without problems because in practice the client’s wishes may have damaging consequences. As such the twin focus on self-actualisation and autonomy in person centred therapy may be problematized for undermining social responsibility and inherent cultural insensitivity.

Generally, the Kenyan culture of raising children under strict cultural and, sometimes, spiritual rules explains why non-direction is not a priority within most Kenyan communities. This is most evident in rural communities where typically family members still live within one homestead and enjoy the support of village elders in handling social and psychological implications.

**Traditional Kenyan’s attitude towards ‘play’**

Through the use of play therapy, my participants’ experiences revealed that some parents consider play as lacking seriousness; a waste of time, hence they express their doubts on play therapy. For example, Abich expressed the dissatisfaction of some parents who would say:

...’so the child was sent there, painted and played with toys’ and they wonder ‘so I go there and pay and they just play’!

According to my participant Ariyo ‘play’ within most Kenyan rural communities is
equated with ‘laziness’ or ‘idleness’ probably due to the ‘expectations’ and ‘chores’ undertaken by the rural population. In her experience of engaging a rural child in a play therapy session, Ariyo attested that:

...‘the child did not play, just geed...I think this was a child from up country, and I want to believe that...they don’t see many adults playing with children there, so it was kind of shocking for him...and I think it was...that cultural aspect, I mean of seeing an adult who is playing with them. ...because in the urban centres children seeing parents playing is very normal, but in a rural setting, adults hardly play, even teenagers hardly play. ...for rural children, I think a bit of work has to be done’.

Ariyo went on to say that... ‘I believe if I had had more sessions with the boy it would have been more fruitful’.

Adeck observed that ‘....the Kenyan community...would be more confident if you told them that you are counselling rather than having play therapy’. Adeck’s observation seems to imply that play therapy acceptance in Kenya is lacking not just in rural Kenya but also in urban areas as compared to general counselling.

Personally growing up as a Kenyan child in a rural area, I did not experience engaging in play with my mother. This could be seen as rooted within a range of factors: the role of women and children; family structures; the lack of infrastructure and support systems; high levels of rural poverty and subsistence living. In their role as caregivers, I witnessed mothers in rural Kenya being overburdened with the responsibility for taking care of their family’s basic needs. These included doing the household work which involved collecting water from a distance for the entire family’ use including the family’s domestic animals. This process would take a whole day during the dry seasons when mothers would travel a substantial distance, making several trips to fetch water carrying it on their heads in small containers. At the same time, mothers tilled land for crops and vegetables which was the main source of food; collected firewood for domestic use; prepared meals; cleaned the house as well as utensils and washed clothes. These services were not only limited to the woman’s nuclear family. In most cases the services were extended to the woman’s marital family members whereby the in-laws demanded to benefit from the woman’s services as a compensation for the family members’ support in paying for the woman’s dowry. Mothers involved their
children in domestic work by assigning them light duties based on the child’s developmental age. As such the heavy responsibilities kept the mothers and their children fully committed and denied them the luxury of playing.

Also relevant were authority patterns within the family. From my own experience, mothers played the role of strict disciplinarians in their relationship with their children, where caning children was the main form of discipline. This kind of relationship instilled fear in the children and created a gap between mothers and their children. Thus communication between the two was rare. Whereas mothers occupied the position of authority, children did not question instructions or ‘answer back’. For me asking my mother to play with me during my childhood days would have seemed disrespectful and could have earned me a beating. Some of these practices are still observed in Kenya’s rural setting, making the rural child surprised when they encounter adults who engage into play with children.

Available literature reflects my participants’ and my own personal experiences. Wenger (1989) and Tudge & Odero-Wanga (2009) state that within Kenyan traditional society children spend much of their time contributing to the household economy and mothers do not play with their children. Similarly, LeVine and LeVine’s (1963) research into child-rearing in the Gusii community in Kenya revealed that ‘mothers did not play with their children, fondle them, or display affection for them openly’. They were also described as not typically praising or rewarding their children and were more likely to use fear to control their behaviour.

The participants’ reported experiences also reflect differing attitudes towards play as discussed within the literature. Reflecting western views on the significance of play, Wilson & Ryan (2005) depict play as a powerful and creative means for children communicating their experiences and feelings, prior to them developing the ability to use language as the primary means of communicating experience. Landreth (2002) and Cattanach (2003) observe that play enables children to step out of their ‘real life’ into a temporary sphere of activity that provides children the opportunity to self-heal in creative, constructive and progressive ways. Reflecting such understandings, western psychologists designed therapeutic interventions based on play as the medium for communication.

While there has been the powerful evidence provided by a number of psychologists on the developmental and psychological benefits of a child’s play from a western perspective (Whitebread, 2012), there are differences in the value it is accorded.
The value accorded to a child’s play, the type of play accepted and encouraged for children, and the playing space available for children varies from community to community worldwide (Whitebread, 2012). The culture in which play activities take place affects their nature, availability and value attached (Tudge & Odero-Wanga, 2009). Such cultural differences in play would seem inevitably to raise questions over the transferability of a play therapy approach developed in the west to the Kenyan context, where play is accorded less value.

Despite the above observations, the Kenyan Government through ‘The Children’s Act, recognizes Article 31 of the UN Convention on the Rights of the Child which enshrines play as a child’s right. Subsequently, the Kenyan’s Early Childhood Development (ECD) policy programme is based on children’s play and aims to provide opportunities for children’s holistic development in the pre-school years (Kaga, 2006). However, the UNESCO policy review of early childhood care and education in Kenya argues that there is a widespread failure to recognise its value for healthy development. It asserts that a lack of concrete evidence will make it difficult to convince parents and teachers of the significance of ‘play’ in facilitating young children’s development, learning and preparation for their future (UNESCO, 2005).

Despite the UNESCO report talking of the universal absence of recognition of play’s significance within Kenya, it can be contended that Kenyan attitudes towards play are affected by socio-economic status. Kiribata (2014) points to the greater assimilation of western values and lifestyles amongst middle class, educated urban dwellers who acquired higher economic and social status during the post-colonial era. My observation is that it is through education that a number of educated Kenyans residing in Kenyan cities are beginning to understand the importance of play for child development and are more likely to embrace play than the rural population, This makes me consider that because the benefits of play on an individual’s development is not tangible but based on assumptions and education, for one to understand play’s contribution to human development, there is need for education and awareness creation which seems more easily accessible within the urban cities than rural areas.

• **Playroom/play space**

Another area of concern mentioned by my participants using this therapy is the ‘playing space’ considered ideal for both rural and urban Kenyan child. My
participants Ariyo, Agwen and Auchiel’s experiences revealed that the use of a playing space within a play therapy room was limiting for a Kenyan upcountry child who often plays in the open field. Ordinarily, play therapy sessions take place in a ‘playing space’ located within a designated room usually referred to as a ‘playroom’. According to my participant Ariyo, the rural child showed signs of discomfort engaging in a play therapy session in a playroom with a closed door. Narrating her experience, Ariyo communicated a feeling of surprise at the rural client’s reaction to a closed door playroom saying:

‘…like the boy I dealt with who was right from the rural home... I don’t know whether it is the preparation. ...Because when you get this child, and lock yourselves in a room then you put a mat down. ...I don’t know what he had been told (laughter)... Maybe they are used to playing outdoors (pause) I don’t know (low tone), I don’t know what wasn’t right, but think that the setting…’

Auchiel also recalled her experience with a rural child saying:

‘...she was brought to town and I had a session with this child, and the child would not keep so much to the boundary. And within me, I thought maybe it is the environment, because the child in the rural is set free.’

Apart from the rural child, who spends more time playing in the open fields finding it difficult to work within the ‘playing space boundaries’ as opposed to the urban child being comfortable playing within a confined space, Auchiel’s experience also revealed that some children such as a child with autism finds it difficult to work within a ‘playing space boundary/setting’ within a play therapy room. In her narrative Auchiel gives her experience of working with an autistic child saying:

‘...first we started...by having a session in a room. But you know autistic children are very hyper, and therefore sometimes she would refuse and go out.’

Ariyo’s experience of working with a Kenyan rural child seems to communicate the inappropriateness of play therapy ‘playing space’ for a Kenyan rural child. Within the Kenyan context, Makau (2010) and Tudge & Wanga, (2009) observe that the rural child engages in play for fun, pleasure, enjoyment and satisfaction, mostly within an open space/field within their environment. However, much as setting up a playroom requires specific features and equipment suitable for facilitating diverse clients’ expressions of feelings, the use of a
playroom being a concern for some of my participants triggered my desire to question whether working outside a ‘playroom’ would still produce a therapeutic movement? Wilson and Ryan, (2005) argue that even though ‘a physical setting should be carefully considered, it should not be an overriding factor and that lack of optimum surrounding should not of itself be a reason for foregoing therapy’ (pg.163).

- **Play materials**

The issue of ‘play materials’ also featured as an impediment in some cases. Ariyo, Adeck, Angwen, Abich and Auchiel all noted that the urban child had no problem using the westernised play materials available in the play rooms to express themselves, while the rural child was more likely to prefer local materials to identify with in play. As such they believed that the therapist has to ensure they stocked varieties of play materials in their play rooms to meet each individual child’s needs. However, most of my participants considered stocking a play therapy room with relevant play materials for both urban and rural children as costly and taking time to realize.

For example, Abich talking about her work station and her selection of play materials says that:

‘...although it is an urban area..., children come from all over ... because there are no counselling centres there... And play rooms have play materials for children from rural areas that they can be able to identify with ... Like the ... traditional hut; family figures; ... the elderly people like parents; ... and those animals that are found in the rural areas. So... when the city child has a toy gun, for the rural child we have got pangas, those small machetes... (Laughter) ...things like that...’

According to Adeck:

‘...using the western types of play materials may not real depict our cultural situation. Because it is not yet integrated into the Kenyan cultural concept, it puts us at a disadvantage that we have to use the western types of play materials which might not give really the impression of what the child wants to come out.... The challenge here is that in Kenya there are no native dolls, but when children come to play they will use anything readily available...’
Elsewhere Ariyo observed that children are able to improvise play materials from resources available to them saying:

‘... but I will also be quick to say, a child who wants to play and wants a ball, even if there is no ball in the play items, ... will take something and make it a ball’...

There are a variety of issues raised around the provision of play materials. While Wilson & Ryan (2005:165) suggest that provision of appropriate play materials enables children to express their *moods and feelings*, Nelson (2004) argues that toys generally reflect the attitudes of a dominant group, and are used to legitimise the ideas, values and experiences of that particular group while disregarding the ideas, values and experiences of others. O’Connor (2005) postulates that a playroom needs to have culturally neutral and culturally specific play items to meet clients’ diverse needs, Mustakas (1973) argues that a range of toys are less important than offering each child an opportunity to use materials of their choice. On the same note Walshaw (2008) observes that the imaginative, creative and common sense use of resources available within a child’s environment is what a child requires in order to experience a therapeutic movement during a play therapy session.

Also relevant to the nature of play materials to be provided is the content of play. According to Morellie et al. (2003), in traditional societies which are collective in nature, children are most likely to engage in work related activities and their play would include more work-associated themes than children in technologically developed societies. Similarly, Kamei (2005) asserts that traditional Kenyan child’s play is an imitation of adults’ cultural activities. Kamei’s statement is supported by Robson (2010) and Tudge & Wanga (2009), who affirm a traditional Kenyan child’s regular engagement in work-related activities which enables them to combine work and play. In support, Johnson et al. (2005) state that children’s play in traditional societies contrasts with children’s play in western and other technologically developed societies where parents have embraced play as vital in enhancing the growth of specific cognitive and social skills in young children and can actively support and promote play activities.

A research to establish the appropriateness of i) a playroom; and ii) the appropriateness of the western types of play materials for use in a therapeutic setting within the Kenyan context are recommended here.
Traditional Kenyan’s attitude towards ‘Professional Counselling’

To start with, my understanding of the term ‘Professional Counselling’ refers to a counselling service offered at a fee to those seeking psychological support from a person who has gained skills and competence through training. However there are incidences where professional counselling may be offered without cost as is the practice within Voluntary Testing and Counselling (VCT) centres in Kenya or elsewhere based on the professional’s own discretion.

In this research study, most of my participants’ experiences revealed that professional counselling in both urban and rural Kenya was stigmatised. It was connected with shame, failure and one’s inability to manage his or her life.

Ariyo’s experience revealed that:

‘…counselling is not very well vast on the kid in the Kenyan community…. Even where it is understood, I don’t know why there is a bit of stigma … attached to counselling. People think when you see someone going for counselling they real have problems… so that also complicate people bringing children for therapy’.

Ariyo also talked of the stigma that is attached to professional counselling in Kenya saying:

‘…in Kenyan schools when guidance and counselling and then discipline were all loaded in the same office, when people heard you were referred to guidance and counselling office, they knew you were in problem. So… when you grow up … and you are going for counselling, there is that understanding that ….you are unable to manage your life. So it is tied to some kind of stigma or failure …

Abich reflected that ‘here in Kenya… counselling for children is not a priority in the family’. Ariyo described the counselling situation in Kenya as ‘hopeless’, saying that ‘you find some counsellors also don’t go for therapy themselves’.

Angwen talked in terms of there being a ‘mind-set’ amongst parents. However, this therapist thought that that it was this ‘mind-set’ that might be changed rather than play therapy, adding that the kind of relationship developed in this therapy facilitated a supportive environment for the client.
My research findings reflect earlier findings from a pilot research study carried out prior to the introduction of play therapy within Kenya (McGuiness et al., 2001). This explored the therapeutic needs of vulnerable children in Kenya and the possible role of play therapy. It found that many Kenyans mistook therapy for psychiatry and thought professional counselling addressed issues of mentally sick people. In my view, such attitudes are understandable. Kenyans’ assumption that professional counselling addresses issues of mentally sick people can be argued to reflect the reality in many western countries. According to Gerstein et al. (2012), clinically depressed people tend to seek treatment from a mental health professional such as a counsellor, counselling psychologist or a psychiatrist. Counselling is increasingly seen as a mental health service, and promoted as such. On the contrary, Gerstein et al. (2012:89) argues that people in the Eastern countries such as Kenya embrace a holistic integrated approach to treat ‘their whole body, mind and spirit’ using a variety of strategies such ‘as communication, rituals, herbs, touch and prayers’ provided by elders, witchdoctors, clergy and the others.

A second source of stigmatisation can be argued to reside in the situation that triggered the introduction of both professional counselling and non-directive play therapy into Kenya. Professional counselling was a response to the HIV and AIDS pandemic within Kenya, officially declared a national disaster in 1989. This led to the opening of VCT (Voluntary Counselling and Testing) centres in Kenya to deal with the pandemic (Kenya National Aids Control Counsel, 2010) and the training of local professional counsellors to man the VCT centres. Thus counselling was connected from the outset with a highly stigmatised illness. The introduction of play therapy followed from the introduction of professional counselling as in response to the growing recognition of the urgent need for appropriate psychological support for vulnerable children. Such children were experiencing the impact of separation; loss; bereavement; illness and caring for ill relatives as a result of the pandemic (Hunt, 2006). Subsequently, as the process of responding to HIV and AIDS infection promoted the introduction of both professional counselling and play therapy to Kenya, from the outset they were connected to stigma and shame.

- The Kenyan Education System

Due to the competitive and directive nature of the Kenyan education system and its focus on academic excellence, the Kenyan education system was considered a
contributor to the inappropriateness of the western model of non-directive play therapy in the Kenyan context by my participants Abich and Adeck.

Adeck observed that therapy could be equated with losing valuable time from school saying:

‘academic-excellency is a priority in most Kenyan schools, the western model of non-directive play therapy took a long time for a child to realize a therapeutic outcome, which means a child attending regular play therapy sessions would probably miss a lot of learning in school’.

Within the HIV clinic where Adeck worked, children who were HIV positive attended regular clinics to refill their ARVs and also receive free counselling. Counsellors who are play therapists might elect to use play therapy with these children. From her experience, she talked of how the educational system could hamper their capacity to work therapeutically:

‘Let me give you an example of children who are HIV positive, there are even comments teachers make... like ‘when will you ever get well? When will you ever stop going to the hospital? This chest of yours, does it ever get better? That is a child who is going for regular clinic. How about if you combine that with regular appointments for play therapy? You find it quite a challenge. So many times what we have done, you make sure that on the day this child is coming for their appointment, you try to see if you can be able to meet them on this particular day. But you find logistics always do not work out. May be the day that this child is coming they need to go to school because there is an exam... May be the parent is going back to work. So the real thing maybe is the refill of drugs. Therefore play therapy is pushed to something that is not a priority.’

Abich pointed to the contrasting cultures of school and therapy and how this could confuse children:

‘a Kenyan child comes from an environment where there is a lot of direction and instructions within the school and family system. When in the play room in a therapeutic setting, the same child is asked what s/he would like to do (non-directed); it becomes overwhelming or confusing for somebody who is used to being told what to do’.
Odongo & Onderi (2014:110) affirms the sense of culture clash:

‘Teachers in African traditional society were directors of learning rather than facilitators of it. Children were not allowed to pursue what they desired in a non-threatening climate but instead teachers ‘forced’ knowledge into the children through authoritarianism and through the use of corporal punishment’.

The authors also observe that education in the African tradition was ‘a communal affair’ where teacher, parents and the community were all involved and played part in a child’s education. This to me explains why my participants found non-direction play therapy causing confusion to a Kenyan child. It also points to a potential difficulty of parents expecting to be actively involved in the therapeutic process and feeling excluded by therapeutic boundaries around confidentiality.

- **Economic and social status**

In Kenya the economic and social status of individual families dictates the family’s ability or inability to access particular services that are offered at a cost. As such Angwen argues that in Kenya ‘children who come for play therapy are children from well to do families’. At the same time, Adeck observed that ‘counselling is not a priority for families living in poverty...’ Even where there may be the need to seek a psychological support for the child, the need to feed the family becomes a primary option. For example, Adeck’s experience reveals that:

‘a parent ... would have been so resolute that this child needs help but then tomorrow ... this very child has no food to eat. So will priority be to take this child for therapy or to get the food to eat? So you find in the end priorities change a lot’.

Giving an experience of her clients’ social economic statues, Adecks says:

‘...where I work, I work with people who have no guarantee what they are going to eat tomorrow. So for them ... therapy is not a priority. ...other times care-givers may consider taking a child for therapy based on the child’s condition at that moment. But after two or three sessions they terminate the sessions prematurely giving reasons such as the child is better now; they are experiencing financial constrains or they may find taking the child for therapy taxing, or taking much of their time and interfering with care-givers’ other commitments such as causing absenteeism from employment’.
Nevertheless, according to Adek, the impact of poverty does not only affect clients seeking access to the non-directive play therapy in Kenya. It affects most Kenyan of similar status seeking access to other models of professional counselling.

Economic and social status was not the only issue pointed to. Other contributors to client’s premature terminations experienced by my participants included parental dissatisfaction with therapeutic outcomes such as the lack of desired results or results that are undesirable. Abich’s experience of premature terminations revealed that:

‘...sometimes they don’t see the positive results coming as quickly as they expected. For example, if the child’s performance were low, they want the child’s performance to come up just like that... So the parent....don’t see the child recovering as quickly as they expected. And in some cases they feel the child has become more active (laughter)... they cannot control the child now..., the child has become bad, the child is talking back to the parent’.

Routes for access for clients seeking therapy also posed a concern. Abich’s experience was that the majority of her clients were referred by ‘children’s charitable institutions or by social workers; schools; hospitals and lately by the law courts... when parents are having marital cases in courts, like divorce, separations or maintenance’.

However Ariyo noted that most of her referrals related to the academic field and concerns about the child’s performance. Others were either referred by other counsellors who knew that she works with children, or in instances where a therapist working with adults found that ‘their issues are more family related and there is a child in the family, then the therapist raises it up and let the parents know that there is part that is available for children.’

Overall, while highlighting the substantial cultural barriers to the acceptance of the value of play therapy, my participants’ experiences seem to communicate that economic factors play a significant part in denying Kenyans the opportunities to access professional counselling services or leads to premature termination of therapy sessions. Adek’s experience is a testimony to this situation where many people living in poverty are unable to access therapy for their children and/or
forced to make premature terminations on economic grounds. Indigenous Kenyan communities had support systems in place within the community for their members facing psychological challenges, with such support offered by designated community members at no cost at the family level. However, rural to urban migration has started to break down these traditional support systems. As community-based support has become less readily available, individuals have needed to turn to alternative available support. However, professional counselling, as one such alternative available to the urban community, in most cases is offered at a cost.

The rural to urban migration in Kenya has been influenced by individual’s desire for economic betterment, a situation that has led to large-scale urban growth with 1 in 5 Kenyans now living in urban areas (Hope, 2012). However, while urban growth has both accompanied and reflected Kenya’s economic development, it has not equated with high living standards for all the urban population. The consequence in many urban areas has been poverty, income inequality, unemployment, underemployment, inadequate housing and access to public services (Hope, 2013). As a result, 56% of the urban community population in Kenya lives in slums, a rise from 33% in Nairobi 40 years ago (Lall et al., 2017). The majority of slum dwellers work in informal economic environments of uncertainty with small scale operations, low productivity and low income (Gutierrez-Romero, 2010). Despite urban communities having better access to basic services than rural communities (Hope, 2009), slum households often lack basic necessities. As such, access to basic services is particularly acute for the urban poor. According to Oxfam (2009), over four million urban food poor live in Kenya, with one third living in Nairobi, while the poorest urban residents spend about 75% of their income on staple food alone. This for me explains why the economic social status of many Kenyans living within Nairobi city where this research study was carried out is a hindrance to the development of the non-directive play therapy sector, along with other models offered by professional counsellors. While desperation may drive many parents to seek and engage their children in therapy, the social economic status of this same parent may cause premature termination of such services when priorities have to shift to the most important needs for the family.

- **Lack of Awareness**

Lack of awareness featured strongly in my participants’ narratives as a condition that seemed to derail not only the development of the western model of non-
directive play therapy in Kenya, but also the development of professional counselling in general. Out of the six participants that I interviewed, five considered ‘lack of awareness’ as a major hindrance to the development of non-directive play therapy in Kenya.

Achiel, Adeck and Auchiel felt that non-directive play therapy was ‘not yet understood’ by most Kenyan parents and children. As a result, they thought that awareness had to be created by therapists whenever an opportunity availed itself.

For example talking about her experience of awareness creation Achiel said that:

‘...most of the clients that I have seen are corporate clients... Most clients are just coming for counselling but few whose parents may know about counselling... Others because they are corporate clients, they have been told they have an option to use for children, but... most of them really do not understand what is involved working with children in a non-directive way. So one of the things I have to do is to... explain to them what the work involves and most of the time I invite the parent into the play room so that they see what their children are going to work with’.

The perceived lack of understanding as well as lack of awareness of the existence of non-directive play therapy practice in Kenya was also blamed on the Kenya government and the Kenya Counselling and Psychologists Association for not involving themselves in the promotion of play therapy in Kenya. Abich argued that:

‘...it is the government’s role to create awareness. ...In this country we don’t have many training. In fact, if you look for training in play therapy in Kenya...you wouldn’t find it. ...So most counsellors have to seek it either online or outside the country. ...We need our professional body of counsellors to encourage practicing counsellors, or upcoming counsellors or student counsellors to also think of taking up courses in play therapy.’

Awareness creation in essence related to practising play therapists’ involvement in promoting this therapy by explaining it themselves to adults accessing therapy due to the slow turn out of clients for this therapy. For example, Ariyo observed that:

‘...in most cases, seeing these children will be a consequence of having adults in
therapy... They will have been the initial clients, and then children now come later when the adult understands that there is provision that is also accommodating the children .......if the parent is struggling, it spills over to the children struggling or going over issues that lead them to therapy.... I advise them to seek therapy as well’.

On the same note, Ariyo further stated that:

’... even when a family ... has been bereaved, you actually have to initiate and kind of educate the family on the importance ...of having the children going for therapy because they are also negotiating grief to certain extent ... but when they eventually came, they again find it helpful. So ... due to that it is quite slow and sometimes as a counsellor you find like you are the one selling it, like you are the one inviting people to undertake the service.

Auchiel shared similar sentiments saying that ‘the people who bring these children to therapy... do not understand what counselling is, so I keep on explaining.’

The importance of ongoing awareness creation by the majority of my participants is described as reflecting their own experience but also as a general recommendation. Adeck talked of how much time it took: ‘as a play therapist, a lot of time is spent explaining (voice raised) what exactly you are doing with the child; what is play therapy…’

Angwen observed the need for awareness creation as an on-going process:

...‘people around ... do not know very much about counselling, and ... it might take sometimes before they come to appreciate counselling. For any one person needing counselling, we have to go out and create a lot of awareness... So we have to continue creating awareness.

It is evident that my participants’ above highlighted experiences tend to associate lack of understanding and knowledge of play therapy’s existence with the lack of acceptance and understanding of counselling generally. As a consequence, Ariyo emphasise the importance of awareness creation, pointing out that ‘in Kenya sensitizing the public on the counselling of children and its benefits need to be intensified’. However within the same Kenyan context, Angwen argues that ‘people sometimes understand what counselling is, but play therapy sometimes they don’t
understand. Auchiel also observed that ‘those of us who are in a metropolitan city, in Nairobi, we are able to understand counselling, but not all of us (voice raised).’ Which implies that though counselling is better understood in urban areas, not all urban dwellers understand it and use it.

Elsewhere Auchiel argues that the appropriateness of non-directive play therapy is dependent on the individual child’s unique experience and situation, citing the model as a possible challenge for a blind child in choosing appropriate play materials. For this participant, non-directive play therapy appears to have majorly been designed for physically able children. For example, recommending an improvement strategy for this model, Auchiel suggests that:

‘for the model ... to be inclusive of children who have various disabilities... some kind of research would be carried out to understand ... what would be most fit for an autistic child; ... a blind child? Because the fact that this child is blind, does not mean this child will not be in distress. The blind child may play with an object, will this object real help this child because they don't have eye sight?’

Based on the participants’ experiences, it would seem that the lack of awareness is a substantial obstacle to the development of non-directive play therapy within Kenya. This could be seen as reflecting the lack of awareness and understanding about professional counselling generally within Kenya. Pederson (2003) reasons that formal professional counselling emerged within the west and has only existed for an estimated period of one century. However, counselling practices and functions have existed since ancient times across the world and such traditional, often community-based forms of support still remain strong in many non-western countries. For this reason, counselling as a specialized formally recognised profession is less common in countries outside the west and support from the clergy, fortune-tellers, elders, nurses and social workers and other community-based support remains significant. At the same time, the lack of publication and exposure to counselling in countries in the east according to Gerstein et al. (2012) has meant a lack of information, limited awareness and understanding of counselling worldwide.

Further discussion of the findings

The main finding of this research study, revealed that the Western model of non-directive play therapy appropriately worked for some Kenyan clients and proved inappropriate (did not work) for other clients. The majority of my participants’
experience of using this model on Kenyan children found the model working especially for children from elite educated families, who in most cases were corporate clients (referred by organizations). For these clients, my participants expressed a sense of satisfaction and fulfilment. However for the urban poor, my participants’ experience showed that this group of Kenyans were unable to access such services or prematurely terminated the sessions due to their social economic status. At the same time, indigenous Kenyans residing in the rural areas seemed reluctant to engage in these services due to their cultural attitudes and beliefs regarding play and professional counselling that is a contrast of the Western culture and attitude towards ‘play’, ‘non-direction’ and ‘professional counselling’. As a consequence, my participants advocated for awareness creation as a way forward for the development of this model and professional counselling in general, while some suggested the integration of the Kenyan culture in the model.

These findings give a sense of my participants shared level of agreement that the model generally works based on their experiences within therapy; that the model provides an experience that promotes client’s personal change regarded beneficial by my research participants. It also gives an impression that at least some children and caregivers give their feedback on how good they have found the experience of using this model, although not according to the finding relayed here, on how it has changed them. It also seems to state that there is no way play therapists can know how effective the therapy may prove on a longer term but that they rely largely on their clients’ experiences during therapy. This observation is supported by my participant Auchiel saying, ‘I cannot exactly say that this is what in itself has changed the child from the way they have been behaving when they came in for therapy to the point where even I can see the changes in the child’.

My research participants also acknowledge how fragile their presence is, due to various potential problems and dissatisfaction with therapy outcomes and processes.

Thus, the therapists were clearly enthusiastic supporters of non-directive play therapy, seeing real value in the approach and witnessing its positive impact on child clients. However questions are still raised over the appropriateness of the approach to the Kenyan context, given the potential cultural difference between western countries and Kenya, particularly in terms of the emphasis on the development of autonomy which can be seen as countercultural. Cultural barriers were identified as a major obstacle to the growth of non-directive play therapy in Kenya, alongside
widespread poverty, the educational system, and a wider lack of awareness and understanding of both counselling and play therapy.

A number of significant areas for further discussion arise from these findings and I now move to discuss them further.

**How effectively can therapists and others assess progress within therapy?**

A question raised relates to both how the therapist and others can identify progress made using this approach. The three themes of empowerment, expressiveness and freedom, as well as fitting uncomfortably with cultural norms related to children, relate largely, although not exclusively, to the therapists’ perceptions of children’s behaviour within the therapy room rather than feedback from elsewhere on perceived short or longer term change. The identified change also lacked a concrete nature which could also be seen as potentially problematic. Achiel pointed to a potential dilemma in this area. The therapist termed this perception a hunch saying:

> ..., one of the challenges I feel, even other counsellors ask me is how will you know the child has progressed? Because parents ... want you to interpret the child’s play which in non-directive play therapy is not something I do. So that is a situation that can only have a hunch of what the child is going through. So it is what is happening with the child in itself, at play, that is therapeutic.

According to West (1996) and Wilson & Ryan (2005), there is no clear-cut means for evaluating a child’s therapeutic progress in a non-directive play therapy. However, West (1996:100) argues that ‘evaluation of a child’s progress may be gained from knowing whether there has been any change in the child’s presented problems’ and in ‘knowing where the child is in relation to the therapeutic stages’ which do not necessarily follow a specific order. Moustakas (1964) suggested four therapeutic progress stages that a child using this model is likely to go through saying: 1. A child’s behaviour at the start of therapy may seem confused, diffused, or inhibited, targeted appropriately and inappropriately. The therapist’s task is to form a therapeutic rapport. 2. The child’s behaviour may appear to get worse with the feelings being more focused on definite people or things outside the child. 3. Positive feeling begin to emerge with a lot of ambivalence. 4. Realistic feelings show more strongly. Finally the child is perceived to feel better inside and is more able to deal with life challenges and to develop an age appropriate relationship with a play therapist. At the same time, caregiver’s feed-back on the child’s
progress is also suggested by Wilson & Ryan (2005) as helpful in evaluating the child’s progress. I would consider these views as guidelines and not absolute considering individual’s uniqueness.

**How important is it how Kenyan play therapists are trained?**

An important area potentially highlighted is counsellor training. The practice of non-western counselling students receiving their training within western universities was alluded to by one participant, who talked of how non-directive play therapy training was only available on-line or abroad. A number of commentators have blamed the internationalisation of training not only for the lack of understanding of counselling within non-western countries but also for perpetuating a lack of cultural sensitivity and critical analysis concerning the appropriateness of counselling models to differing cultural contexts (Gerstein & AEgisdottir, 2007; Heppner, 2006; AEgisdottir & Gerstein, 2010). Common deficiencies of such training provision are highlighted: the failure to put in place structures and policies to empower such students to share their worldview, indigenous knowledge and practices; the failure to affirm and value their contributions; the lack of encouragement of critical examination of the validity and applicability of theories and methodologies in relation to their home cultures.

According to Arredondo et al. (1996), this reflects a lack of wider professional cultural counselling competency and sensitivity. Professionals’ lack of awareness is said to include: their client’s worldviews, cultural values and biases; how their cultural backgrounds and experiences influences their help-seeking behaviours and beliefs about psychological processes; the suitability of the counselling approaches. These are some of the dimensions identified as important to cross cultural counselling competency and sensitivity. In this regard, Marsella & Pedersen (2004) consider the internationalization of the counselling profession “the biggest impediment” (pg.414) to practices outside the west.

This leads to my questioning how the Kenyan non-directive play therapists’ training by western trainers may have contributed to the model’s inappropriateness within the Kenyan context. According to Leong & Gerstein (2008) and Neville & Mobley (2001), one way of promoting cultural awareness in counselling is for counsellors to have an ecological system perspective to enable them to understand the influences of culture on the attitudes, values and behaviours of their clients. At the same time, counselling professionals providing
counselling services need to be aware of their influences on individual’s thoughts, feelings and behaviours and be cautious about separating observations from interpretations, as interpretations of one’s environment is mainly influenced by ones values, biases and experiences (Varenne, 2003; AEgisdottir & Gerstein, 2010). In this regard, I observe that the western model of non-directive play therapy developed and interpreted within the western context is undoubtedly in contradiction to Kenyan cultural norms and is likely to lead to confusion used within the Kenyan context if cultural difference/sensitivity is not observed.

On this note, Gerstein et al. (2012:235) emphasises the importance of counsellors’ training programmes and developing practical awareness that is:

‘focusing on and valuing indigenous healing systems and the cultural context of psychological difficulties supports and fosters the development of indigenous psychologies and counselling approaches.’

Such training according to Gerstein et al., (ibid) should combine western models with skills and knowledge indigenous to countries where professional counselling is becoming established. According to Walker (2005), therapeutic work with children and young people, among other things addresses the belief systems of the individual and/or their family, such as exploring the clients’ beliefs about their problem as a therapist establishes a helping relationship. Therefore I observe that in Kenya for example, the client’s belief may relate to religion and/or spirituality. So where the therapist is unable or unwilling to explore the client’s belief system or applies his/her own belief system during a therapeutic session with a client, then the therapist may be missing an important component of the individual client or client family’s overall belief system about how the world works and how problems arise and what is likely to be effective treatment. It goes without saying, therefore, that play therapists using the western model of non-directive play therapy need to develop cultural sensitivity in their practice.

From my personal experience as a beneficiary of non-directive play therapy brief training in Kenya, the integration of indigenous knowledge, skills and details on how counselling is indigenised in the Kenyan culture was lacking. I would say that the training was ‘copied and pasted’ from western theories and assumptions into the Kenyan context, an area that calls for a review for effective services to a Kenyan child. Even though my research participants focused more on their Kenyan clients lacking awareness of the counselling services using this model and the
impact of this counselling model within the Kenyan context, I am left questioning the competence of the Kenyan play therapists using the western model of non-directive play therapy without integrating the model with indigenous knowledge and skills as I consider the misfit between non-direction and Kenyan culture and its implication. Furthermore, in the light of the contrasting beliefs on ‘play’ and ‘counselling practice’ within the Kenyan culture and the western culture, one may wonder how well the brief training in play therapy by the Western trainers prepared the Kenyan therapists to deal with issues of cultural difference? Homeyer and Morrison (2008:218) consider the application of western play therapy theories and practices in other cultures an area of concern, suggesting that ‘individu als who either provide training in other countries or in other cultures or return to their own countries after training abroad must consider cultural differences and must be responsive to their clients’ culture’.

Homeyer and Morrison’s (2008) views challenge the Kenyan play therapists beneficiaries of the brief training offered by the western play therapist trainers to observe cultural differences and to consider their clients’ culture in their practice.

**Does non-directive play therapy have a place in Kenya?**

In the practice of human beings listening and assisting each other, counselling has been practised in various forms throughout the history of mankind, and the argument is that whether provided by witchdoctors, psychiatrists or psychologists (Torrey, 1972), all these support providers rely on similar philosophies and strategies to help their clients. Hence the critical factors to the outcome of a healing relationship and the effectiveness are based on the healers’ ability to instil hope on their clients and for the clients to ‘have faith in their provider’s talents, believe in the treatment, and expect positive outcomes, share the same worldview and experience similarity in how the helper cognitively and perceptually approaches the world’ (Gerstein et al., 2012:80).

Even though counselling as a specialised formally recognized profession is less common in countries outside the west, the services provided by counsellors in the west, in other countries are offered by individuals such as clergy, fortune-tellers, elders, nurses and social workers.

Okech & Kimemia (2012) observes that:
...‘although the talking cure is hardly new among Kenyans, the contemporary Western concept of professional counselling is new and one that the wider Kenyan community has been slow to embrace because in the past Kenyan children and youth were traditionally mentored and counselled by informal network of relatives and family members. Hence the notion of consulting with a stranger about personal or family problems was unusual concept and even frowned upon as families resolved their social challenges privately to safe guide their name and reputation’.

Okech & Kimemia (2012) associate the growth of professional counselling in Kenya with the erosion of traditional societal structures caused by several social, economic and political factors in the recent past. Gerstein et al. (2012) argue that there seems to be an assumption that the Western model of counselling is superior because professional counselling began from the West. Okech and Kimemia (ibid) however argue that counselling should reflect the needs of the society within which it operates. For example, while the Western culture emphasises individualism, the Kenyan communities of 43 ethnic tribes emphasize collectivism, where the role of the family including the extended family, the clan and tribe is very important. Furthermore, as witnessed by the play therapists in this study, the provision of autonomy and freedom, which are considered core elements in the non-directive play therapy practice, contradicts Kenyan cultural norms.

The assumption that culture reflects a set of learnt behaviours and ideas acquired by members of a specific society or group (Gerstein et al., 2007), implies that the western model of counselling is likely to clash with local Kenyan cultural traditions that are most significant to her populace (Emavardhana, 2005). Gerstein et al. (ibid) emphasise the need for counsellors to understand their clients’ local culture as well as the issues they bring to counselling. The cultural context not only affects the expressions of psychological distress but also the constructions of cultural systems of healing and helping. For example, cultural misunderstandings may arise through non-verbal messages whose meanings may vary from culture to culture (Bradley, 2000). A research study conducted by Lever (2006) with African traditional healers stressed the significance of recognising local customs and indigenous practices when working in areas affected by illness such as HIV and AIDs. Lever also noted that the majority of Sub-Sahara Africans obtain health care services from traditional healers. At the same time, Gerstein et al. (2012:88) attests that ‘the central role of religion in the lives of many clients’ especially in Africa cannot be ignored.
CHAPTER FIVE: RESEARCH CONCLUSION

Introduction

In this concluding chapter, I summarise my research findings, look at the limitations of this study and discuss how my research findings contribute to knowledge. I make recommendations for both practice and for future research into strategies to improve the appropriateness of this model within the Kenyan context. I conclude with a reflexive section examining the learning that I took from this study.

Summary of Findings

In investigating the experiences of trained non-directive play therapists using the western model of non-directive play therapy on a Kenyan child, the study aimed to establish the model’s appropriateness for use within the Kenyan context and the possible challenges experienced by the therapists in the course of their practice using this model. The research findings revealed that the western model of non-directive play therapy was in a large scale appropriate for use within the Kenyan context, especially among the elite Kenyans residing within the Kenyan urban cities. For the Kenyan rural child, however, the model was found to be less appropriate, largely due to traditional Kenyan cultural beliefs and practices which conflict with the western individualistic culture within which this model was developed.

I feel confident that this research study has addressed my research question by the collection of illuminating subjective descriptions of non-directive play therapists’ experiences and the personal meanings that these therapists attach to their lived experiences of working with Kenyan children using this model of play therapy. Much as it can be argued that person centred counsellors have a duty to see clients’ issues in the context of their client’s culture, Parritt (2000:37) claims that ‘counsellors are looking to developing therapeutic relationships with clients as unique individuals but come to them with their own beliefs, experiences and models of working’. It seems evident that the Kenyan play therapists bring to their work beliefs and models of working rooted outside the Kenyan cultural context. I attribute this to their brief training in this model of therapy developed within a white western paradigm and offered in an unmodified form by western trainers to the Kenyan trainee play therapists.
A number of authors (e.g. Walker, 2005; Haugh, 2008; Mohamed, 2000) have stressed on the importance of therapists acquiring cultural competence to enable them to work effectively with the cultural diversity of their clients. Kim (1995) identifies five components for culturally competent care. These are: awareness and acceptance of cultural difference; the capacity for cultural self-awareness; an understanding of the dynamics of differences; developing basic knowledge about the family’s culture; adapting practice skills to fit the cultural context of the child and the family. As it can be argued that there was a lack of attention to these components in the Kenyan play therapists’ brief training, acquiring such competence calls for further training. This is consistent with Wilkins’ (2000:194) views that ‘however good primary training was it is bound to have gaps... maybe in areas of cross-cultural theory…”

Therefore, an immediate option is for the Kenyan play therapists themselves to address such gaps and other concerns such as the lack of public awareness, the shortage of support and supervision and absence of advanced local training in this model. I suggest the formation of personal/professional development programmes alongside acting as an important forum for enhancing play therapists’ development. Wilkins (2009:191) argues that involvement in personal/professional development activities is both an essential component of training and an ‘on-going professional obligation of practitioners’. Johns (1996:10) sees professional development forums as ‘focusing on ethics and practice; theory and skills and on supervision’, components that I foresee aiding Kenyan play therapists’ expansion of knowledge for their practice. Other potential avenues for ongoing personal/professional development cited by Wilkins (ibid) are attendance at training conferences and purposeful readings.

**Limitations of this research study**

My choice of a small sample size of six play therapists working within Nairobi city and recruited from one particular training institution may be regarded as a limitation of this research study. As such the findings do not represent the experiences of play therapists using this model throughout Kenya and cannot be regarded as generalizable. My aim, however, was not to produce data that I would claim as representative of Kenya as a whole. I wished to begin an exploration of the experiences of play therapists applying the non-directive model within Kenya. While there is some literature concerning its introduction to Kenya (e.g. Hunt, 2006) the progress of non-directive play therapy since that time has gone largely unexplored. Importantly, this study aimed to illuminate individual experience, to
collect rich data on the subjective experience of practitioners in the field. The amount of data gathered from these participants was substantial and, I would argue, provided the basis for a rich exploration of the phenomenon under investigation. This is consistent with Fossy et al.’s (2002) view that ‘qualitative sampling may involve a small number of participants, while the amount of data gathered can be large…’ (p.726). Patton (1990) similarly attests that ‘validity, meaningfulness and insights generated from qualitative inquiry have more to do with information richness than with sample size’ (p.185).

It could be argued that another potential weakness or limitation resides in the sampling strategy for the study. Having picked my sample of research participants among my working colleagues within the same training institution where I work, the issues of power and dual role may be perceived as determining how I was seen by my research participants and influencing the researcher-researched relationship, as well as shaping the data that was collected. As explored in the methodology, I remained aware throughout of such issues and attempted to respond appropriately. I observed research ethical obligations in my interactions with them by recognizing my subjectivities and how my positioning may impact on the researched and the research process. I attempted to manage my research in the best manner to ensure integrity and authenticity as postulated by O’Leary (2004). I think one measure of my success in managing this is reflected in the depth of the data produced and the participants’ willingness to share their struggles as well as their successes. I also think it was demonstrated in the way some participants felt empowered to, for example, change agreed interview dates at short notice.

Another area of potential concern was my insider membership in this research process. As a researcher I researched an area of my practice. I had my own experiences and held my own views. To reduce the potential concerns associated with insider membership and to ensure trustworthiness of my research findings, I attempted to apply disciplined bracketing and detailed reflection on the subjective research process, with a close attention paid to an awareness of my own personal interests. As I acknowledge in the section on reflexivity, however, it was only biases of which I was consciously aware that I could attempt to bracket. I became aware during the study, for instance, of the deeply embedded, unconsciously held cultural values around play that I had brought to the research. This reinforced the importance of reflexivity as an ongoing process and the difficulty in ever ensuring the complete nature of the most disciplined bracketing approach. Generally, I
remained authentically and deeply interested in the experience of my research participants and committed to accurately and adequately representing my participant’s experiences, an attitude regarded as important to trustworthy research according to Dwyer & Buckle (2009).

I also cite the lack of Kenyan literature in this field to support and contextualise my findings as being an area of limitation for this study.

**Contribution to Knowledge**

This study provides an important contribution to understandings of the importance of cultural competence to effective therapeutic practice. It demonstrates, moreover, how the cultural underpinnings of non-directive play therapy may make it inappropriate in its current form for direct transfer to non-western countries. As one of the Kenyan pioneer researchers in this field, the findings produced relevant literature on the appropriateness and inappropriateness of this model within the Kenyan context on the basis of therapists’ lived experience of its application.

At the same time, the study has created opportunities for personal and professional learning for me, the participants and Kenyan play therapists generally. It revealed, among other things, the omission of cultural considerations in the Kenyan play therapist training that was offered by the western facilitators. The model itself was based on a theory built on western assumptions, a situation with the potential to promote cultural insensitivity, biases and incompetence in Kenyan play therapists’ practice locally. The study thus, by opening up exploration of a little researched area, potentially forms the basis for the development of a more informed indigenous training system for play therapists. It also offers Kenyan play therapists using this model opportunities for further research that would lead to the model’s improvement and development within the Kenyan context.

Dissemination of this research study findings is likely to be another way of adding my findings to a body of knowledge. This I intend to do by disseminating my findings to interested stakeholders verbally or in written forms at workshops, seminars or conferences, or through the publication of a single-authored work either in an international referred journal or locally, and/or through co-authorship with my supervisors. Presenting my work at conferences, workshops, seminars or other relevant educational forums locally and internationally will also expose me to the world of play therapies. It will give me experience and confidence in this
type of forum, enable me to generate new research ideas, and allow me to network in the field of psychology.

**Recommendations**

Whereas the findings of this research study revealed that the play therapists experienced the western model of non-directive play therapy as in large measure appropriate for use within the Kenyan context, they cited instances where the model proved inappropriate, largely due to Kenyan cultural beliefs and practices. On the basis of the model’s lack of fit with Kenyan culture, further research is recommended to enhance the models appropriateness for use within the Kenyan context by integrating Kenyan traditional cultures in this model.

Similarly, lack of public awareness of professional counselling featured prominently in this study as one of the contributors to the model’s inappropriateness within the Kenyan context. This thesis, therefore, recommends awareness creation on the appropriateness of professional counselling services in general and for play therapy in particular among the Kenyan communities.

While lack of local training opportunities for Kenyan play therapists and subsequent professional support was also cited as an impediment to the development of this model in Kenya, forming a support forum for Kenyan play therapists within the Kenya Counsellors and Psychologists Association and the training of play therapy supervisors would be a source of support and development of this model in this region.

**Reflexivity**

Reflexivity has become an increasingly recognized feature in social science research in recent years (Etherington, 2004). According to Cresswell (2007), reflexivity relates to a researcher’s own consciousness of the biases, values and experiences they bring to a study. It also encompasses the researcher’s experience of the research and in this section I explore some of the discoveries I made about myself in the process of undertaking this research.

As a Kenyan woman researcher in my late sixties, I increasingly came to recognise that I am sandwiched between yesteryear and present year life, between traditional and more modern lifestyles. Even though Kenyans are adapting to changes in their lifestyles connected to urbanisation/urban immigration, in many
communities in Kenya traditional ideas of a woman’s role as family caregiver still dominate. Traditionally, woman’s place was predominantly in the kitchen. Whereas educational and professional opportunities were accorded to men, women and children were considered inferior. Decision making was solely vested in the male counterpart as family head, a practice that rendered women and children voiceless. This scenario encouraged patriarchal leadership within most Kenyan communities where guidance and direction by the elders and teachers was sought in dealing with challenges, including emotional challenges and others. Maintaining the family image was regarded as important. Seeking emotional support outside one’s own family was regarded as a sign of weakness. It could bring disciplinary retaliation as it brought disgrace to the family by indicating the family’s inability to manage its own affairs. This made it almost impossible for children as well as women to disclose their emotional challenges to outsiders in the name of seeking psychological support because within the family system such support was available and provided by identified members of a family/clan.

As a professional counsellor, I did not realize how much my cultural values were deeply ingrained in me and only discovered it in the process of this research study. For example, I became aware that my priority has been to seek emotional support from my family members or from a spiritual leader rather than from a professional counsellor, probably due to my belief system emanating from my cultural beliefs and practices. While this research explored the appropriateness of non-direction within the Kenyan context, I must acknowledge that what I viewed as the lack of direct teaching on the doctorate programme was initially a substantial challenge to me based on the Kenyan system of education in my previous studies. Within my subconscious lingered the idea of being taught during my doctorate programme, leaving me with unmet expectations which I had to work on in order to move on with my studies.

Another reflexive awareness gained during this research study was the mistaken nature of my belief that I had changed my perspective regarding children’s play after my professional training as a play therapist. I thought that I had left behind the perspectives of most traditional Kenyan communities, where play was equated with idleness, lack of seriousness or commitment and children were given differing levels of domestic responsibility in a bid to mould them into responsible future adults. This is less true for urban areas, where the growing practice of employing help within the house has led to a good number of children having fewer responsibilities and hence, unlike rural children, having no time to play. One day
in the course of this research study, a neighbour came out furious at the children playing outside his gate chasing them away and accusing them of being left idle by their parents when they could be engaged with the household chores. As I moved outside my gate to witness the commotion, this neighbour approached me complaining about big children being left idle to play instead of being engaged into meaningful activities. At this point, I found myself siding with my neighbour and blaming the children for being left idle instead of advocating for children’s play as a play therapist. This incident made me realize how much traditional cultural values continue to influence me, even as a professional.

My discovery of siding with my neighbour in his opinion of disregarding children’s play, seeing it as lack of parental responsibility in rearing lazy and irresponsible children, and my preference for seeking spiritual or family support in dealing with my psychological challenges, in my view had potential implications for both this study and my practice as a therapist. As unconscious biases, they were not available to me to bracket effectively at the start of the study and hence my sense of reflexivity as an on-going process was reinforced. At the same time, this discovery also affirmed to me that different cultures teach different values and priorities and reinforced the importance of cultural awareness and sensitivity in the development and application of therapeutic models.
Reference


Attride-Stirling, J. (2001) Thematic networks: an analytic tool for qualitative research: *Qualitative Research 1*, 385-405


126


Bond, T. (2004) Ethical guidelines for researching counselling and psychotherapy, British Association for Counselling and Psychotherapy


Centre for Research, Communication and Gender (Creche) (2010) Kids to Play: called for policies to protect this right. Nairobi: 'Daily Nation' News Paper, Wednesday May, 19th


Emavardhana, T. (2005, December) Counselling across borders: How to counsel within the Thai culture. *Keynote presentation at the 11th International Counselling Conference,* Bangkok, Thailand


Guerney, L. (1983), Child-centered (non-directive) play therapy. In C. E. Schaefer & K.J. O’Conner (Eds.), *Handbook of play therapy* (pp.21-64. New York: Wiley


Kamei, N. (2005), Play among Baka Children in Cameroon. In B. S. Hewlett & M. E. Lamb (Eds.), Hunter-gatherer Childhood: *Evolutionary developmental and cultural perspective* (pp. 343 – 349) New Jersey: Aldine


Langeveld, M. (1955) Bevrijding door beeldcommunicatie (Liberated through imagery-communication). Nederlandsche Tijdschrift van de Psychologie (Dutch Journal of Psychology) 2, 443 – 455


McLeod, J. (2011) *Qualitative Research in counselling and psychotherapy (2nd Edn.)*, London: Sage


Mudavanhu, Y. (2017) Quality of literature review and discussion of findings in selected papers on integration of ICT in teaching role of mentors, and teaching science through science technology, engineering and mathematic ( STEM). *Academic Journals Vol.12 (4), pp.189-201, 23rd February, 2017*


Popay, J., Rogers, A. And Williams, G. (1998). Rationale and Standards for the systematic review of qualitative literature in health services research. *Qualitative literature in health services research* 8: 341 – 351.


Tudor, K. (2011) Rogers' therapeutic conditions: A relational conceptualization, Person-Centered & Experiential Psychotherapies, 10:3, 165-18


Waterhouse, R.L. (1993) ‘Wild women don’t have the blues’: A feminist critique of ‘person-centred’ counselling and therapy. *Feminism and Psychology, 3*(1), 55-71


Appendix 1: Sample letter of invitation to research participants

Study Title: What is the experience of a trained play therapist using the western model of non-directive play therapy in her/his therapeutic work with a Kenyan child?

Dear .................................................................

I hereby introduce myself as Mary B. Otieno, a doctorate student in counselling studies at The University of Manchester in Britain. I am conducting a research study as part of the requirements of my doctorate in counselling studies, and I would like to invite you to be my research participant in this research study that investigates the experiences of trained play therapists using the western model of non-directive play therapy in their therapeutic work with a Kenyan child.

Should you decide to participate, you will be invited for a one to one in-depth interview. And be asked to describe into detail your experience of using the western model of non-directive play therapy within the Kenyan context.

The venue of the interview will at a place and time convenient to you, and the interview should last between 45 minutes to 1 hour. The interview will be audio taped and the tapes will be played only by me as I transcribe and analyse the data after which they will be destroyed.

Participation is voluntary and confidential. Study information will be kept in a secure location only accessible by me. The results of the study may be presented at professional meetings or conferences, but your identity will not be revealed.

If you feel uncomfortable at any point of the study, you are free to withdraw without any penalty. You may contact me at (+254 733 778 998 e-mail marybotieno@yahoo.com) or my research supervisor ........................................ and or Research Ethics office at the University of Manchester at .................................................................

With kind regards Mary B. Otieno
P.O Box 5786, 00200, Nairobi - Kenya
Appendix 2: Research Participant Consent Form

<table>
<thead>
<tr>
<th>Project</th>
<th>Doctorate Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>An investigation into the appropriateness of the western model of non-directive play therapy within the Kenyan context</td>
</tr>
</tbody>
</table>

1. I confirm that I have read the attached information sheet on the above study and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.
2. I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason.
3. I understand that the interviews will be audio/video-recorded.
4. I agree to the use of anonymous quotes.
5. I agree that any data collected may be passed to other researchers.
6. I agree that any data collected may be published in anonymous form in academic books or journals.

Participant’s name:  
Signature: Date:  
Date:  
Interviewer’s name: Signature:
Appendix 3: Sample of interview transcript

Participant: Abich:

Researcher: So Abich (not her real name), thank you so much for accepting to be my participant. In the study I am undertaking, I am investigating the appropriateness of the western model of non-directive play therapy to the Kenyan context. And what I want to get from you is your experience of working with children using this therapy. Whether you find it applicable to the Kenyan context and if you have any challenges, what are the challenges and what improvement could be made to it? So this is what has brought me here today yahaa.

Participant: So do have any specific questions? Because eeh? Okay fine, I can say that it is relevant,

Researcher: Yahaa

Participant: in some situations and in some situations it is not. Aaa but mostly you know, on a larger scale basically it is relevant aaah because our Kenyan children comes from environments where there are a lot of directive. In the school system where they come from, if the teacher is directive, the child is passive, you know. Even at home you find the child is a passive receiver of adult’s directions and instructions... but when they come to the play room, when I adopt the non-directive play therapy, you know, aah, sometimes, you find the child, you know, being a bit surprised because they come expecting the same experience with adults out there, and in settings like schools. So they came to the play room and they find the non-directive approach or setting and then it seems sometime to take them by surprise. But with time they adjust and it really, it really works - yahaa. I can say that, for many children aah with different issues it gives them an opportunity to be themselves.

Researcher: Eeehe

Participant: some children say after going through the therapy, some children say that...“aah you know, I know what this place is now. This is a place where children come to be listened to".
**Researcher:** Okay!

**Participant:** Which means, you know, the child begins to realise that this is not a place where the child comes to be talked to, or to listen to adults, but they came to be listened to and that for me is the essence of non-directive play therapy, and that is how the children perceives it, yahaa, a place where they come to be listened and where they can be themselves, yahaa.

**Researcher:** So Abich, what pushed you to learn play therapy?

**Participant:** Aaah what pushed me to learn play therapy? Aaah it was... basically for me it was actually after the 1998 bomb blast...

**Researcher:** Yahaa

**Participant:** yahaa, because aah, there were children who lost their parents, there were children who were traumatized and when we started working with children and mixing them with adults, I realised that the way in which children were expressing themselves was a bit different from the way in which adults were expressing themselves and we needed to use an approach that was child friendly, and one that aah... you know, children could use able to use to express themselves. That was the first time I come across play therapy. So I trained in it as part of capacity building for counsellor were seeing children because I was in the group of counsellors who were seeing children. So once I got into understanding, and so that it could work, I have not looked back.

**Researcher:** You have not looked back!

**Participant:** ooh no, yahaa... mmm.

**Researcher:** So do you find it therapeutic in working with children?

**Participant:** Yaha...yes, yahaa, yahaa it does achieve the aims of counselling just like any other lots though I would say the age group matters in which play therapy can be used or non-directive play therapy can be used, but I have found it very effective for children because it is basically eeh just going along with what the child uses to communicate in play, anyway under normal circumstances, so just putting that into therapeutic setting and providing the child with the
materials that they need to use to express themselves. So it does. It provides that kind of therapeutic outcome for the child. In fact, it doesn’t, eeh you know, the child’s issue, doesn’t even kind of, doesn’t have to be over. Sometimes it is just for processing, like, for example loss. You know a child who has lost their parent...

**Researcher:** Yes

**Participant:** … they are processing the loss. But through the use of play therapy the child can be able to express themselves, to express their loss, to mourn the loss of that parent, to express their anger and you know, at some point to reach at some point of acceptance. So it is therapeutic in terms of it provides the child with that opportunity that they don’t get out there in the schools or at home to express themselves. Yahaa. In that setting of non-directiveness, where the materials are displayed, so the child gets to choose what they want to work with because I don’t. I don’t pre-choose for the child so that if they were, example sexually, abused, I am not putting an atomically correct dolls there, doll, house or whatever, or materials or things that are related to sexual abuse. But the play room is set up in such a way that the child can be able to choose whatever they feel that they want to work with. For me that is what non-directive. And again, I do not bring the agenda. The child is the one that comes with the agenda. Yahaa, they see what they want to work on, to them … yahaa, for that session. So, that in itself is therapeutic, because they can think out there, is like they don’t get to experience things like that, so they get amazed and they think what kind of a place is this, this is not a school, this is not a hospital, it is actually a place where children comes to be listened, So I think they get it (laughter) … yahaa.

**Researcher:** So, you did mention that if you were handling, for example, loss and grief then it is a process that could take a child to acceptance. When would you know that a child has accepted the situation that they are in?

**Participant:** Yahaa, eeh… like, for example, when they begin to speak about the person they have lost in the past tense, you know, and when they are able to mourn and able to ask the person questions, and sometimes they will pick a doll eeh, and pretend it is the person who has died, or they are doing something in the sand tray, but you can see where they are is not where they were when they came for therapy. This is for one to tell that the child is almost reaching that place of acceptance. Although, of course, they could not, in loss and grief eeh,
you know these stages tend to fluctuate. So at one time they are okay, the other time they are not. But basically through play, through the process of play therapy, I can be able to monitor even through their drawings, that the way they draw things in the first session, the drawings are changing, they are beginning to have some signs of life, there are some sign of, you know, moving on, yahaa, yahaa. Relocating, you know, adjusting to the loss without the person, I mean, adjusting to the situation without the person who they have lost. So, one can be able to tell.

Researcher: So approximately, how long would you take with your child client before they can achieve therapeutic movement?

Participant: Eeeh, how long?

Researcher: Yahaa

Participant: Eeee... between ten and fifteen sessions, yahaa because basically the way I work, eeeh?...,

Researcher: Yes

Participant: ...aaah being non-directive and having the child lead the way,

Researcher: Yes

Participant: Typically the first three sessions...

Researcher: Ehee

Participant: ... I can say, are about creating rapport because the relationship is so important...

Researcher: Eeehe

Participant: ... if the child does not have a sense of trust...

Researcher: Eeehe
**Participant:** ...in the therapist, then we are not able to play, so we must have that ground. So we work on relationship. I am a stranger and the child is coming to this strange place, we haven’t met before, they think, it is a place where, may be, they are coming for discipline because they have been bad or they are coming to have their hair fixed or whatever the adult might have told the child. So, of course, I have to work with those assumptions to stop the child to be with those assumptions, by creating a rapport.

**Researcher:** Eeeh

**Participant:** And then, of course, there is some assessments that I do, on-going assessments. So, you find, like in the three sessions, we have some sort of working relationships, we have engaged, and I have been able to pick the issues that the child is presenting, in addition to what the guardian has said.

**Researcher:** Ehe

**Participant:** Yahaa. Then, I make a treatment plan after those three sessions but based on what I can be able to see, and now that we have a rapport. So we could say these are the issues, this is how we will work on them. And sometimes you just put it to the child that, this is what you want to work on, and when you come here it is your responsibility to tell me which issue you want to work on today.

**Researcher:** Okay

**Participant:** Yahaa. So, so that is why it takes around that time. Yahaa. The parent will say it is a long time, it is a lot of money, but, eeh you know, we also talk with the parent so that they can be able to see the value it has, so that therapy cannot be rushed just to achieve, eeh, some outcome for the parents. But it is more of empowering the child, so that even after counselling has ended, the child can be able to, somehow deal with some other challenges that they meet in life. So it is not problem solving, dealing with the problem that there is but we need to empower the child.

**Researcher:** How is your clientele flow like?

**Participant:** Eeee, I do ab...o..ut seven hours a week (laughter)
Researcher: Seven hours a week?

Participant: Yes, on average eeh, because that is when I am really busy. Because the other challenge here in Kenya, you know, is that counselling for children is not a priority in the family. So when I say seven hours a week, that is a child who is having two sessions or those are seven children.

Researcher: Yahaa

Participant: That is when it is really busy. When it is not, yahaa, and you see the clientele keeps on fluctuating. One is ending, another one is beginning, one is ending, and another one is beginning, like that. Yahaa. And then of course we are many counsellors. Aaah, like now, aaah these are both young children in adolescence. Aaah I think of a total as at today is about 57 children under eighteen between the counsellors.

Researcher: So do these children come from particular institutions or just brought individually by parents?

Participant: Eeee, they are referred. Majority are brought by parents, we have those who come from charitable children’s institutions, so they are referred by social workers in these institutions or administrators. School also, eee because of issues of aggression, eee school performance, then we have eee hospitals referring children and then lately we have the courts. Which is a good thing, they have become to appreciate the role of play therapy. So like when parent are having marital cases in court like divorce, separation, maintenance, these days we are seeing children’s courts referring children for an assessment or for some kind of support because the court now acknowledges that when parents are fighting children are affected, so they want children to come for counselling to be able to deal with these. They even ask for a report from the counsellor on how the children are faring, yahaa, which I a good thing in our country. Yahaa.

Researcher: Ok, You did mention that play therapy work better with children. I would like to know the ages of children that you work with in Play therapy.

Participant: Aaah, I can safely say twelve years and below.
**Researcher:** okay

**Participant:** Yahaa, aaah, the youngest child I have seen, eee, was two and half but, you know, that was a unique case. A two and half year old child who was being sexually abused by the uncle, but, yahaa, we have that age. But if some adolescence want to engage with play therapy then they are allowed to do that. Eee, yahaa. But basically twelve years and below is very appropriate and they embrace it, yahaa, that is the age that I do play therapy with.

**Researcher:** You say that if adolescence would like to use play therapy then ... Participant: They do, yahaa, because I see them in the same room (voice raised). Researcher: So who suggests that you use play therapy with the adolescence?

**Participant:** Eeh, yahaa, yahaa, the adolescence. You know, an adolescent would say that I don’t want to talk about this, can I just show you these things. Can I draw what I am talking about so that you can understand me? Can I put it here in this sand tray? Which is okay? Yahaa. But because adolescence are more verbally capable of expressing themselves, we will talk but we also integrate a bit of play in their therapy, especially at times when they are faced with difficulties in expressing themselves using words because of the intensity of the feeling associated with what they want to talk about. Yahaa or they feel that if they were to express themselves using, eeh, play materials then that would come out better, and they are allowed to do that. And I allow them to do it. When they come into the play room I tell them that there are many ways in which you can express yourself. You can talk if you don’t want to talk you can draw or you can play.

**Researcher:** What are the worst moments that you have had using this therapy?

**Participant:** Worst moments? Yahaa, aaah (voice raised) okay. When children want to go home with the toys (laughter), with the play materials, and if I don’t allow them to go with the materials they throw temper tantrums (laughter), they get annoyed and they say I am a bad person (voice raised) because I have refused to give them that car, I have refused to give them that mobile phone that they need so much. And also sometimes, okay the play room has rules, and we do say to these children that, you know, that the toys remain here, and you
can play with these toys in as many ways as you want, but you cannot take them. So I have been attacked with water gun, splashed water all over my head (laughter)...

**Researcher:** (laughter) because you refused...

**Participant:** ... I have just come from a saloon and, chichichi, you know (voice raised), yahaa so aaah that. But also you know, aaah is when I have just began, you know, to work with the child, and the child is opening up and then the parent withdraws the child...

**Researcher:** Ehe.

**Participant:** Yahaa. Which is really bad, because you know, it is like putting the child on the operating table, opening them up and then the parents takes the child and you don’t see them again. So I keep on wondering what happened to the child even the follow up on telephone, you know, to find out why the child is not coming, you know, the parent will come up with some excuse, and say it is the time, you know, it is finance and things like that. Yahaa.

**Researcher:** So what do you understand by this withdrawal of children by parents prematurely?

**Participant:** I, I, okay, aaah, mostly parents find financial reasons eeh, time reasons yahaa. But I think sometimes it is also they do not see the results coming as quickly as they could have expected. So, and others think that play is a waste of time and not a kind of therapy. So the child was sent there, painted and played with toys, and they wonder ‘so I go there and pay and they just play’. Although aah, during the intake, and parents consultations I do explain the model, but it is like, you know, the parents wants if the child’s performance was low, they want the performance to come up just like that. So they say I am bringing the child to counselling and the performance is still there. Yahaa. So they don’t see the child recovering as quickly as they expected, and in some cases aah they feel that the child has become more active (laughter)...

**Researcher:** okay

**Participant:** Yahaa... (laughter) so sometimes they need help from us.
Researcher: They feel they cannot control the child now?

Participant: Yes, yes. They cannot control the child now, the child has become bad, the child is talking back at the parents, yahaa, yahaa so...

Researcher: So they feel threatened and withdraw the child.

Participant: Ehe, ehe, but those are few cases because, you know, most of the parents would say it is the child who wakes me up and says I have an appointment with the therapist today. And you know, sometimes you just use that word and the child feels very aah amused, and you know, when they are saying they are going to see their therapist (laughter)... 

Researcher: (laughter) a big word.

Participant: Yahaa, I actually prefer to use that word. I tell them you know I am a person who play even talk to children, sometimes they are called counsellors sometimes they are called therapists and the child just chooses that word ‘therapist’ (laughter)

Researcher: Therapist?

Participant: Yahaa, this is not a teacher, this is not a doctor, and you know, so it is another person. Yahaa.

Researcher: So what are the best moments that you can remember working with children using this therapy?

Participant: Yahaa, many. Aaah, it is when you can see a child who when they came for counselling could not even speak loudly, you know, it is like they are whispering eeh. Aaah could not even look at me, you know, always their back turned towards what they are doing. Or standing in the front there for thirty minutes or, you know, sitting in the car talking to themselves, and then aah after working with the child, the child is so confident. Or the child who cannot come to the play room unaccompanied by their parents, they cry and they need a parent to be there because they are fearful or they are anxious eeh. Then, you know, we are going into the play room, and the child says to the parent wait
down there…

**Researcher:** Okay

**Participant:** You know that is good because it is like now the child has built trust, I know now that we have a relationship now, the child feels safe with me, the child has gained some degree of confidence, so you know, those are good moments or when a parent says, you know since my child started coming here they have become different, the nightmares are not there, things like that. Yaaah (laughter). That is when I want to go again and see another child, I am encouraged and I see like it is not in vain.

**Researcher:** Ehee

**Participant:** mmm

**Researcher:** So being in the urban area, I imagine that most of your clients are within the urban area and I am wondering if you work with children from the rural settings.

**Participant:** Oh yaaah, oh yaaah, aah, although it is an urban area, but children come from all over as far as Eastern province. We have children from Mombasa, not Mombasa city, the, the, the rural eeh

**Researcher:** The coastal area?

**Participant:** Yaaah, yaaah, eeh from central, yaaah, because you see there are no counselling centres there, eeh, so they are brought. And the play room has play materials for children from rural areas that they can be able to identify with.

**Researcher:** Okay

**Participant:** And play materials for children from urban area so that the urban child when they come in, does not look at it, and you know, they have nothing that they can use to communicate about their world. And the rural child does not come in and see a place that looks like it has nothing that they can use, so yaaah. So they do come eeh both. But overall there is, of course, majority come from the city.
**Researcher:** So what are some of these materials that you use for children from the rural area?

**Participant:** Like the hut, you know the traditional hut?...

**Researcher:** Yahaa

**Participant:** ...Yahaa, family figure...

**Researcher:** mmm

**Participant:** ...the elderly people like the parents, you know, we have like in the animals, we have domestic animals like cows, goats and sheep those animals that are found in the rural areas, eeh so you know, such things. Eehh when the city child has a toy gun, for the rural area (laughter) child we have got pangas, that small mashets, eeh things like that, that they can be able to use here, bridges, you know, different varieties - Yahaa, of things, balls, of course a ball is a common thing, but you know, we have things especially the households, and trees, yahaa, that you find in the rural area, yahaa are there. But the sea animals, the fish, the domestic animals, the chicken, the wild animals yahaa. Children in the rural area are not able to identify with the children in the urban area.

**Researcher:** mmm great.

**Participant:** Yahaa. So it is a well-integrated play therapy room.

**Researcher:** Do you experience any challenges getting play materials?

**Participant:** Yahaa, aah definitely, aah a lot (laughter). Aahhm, like I remember there is a time I went to order for an atomically correct aah material in the Masai market there, so I was asking them to curve eeh wood curving, eeh curve a girl, and a boy, a man and a woman with all their body parts and they refused. They said what do you want that for (laughter)? We don’t do that (voice raised- laughter) Yahaa, you know they were looking at me suspiciously (laughter), It is funny, what does she want these for? So I explained, you know, this is for those children who come to counselling, they have been sexually abused and you know sometimes, we use this. Or even when we are just doing child protection, you know, like for education purposes...
Researcher: Yahaa

Participant: ...we use this material. So they said aaah, so you know, she told me, the lady, told me, I will go and do them at home, and you come and pick them. So it is like not...

Researcher: At home?

Participant: ...yahaa, not displaying here,

Research: Okay

Participant: ... I will go and do them at home, so you come and pick them here. So that is what happened. Yahaa, there is that but also aaa, you know, a play room is not a matter of putting anything, it is a matter of collecting, and takes over time. Like my play room, aaah, I started building it, or making it since 2005...

Researcher: Ehee

Participant: ... this is 2012 aaah?...

Researcher: Yes

Participant: and there are still some things I am looking for and I cannot just get them eeeh, so I look for them everywhere. I am walking on the streets and I see a street vender selling a book about dinosaurs, and I am like, this could work in my play room or this family that was afraid of the dark. So sometimes I go there and I am standing and they are saying, which book are you looking for? There are so many story books here for children just see that! No, I just don’t want any story book; I want books with certain themes. Yahaa, so, it is a matter of, you know, deliberately looking out for materials that imitate inner themes and flow, yahaa, because it is not a platform, yahaa so they must have a meaning. For me that is the role.

Researcher: So when do children look at these books?
**Participant:** Yes, yes, and sometimes you just read the story, yahaa...

**Researcher:** You read together with the child? Participant: ... and it talks about certain themes Researcher: eeh

**Participant:** so, you read out the story, and say things about the story, and what are you telling out there. Is there anything about this story of this animal that, you know, is familiar to you? So, yahaa we do...

**Researcher:** mmhmm

**Participant:** ... Yahaa. So materials are there, but some are very expensive and making a play room is not cheap also. It is expensive...

**Researcher:** It is expensive.

**Participant:** Yahaa, so you just make slowly, slowly. Yahaa, you don’t have to have anything anyway (laughter)...

**Researcher:** mmhmm

**Participant:** ...yahaa (voice raised) but at least, the basics, the basic materials are there.

**Researcher:** Okay Abich, so what are the major challenges that you experience using this therapy?

**Participant:** Aaah, like I said, children taking time to understand it. Because, see the situation I was telling you, eehh, where children come from. You go into the classroom and the teacher say, now it is time for mathematics so take out your books. If you go to a play room and somebody is asking you, what would you like to do today (laughter)? That is kind of overwhelming for somebody who is used to being told, it is time to go for tea break, it is time to play, it is time to come back to class, it is time to eat, it is time to sleep. So here, it is like, you come here, the only thing that you are knowing is that we have thirty minutes, we have forty minutes. And this is your time. This is your special time. So some children are kind of mistrusting, are you serious? Are you for real, yahaa, this my time? Yahaa, so that is one challenge, that you know, they might take long to
understand the process, yahaa. Then of course, I talked about the, the premature termination, or withdrawal of children aah, by their guardian. That is the biggest challenge. Aaah, the other challenge, is referral, eeh, yahaa there aren’t as many referrals for the children in this country, you know. Where we are now, we know that children have issues, when there is a conflict in society children are affected, when there are natural calamities and critical incidences, children are affected, when there is loss, there is increase in separation of parents and domestic violence, there is sexual abuse, but where are those children? So there isn’t as much. Our country is still to appreciate play therapy, yahaa. Then of course, aaha, you know play therapy in the country and supervision of the same.

Researcher: Eeeh supervision?

Participant: Yahaa, that is a very big challenge. There aren’t many. In fact in KCA (Kenya Counselling Association) I don’t know how many there are, aah, but I wish they were more. Because if they were more, may be, the awareness creation in the community or society would be more, which would translate to many children seeking counselling. Yahaa. So even in the kind of setting where I work, aah, sometimes I get overwhelmed because when young children of five years, or six years old come, other counsellors shy away, saying she/he has to wait until Abich is available, which shouldn’t be the case. I mean, people should train and be able to see children.

Researcher: So what are some of the reasons for young children having to wait for you?

Participant: Because there is no other play therapist. Researcher: Okay, because they need to use play therapy? Participant: Yahaa, yahaa, yahaa.

Researcher: So they prefer you see them because of play therapy?

Participant: Yahaa, yahaa, so there is that.

Researcher: You talked about referral, for what special services would you refer the child client?

Participant: For, okay for psychiatric assessment, for special need assessment
yahaa, yahaa such things, mmmm, and then of course, sometimes for physical safety. Yahaa, like if the child is a victim of physical abuse or sexual abuse. You know, before counselling commences, before play therapy takes place, where will the child be? This is important, yahaa, yahaa.

**Researcher:** So under such situations when you get stuck, you are not able to refer children?

**Participant:** Okay we, but you see the services on the financial cost, you know some parents insist that he just has to be the one to see the child because I cannot afford to go and see a psychiatrist, yahaa or for my child to be assessed, yahaa, so, and of course, you know in our country, I think there are only two child and adolescent psychiatrists.

**Researcher:** mmmhmmm

**Participant:** Yes, that is another challenge. Yahaa. So basically anyway, the doctors are there but you know that, that referral is a challenge.

**Researcher:** mmmhmmm

**Participant:** Yahaa

**Researcher:** So what recommendations would you make for improvements of this therapy?

**Participant:** Aaah, awareness, awareness amongst parents and adults because in play therapy the child does not bring themselves, the child is accompanied, they are too young. They are not in control of that. It is the parent or the guardian who makes decision to take the child to therapy. But they cannot make that decision if that awareness has not been created in them. So there is need for awareness in our communities and for parents to be able to know that taking their child for therapy is not a sign of weakness, it is a sign of love. Yahaa. And that it is not their fault. Sometimes I think, you know, a parent will insist in staying with a child in the house when the child has a problem to see a therapist saying, ‘a child this young, going for counselling! So what has happened?’ You know, so they need to know that it is just the same way when you take your child to school when it is time for them to go to school. When it is time for the
child to seek some help that me as a parent, cannot be able to give, so a need to take to a professional to see my child, does not mean that I am a weak parent, does not mean that, you know, I am a failure. I am a parent, I am doing the best. So that needs to be kind of sensitised (laughter) to our parents in our communities. Aaahm, in this country I have realised that some things work when the government put its foot in it. And in our constitution, children have been identified as a special population among the list of venerable population. In fact children’s right has been entrenched in our constitution, so the government need to support the counselling of children through the ministry of health and through the ministry of education. This is where children are increasingly mentioned and, you know, there are those eeeh, eeeh, legal statutes that talk about, eeeh, services to children. If there was that, then we would find, you know, eeeh play therapy or counselling of children being advanced because there is support, so that even those children who are not able to afford, for example the same service, may be in an hospital or in school. In most school which were built along time ago, there is actually no space, no physical space for play therapy to take place. So, that is why I am saying if the government, kind of, came in and supported, the whole venture, then you would find other organizations making the move, then more children are able to access this service. Yahaa, it does, it does rely so much on the good will of the school, on the good will of the agencies but we need more than that. We need it to almost become a law, so that we have, every school have at least somebody who is in charge of psychological welfare.

Researcher: Now in your view, who would create this awareness to the government?

Participant: You know, it is the government’s role to create awareness because, okay fine, the counsellors can, through our counselling profession, we can, but the government should take it up because... and I know there are few, few initiatives like child protection in schools and all those things eee, but we need to do more than that, we need to have other structures and the human resources training of people, yahaa, that is the other thing. In our country we don’t have many training. In fact, if you look for training in play therapy in Kenya eeeh you, you would not find it. I don’t know, may be eeeh, you would not find it yahaa. So most counsellors have to seek it either online or outside of the country, yahaa, so...
**Researcher:**You are talking about information?

**Participant:** Yahaa, information and training of play therapy, yahaa, so we need to have also training, we need our professional body of counsellors to encourage practising counsellors or upcoming counsellors or student counsellors to also think of taking up courses in play therapy. Yahaa, because, we the helpers need to know that children are people too, and they constitute our ethical mandate to the community just like the way adults do so, so that we can have many people doing this, yahaa. So those are some of my recommendations.

**Researcher:** Now in the process of working with the child, do you ever make any visits to the child’s family just to find out the progress and to hear from the parents.

**Participant:** Aaaha. Home visits?

**Researcher:** Yahaa

**Participant:** Not many times. Eeh, Aaah, sometimes I do take play to the child, eeh not in town, at home eeeeh. But in terms of progress, visiting the child at home early, the child is at school a lot of the time, and the child is brought, eeeeh. But what happens, the family can come to the child’s station. Eeeeh, so the family comes to the child’s station in this way, the child might say, I want my parents or we discuss with the child and say my mum and dad can come to my station. Yahaa, so that happens. My brother, whom I fight with all the time, needs to come so that we can talk about this here. So that happens, but as far as, eeh, following up the child at home, eeh, not frequently. The only time I do that is when a parent calls and say my child is sick or the parent is sick or because of some circumstances the child cannot come, so I can go and visit the child at home, or at school, or at the institution where the child stays, yahaa.

**Researcher:** What happens when a child’s play manifests that a member of the family is hurting them?

**Participant:** Yahaa, eeh, then, eeh, I have a discussion with the child’s guardian; about it. I have a discussion with the child but I have a discussion also with the child’s guardian to verify the information, yahaa, yahaa, that, that, that will do.
**Researcher:** Do you also observe confidentiality in working with a child?

**Participant:** Yahaa, up to a certain degree, depending on the age of the child, they have freedom. The parents, for me, I real believe up to a certain degree need to know some things so that they can be able to help the child, yahaa. And, most of the time, the parents already know, after all, they are the ones who have brought the child. If, if, if the mother and father are separating or there is domestic violence, or they are divorced and the child is affected because one parent has left the home, I mean, they both know that. But maybe there are other things that they don’t know, that the child would like to tell them. So we have the parents come and we have that child/parent session. There are some things that children will think that I do not want parents to know about me. So that we keep it, I leave the child, you know, and go down stairs I will be talking to the parent about this or that saying is there anything you would like them to know... But even as we contract with the child, I will tell the child that I am not supposed to tell what we discuss, what you tell me. But you are free to tell if you want. You are free to tell your parents, so that the child doesn’t feel like they are real bound by the confidentiality. Interestingly, most children choose not to tell their parents (laughter) yahaa, they choose not to tell their parents. Otherwise, I have this information booklet, I mean, sheet, which I give parents at the beginning of therapy which says, for example, on the way back home from the therapy session, please do not ask your child to tell you what they did, because again now, you are putting them at a difficult position, yahaa. Asking them, you know, tell me what you did or what you said, you know, that is confusing to the child.

**Researcher:** Restricting their freedom to play

**Participant:** Yahaa, so that is how we try to work around confidentiality.

**Researcher:** So what comments would you wish to make upon this Research study?

**Participant:** I think it is good (voice raised), I haven’t heard of a study like this eeeeh, in Kenya, of course, I think it will be the first, I will be happy (voice raise) if I could get the finding, yahaa. And, I hope that it will not just be an academic study which shelf recommendations which come from it. Implement them,
yahaa. I hope one of the recommendations is that we need to have a forum for play therapists in this country. Because sometimes I feel we are not understood by the other counsellors’ eeeh, yahaa, who feel that we just… So a forum, where we can, you know, together create that community awareness, lobbying with the government, open play therapy centres, you know, or help, help. I know there are children homes, for example, who have everything. They even have the room but they don’t know how to structure the whole thing, yahaa. So, you know things like that. We have children in hospitals, so only when you are in a group can you be able to do such things.

Researcher: So thank you so much Abich.