How do Non-directive Play Therapists Experience their Work with Children in the Kenyan Context?

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

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<table>
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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>KAPC</td>
<td>Kenya Association of Professional Counsellors</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>NGO's</td>
<td>Non-governmental Organisations</td>
</tr>
<tr>
<td>IDP's</td>
<td>Internally Displaced Persons</td>
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<tr>
<td>BACP</td>
<td>British Association of Counselling and Psychotherapy</td>
</tr>
<tr>
<td>KCPA</td>
<td>Kenya Counsellors and Psychologists Association</td>
</tr>
<tr>
<td>GoK</td>
<td>Government of Kenya</td>
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<tr>
<td>UNICEF</td>
<td>United Nations international Children's Fund</td>
</tr>
<tr>
<td>APT</td>
<td>Association of Play therapists</td>
</tr>
<tr>
<td>CPRT</td>
<td>Child-Parent Relationship Training</td>
</tr>
<tr>
<td>IPA</td>
<td>Interpretive Phenomenological Analysis</td>
</tr>
<tr>
<td>UPR</td>
<td>Unconditional Positive Regard</td>
</tr>
<tr>
<td>FIDA(K)</td>
<td>International Federation of Women Lawyers of Kenya</td>
</tr>
<tr>
<td>NDPT</td>
<td>Non-directive Play Therapy</td>
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Abstract

“Seeking knowledge of human experiences requires a transformation of attitude” (Wertz, 2005 p.168).

Title: How do non-directive play therapists experience their work with children in the Kenyan context?

This study explores the experiences of play therapists practicing in the coastal region of Kenya.

The study adopted a qualitative approach using descriptive phenomenological method. Six respondents with a practical experience of at least three years participated in the study with the use of semi-structured interviews. The data was analysed using Giorgi’s (1985) method of analysis because of its descriptive nature. Informed consent, confidentiality and non-maleficence ensured the overall wellness of the study participants’ wellness. Anonymity and confidentiality safeguarded their data.

The findings established that therapists in the region lack confidence to practice non-directive play therapy. It also established that retrogressive culture and lack of professional support were the major contributors to the lack of confidence among the therapists. The study recommends that therapists in the region enhance professional development.

Chapters 5 and 6 discuss limitations of the study and areas for further research. In chapter 5, there is an in-depth reflexive statement on my personal learning and growth. Workshops and conference presentations will be the means to disseminate the findings as a contribution to the enhancement of play therapy.
Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

Signature .................................................. Date..................................................
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Dedication

I dedicate this study....

...to the African child.
Acknowledgements

I would like to acknowledge and appreciate the following people for the direction, and support without whom this study would not have been a reality.

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 my husband Mr Joe Awimbo, thank you for your support and encouragement and your belief in me, this gave strength to carry own even when my confidence and my ability was failing.

To my family for being there when I needed your support, thank you for your support, love and understanding.

To my dear friend Ms Joan Ngetha thank you for being so accommodating, understanding and supportive. I owe a debt of gratitude to you.

To the study participants, thank you for your generous contributions to this study.
The author currently holds a masters’ degree in counselling and is currently working as a play therapy consultant with various children organisations. She has a passion for children and is concerned of their well-being hence, embarking on exploring the experiences of the service providers. Within her own practice, she faces and continues to struggle with professional challenges. They have propelled her to undertake this research with the hope of enhancing the play therapy practice in the area of study.
CHAPTER ONE: INTRODUCTION

“Who is willing to comprehend and carry the hurt and agony of these helpless, innocent and frightened ones? Who will restore their robbed childhood before it is too late? Someone must hear their desperate cry – a cry for unconditional love and acceptance, for counselling and therapeutic interventions that bring hope and restore developmental milestones”

(Mwiti, 2006:18–19)

1.0. Introduction

This study investigates the experience of play therapists practicing in the coastal region of Kenya and illuminates the context within which they practice. The Association for Play Therapy (2001) defines play therapy as “The systematic use of a theoretical model to establish an interpersonal ‘process’, wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development” (APT, 2001:20).

Play therapy is practiced in a context characterized by complexities, in a diverse cultural background that includes the HIV & AIDS pandemic, socio-political instability, religious tension in the area, and the ever increasing poverty levels in our society (Okech & Kimemia, 2012; Wainaina, Arnot, and Chege; GoK, 2008). As a practitioner, I have experienced play therapy as phenomenal and I have often tried to conceptualize it in many ways. This experience forms the rationale for my research. In it, I briefly describe my reasons for the choice of topic and of participants, highlighting their training background. I have often wondered how my fellow play therapists understand this phenomenal world of play therapy practice and thus I ask the research question:

How do non-directive play therapists experience their work with children in the Kenyan context?
I hope the study participants will provide valuable insight to this question. I explore the origins of play therapy practice in general and the development of non-directive child centred play therapy in particular, how the practice started in my own country, and the situation in present day Kenya. My personal experience as a novice practitioner and my reflections on being a researcher precedes the context and background of the problem, research objectives, nature and structure of the thesis.

The study uses a qualitative research methodology and is descriptive in nature, influenced by the Duquesne school of philosophy (Giorgi, 1985). The work of Giorgi, (1985) was inspired by the work of Edmund Husserl (19-13-1962), who placed emphasis on description of experience from the first person's perspective, and this forms the basis of this phenomenological approach. It “aims at connecting directly with the world as we experience it” (Finlay, 2011:23) and to clarify taken for granted life situations (Seamon, 2000). I am a practicing play therapist researching on other practitioners and a researcher familiar with the field of study. This makes me an insider researcher, one who is familiar with the terrain that fellow practitioners tread (Hewitt-Taylor, 2002). Being an insider has its advantages; it can be a means of enriching practical understanding and learning in many areas (McLeod, 2011). This position can bring enhanced empathy and sensitivity to potential issues (Finlay, 2011). The potential danger, however, is the imposition of my presumptions based on my experiences onto the data (Van Heugton, 2004). Through research, I believe I will explore more widely the issues and challenges the play therapists face and generate useful information, which is necessary in the development of a profession (Partridge, 2005). Not only was my methodology chosen because it focused on capturing rich portraits of individual experience, but also because of its focus on the discipline of capturing and putting to one side of researcher preconceptions, which I believed would help my ability to see the world of play therapy afresh (Finlay, 2011).

I started my professional training with general counselling studies, graduating at the level of Masters’ degree and later specialised in counselling training and supervision. I later trained in play therapy to enhance my career and have since worked with young children of 7 to 14 years in a field which touches the very core of my person. My work has rewarded me with joy for the wellness it offers to children, but is also frustrates and confuses me with dark areas it presents, a mystery
which often challenges my capacity to offer necessary explanations to myself or others. This mystery has been my deepest motivation to carry out this study.

The encounter with my first client immediately after graduating from play therapy training was astonishing and left a mark on my mind to this day. My client’s name is John (not real name). As part of his background, he had experienced not only the death of his parents and other caregivers but abandonment by wider family leading him to become a street dweller at a young age. A second psychiatrist had recommended John for a correction centre for his aggressive behaviour both at home and in school, frequently involving himself in fights with boys and stealing from the other children as well as his teachers. These behaviours were associated with mental illness. The sessions took 30 minutes once on a weekly basis. In my exploration, I discovered that John liked football and was entertaining the idea of one day becoming a professional footballer. Therefore, I capitalised on that. Most of the plays were football oriented, and artwork as well was done. During the football plays, he involved me in the role of a goalkeeper and appeared excited at every score. After six sessions, his behaviour began to change, and he became more acceptable both at home and at school. He changed his attitude towards others and developed positive relationships with other children.

John’s behaviour might be understood as the kind of attachment with the caregivers which, according to Bowlby (1973, 1988, 2004), is important for the child’s subsequent social and emotional development. This is important when it comes to regulating stress and fostering adaptation to different situations and contexts (Landry, Simon, Webb, & Mistlberger, 2006). Lack of this may be threatening and lead to emotional reactivity and difficulties expressing emotions (Pietromonaco and Feldman Barrett, 2000). Alternatively, John’s positive self-concept may have been undermined.

According to Roberts (2006), the positive self-concept of a child becomes undermined if others do not recognise painful feelings as being normal and acceptable. This builds on the work of Goldfarb (1945), Spitz (1945) and Bowlby (1951) who had made a considerable impact in this regard in highlighting the behavioural, emotional and cognitive difficulties that were present in institutionalised children. It also supports what Johnson, Browne, & Hamilton-Giachritsis (2006) later reported after
conducting a review of various analytical (controlled) epidemiological studies on the effects of residential care. These writers found that the type of institution and care played a role in the development of the children concerned, who were at risk not only of important delays in their social development but also of attachment disorders and behavioural and cognitive difficulties. These findings are consistent with data published by the Child Welfare League of America (2005), which reported that over 80% of children in care presented emotional or developmental problems having experienced significant trauma (Tomasulo & Razza, 2007).

Was John’s behaviour a desperate cry for unconditional love and acceptance? It has been reported that in play therapy the child can work through their challenges and issues using the toys that they choose, revealing their inner dialogue. In an environment of unconditional positive regard and acceptance (UPR), the child is encouraged to feel safe enough to be able to explore their inner selves without censorship (Landreth, 2002). This then may make play therapy the kind of counselling intervention that would bring hope and restore developmental milestones for the children that Mwiti (2006) refers to.

I met John again and was impressed that he had sustained the acquired new behaviour and had redefined the concept of the self as portrayed by his own words, “I am now a good boy”. On several occasions after therapy, his caregivers wondered and asked what ‘miracle’ I had performed to change John’s behaviour: to them, John was beyond help.

Over the years I have remained curious about this ‘mystery’ and have often wondered how other play therapists survive through practice, knowing how riddled our context is by the tensions aforementioned. This curiosity strongly influenced my motivation to carry out this investigation and forms part of my rationale.

1.1. Meet Lillian Awimbo...

I define myself based on my social history and orientation (Gilbert & Scher, 2009; Nutt and Brooks, 2008; Williams, Hurley, O’Brien, & De Gregorio, 2003) which I have come to accept and
subsequently informs my interaction with my environment (Gergen, 1991; Kitchen, 2009). I am a black African female of middle age, educated, in a society where there is gender inequality (Nasang’o and Ayot, 2007), and a “Luo” by tribe. Luo is one of the 43 tribes of Kenya and the third largest ethnic community, making up 13% of the total Kenyan population (Kenya National Bureau of Statistics, 2010). Because of our immigration patterns, other Luo groups live in Uganda, Ethiopia, Southern Sudan, Eastern Congo, and Tanzania. Traditional “Luos” are principally fishers given their proximity to Lake Victoria (Campbell, 2006; Oburu, 2004; Ogot, 1967).

I am married but childless, which classifies me as an infertile woman. Knauer, (2002) and Rycroft and Perlesz (2001) have classified infertility as ambiguous loss, which can cause one to view the self as less than ideal, a failure as a man or woman. In most African cultures or societies, including Kenya, a woman is construed in terms of marital childbearing (Izugbara, Otsola, and Ezeh, 2009).

“Centuries of high infant and child mortality led to great value placed on fertility. Parents also increase their social status by having more children….fertility communicates to the rest of the community that the mother and the family are in good spiritual and physical health” (Levine et al., 1996:142).

Among the Luos of western Kenya, the community to which I belong: “Serious problems arise when the harmony of an individual’s spiritual component is broken” (Owuor, Okech-Rabah & Kokwaro, 2006:423). Just being a parent contributes to one’s identity and respect in the community (Oburu, 2011). For example, the name “Baba Otieno” (father of Otieno) brought jobs and pride to fathers, just as “Mama Otieno” (mother of Otieno) gave identity to a mother.

I have a vast experience of 15 years in counselling adults and 11 years of practicing play therapy. Currently I am in part time consultancy practice with different organisations who work with children. I am a holder of a Certificate in play therapy after a brief play therapy training conducted by Dr. Margaret Robson and Dr. Katherine Hunt held at the Kenya Association of Professional Counsellors (KAPC) in Nairobi in 2004. The brief training course was 120 hours long and was based on a model of child centred play therapy (Axline, 1947/1969), derived from the adult model of person-centred therapy developed by Carl Rogers (1951).
The aim of the course was to introduce participants to theories of play, the development of play as a process in childhood, and different kinds of play, sensory, projectory, and dramatic (Hunt, 2006). It also introduced an ethical framework for using play therapy with children to introduce and explore child-centred play therapy and other methods. Theory presentations, case presentations, practical skills demonstrations, instruction with tutor feedback, self-development awareness and group teaching were the methods used to deliver content. The course aimed to develop participants’ personal awareness of the experience of childhood within Kenya. It also offered the chance to identify and discuss the continuing professional development needs of those attending (Hunt, 2006).

I was born and raised in Nairobi. I am currently living and practicing in Mombasa, one of the cities of Kenya. I practice the Christian faith. My first language is “Dholuo” which is my mother tongue. Graham (2010) suggests that a person’s mother tongue is the first language a child learns and that children are better able to think in their first language. He further says that, as a mode of expressing and transmitting culture, it is a way of providing links between school and home and facilitating the establishment of literacy skills.

The majority of Kenyans, 66%, speak the six Bantu languages, forming the largest language groups (Masau, 2003). A minority of Kenyans, 31%, speak Nilotic. The Luos, who speak in “dholuo”, belong to this language cluster. The Bantu and Nilotic are the largest language groups and the two groups have tribal lineage and similarities in both their cultural and linguistic structures. In total, they comprise 75% of the population of Kenya (Masau, 2003).

An estimated 70% of the Kenyan population speaks the national language. Its roots are found in the extraordinary outcome of the close interpersonal interactions between the Arabic and indigenous people, who were Bantu immigrants. Centuries of international trade with those living along the East African coastline and involved merchants from Europe, the Far East, and interior of Africa governed the earlier relations. The deeper interactions between the Arab and the indigenous people through intermarriage gave birth to the Swahili people, a phenomenal nation, leading to the emergence of Kiswahili language. It became officially recognised in post-independence years as the national language of Kenya. Missionaries used it to spread Islam and Christianity. The
government of the day also used it during the urbanised of the coastal city-states. It continues to be used along the trade routes across many parts of East and Central Africa to date. It is popular in most Kenyan households and is commonly used as a means of communication within families (Mbiti, 1969; Kioko and Muthwii, 2001).

My third language is English which, unlike Kiswahili, I learnt in school. The English language has long been associated with schooling and, therefore, social and economic advancement (Graham, 2010). Mazrui, a Kenyan scholar, has not taken this well and he is of the opinion that linguistic dependency on western languages has led to intellectual or scientific dependency (Mazrui, 2002).

English is spoken by 17% of the Kenyan population, as a second language to the urban dweller. Sure (1999) reported that educated Kenyans are likely to use all the three languages. Consistent with Heugh (2013), I consider myself as trilingual since all my interactions are carried out in a mixture of all the three languages. Although Kiswahili is the national language, it is interesting to note that English is largely the language of use in official matters and across the education system (Mbaabu, 1996), a trend that has been carried forth to post-colonial Kenya. Attempts have been made to introduce Kiswahili into the education system at primary education level but have achieved little success (Kenya Institute of Education (KIE), 2002). However, during colonial times it was instrumental to an individual’s access to white-collar jobs and other privileges, therefore to upward mobility for the Kenyan, which made it a language with a lot of prestige and power (Mazrui, 1992).

This creates a notion amongst the Swahili speaking communities that the elite and educated enjoy a higher status. Fluency in the English language has been a challenge to the majority in these communities. For the majority of the coastal Swahili speaking communities, the earliest formal learning takes place in the madras (the Islamic religious training for young children) and is taught in the Arabic language. The Arab legacy and Islamic religion placed greater emphasis on learning the Koran and going to madras as opposed to going to school for fear of being converted to Christianity by the early missionaries, at a time when the "missionaries were the only agents concerned with education of Africans” (Kioko and Muthwii, 2001:202). Hence, the English language was equated to Christianity.
A large number of Kenyan children are bilingual, and many can speak three or more languages, with the exception of the category in the area under investigation. As a play therapist, I have often experienced an unspoken barrier between some of my clients and myself during sessions. These are particularly the clients to whom I use both English and Swahili interchangeably. I find two possible explanations: Firstly, while I am comfortable speaking English, I have become increasingly aware that communicating in Kiswahili is a challenge to me. I believe that another reason might be the fact that there is an assumed social status silently ‘assigned’ to me by the mere use of English by the communities I serve.

Throughout the study processes that involved them, I was not aware that the use of language was a concern as no one expressed any anxiety on the same. I must have assumed that they would have highlighted this aspect had it fallen within their experience. Nevertheless, I wonder how this mixed language affects my client’s perceptions. Alter (2013) argues that experiments on social psychology have shown that minor cues in language can dramatically change our perceptions of events as well as our memories of events, which affect our emotion and behaviour.

Making claims about bilingualism, Pavlenko (2006) is of the view that people who are bilingual may translate their emotions into the different languages they speak. As a researcher, I wonder the effect this may have on my findings and consequently my study. Would the findings have been any different had I used Swahili instead of English in the interview? Did the phonetics affect the way in which I received the messaging during transcribing, and how might this have affected my interpretation of the results?

1.2. Personal Experience as a Therapist

As a researcher and an insider, my passion for doing the study is as a result of my curiosity, experience and listening to the voices of my fellow play therapists in getting to understand play therapy. In my practice as a play therapist, I have worked with children struggling with sexual defilement, phobias, loss of parent(s), and socially un-acceptable behaviours such as
aggressiveness, stealing and bullying. Their teachers, orphanage homes administrators as well as parents refer these children to me from schools.

In my work as a play therapist, I have often experienced feelings and thoughts of incompetence. Yet there is remarkable positive behaviour change on engaging these children in therapeutic play. This feeling of inadequacy in spite of success has been my question over the last 11 years of practicing play therapy. Clance and Imes (1978) are of the opinion that despite their hard-earned academic achievements, high achieving women do not experience an internal sense of success and continue to feel as imposters, a condition called the ‘imposter syndrome’. Could this feeling of inadequacy be because of my self-concept being a woman in a society where women are considered incompetent, coupled by the fact that as I do not have children, I am therefore a failure when it comes to children’s issues? I believe my self-concept is firm in the world of dealing with adults like myself, as this feeling has not affected me in my adult counselling practice.

Might it be the fact that I did not understand the mysteries of the healing powers of play therapy, therefore harbouring fears that sooner or later it will be discovered that I do not understand play therapy and therefore do not know what I am doing? This fear may have pushed me to want to understand how therapy works, hence undertaking this study. Yet the conviction by Russ (2007:15) that “.. there is something about play that acts as a vehicle for change” gives me the desire to understand this “something”.

Since I do not have children of my own, I lack ongoing close contact with the experiential and emotional world of children. I never thought that I would be good with children or gain the trust of significant others in the children’s lives, but after years of practicing play therapy and now researching on this topic, I have been on a journey of rediscovering my childhood, a journey which began during my play therapy training. It is my hope that this continued search in the practice of play therapy will enhance the profession (Schaefer and Drewers, 2009) and open up other areas of research. Similarly, I hope that change will not only be personal but that it will spread to the society as a whole.
1.2. What is play therapy?

Play is a powerful force in the lives of children. It has been observed in virtually every culture since the beginning of recorded history. It seems to be as a universal expression that can transcend differences in ethnicity, or other aspects of culture (Drewes, 2006). Ordinarily, play in children is perceived as entertainment and fun and most adults pay little attention to it in detail. “Below age 10 to 11, most children experience difficulty sitting still for sustained periods of time. A young child has to make a conscious effort to sit still, and thus creative energy is consumed in focusing on a nonproductive activity” Landreth, 2012:9).

Bruner (1976) described the developmental role of play as critical in humans. This view has been promoted by the United Nations, 1989, Convention on the Rights of Children, Article 31.1, which recognises the right of the child to “...engage in play...and to freely participate in cultural life and the arts” (Schaefer and Drewes, 2009). Earlier Piaget (1951) was one of the first child development experts to suggest the value of symbolic play in children’s development. It is in this symbolic expression of their world that they find a place for the exploration of relationships, description of experiences, and disclosure of wishes and become self-fulfilled. Play therapy, then, is to children what counselling or psychotherapy is to adults (Landreth, 2012).

Landreth (2002:16) provides a broad definition of play therapy as:

“... a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures. He provides selected play materials and facilitates the development of a safe relationship for the child (or person of any age) to fully express and explore self (feelings, thoughts, experiences, and behaviours) through play, the child’s natural medium of communication, for optimal growth and development".
In this medium, the children reflect on their perception by re-enacting situations modelled by adults (Landreth & Bratton, 2006). From a developmental perspective, typically children cannot engage in mature abstract reasoning and thinking until the approximate age of 11 years (Landreth, 2002; Piaget, 1951). Because of its responsiveness to children’s unique developmental needs (Bratton, Ray, and Rhine, 2005; Josefi & Ryan, 2004), play therapy enlists this powerful medium to understand and help children. The child is argued to find freedom that is unusual and inconsistent with their usual experience with adults. It is considered as a counselling intervention where trained play therapists use the themes that arise in therapy as working hypotheses to capture the main issues they symbolically express through therapy (Ryan and Edge, 2012; Ryan and Courtney, 2009). In play therapy “toys are viewed as the child’s words and play as the child’s language” (Ginott 1960:243) and play therapists use the “themes” that come up in a child’s play as shorthand for experiences that they assume demonstrate emotional patterns and unique meanings for the children themselves (Landreth, 2002).

Play therapy is not so unique as to escape the theoretical camps that define much of psychotherapy. Therapy is shaped by therapist’s orientation (Neil, 2004). Play therapy is not based on guess, trial and error of the play therapist, but rather is a philosophically conceived and developmentally-based approach which is research-supported (Van Fleet, Sywulak and Sniscak(2010). There has been a proliferation of play therapy models and modalities, beginning with the earliest Freudian schools of play therapy which believed that symbolic play helped children deal with unconscious conflicts (Piaget & Inhelder, 1966/1969). Development of models continued through to the most recent cognitive-behavioural approach presenting play therapy as an opportunity for cognitive strategies to support children in coping (Knell, 1999) and the Eco systemic play therapy model which focuses on the balance between the child, biological forces, cognitive processes, systemic influences, therapeutic relationships and play (O’Connor, 2000). Though based on different theoretical philosophies, they all embrace the therapeutic and developmental properties of play as supportive of children (APT, 2001) According to Landreth (2012:12):
“Play is to the child what verbalization is to the adult… provides a developmentally responsive means for expressing thoughts and feelings, exploring relationships, making sense of experiences, disclosing wishes, and developing coping strategies.”

Play therapy is also used in Paediatric Oncology (Chari, Hirisave & Appaji, 2013) and may be used as a therapeutic intervention with children with a variety of presenting issues (Landreth, Sweeney, Ray, Homeyer, & Glover, 2005). In spite of this, play therapy has not received widespread acceptance from the scientific community (Azerrad, 2000). There is therefore an increasing emphasis on child therapy literature to illuminate play as an ideal avenue for treatment of a wide variety of emotional and social difficulties (Josefi and Ryan, 2004).

1.4. Background and Development of play therapy

Children must be understood from a developmental perspective and within the expression of their own concrete realities, which, according to Landreth (2012), occurs within the medium of play. He continues to say that the significance of play in the life of a child has long been recognised in history, tracing the earliest observations of children in play to as early as the 18th century, in the work and writings of Rousseau in 1762. It was not until the early 1900s that therapists introduced play into a therapeutic setting as a means for children to express themselves (Bratton, Ray, Rhine & Jones, 2005).

Homeyer and Morrisson, (2008) have given an overview of a rich history of play therapy, where they have discussed the origin and the current issues in the field of play therapy and its perceived benefits as an intervention. They report that the beginning of play therapy was triggered because of the report published in 1909 by Sigmund Freud, which advocated the use of play with little Hans, a 5-year-old boy with a phobia (Freud, 1955). Drewes (2009) traces the use of play to treat children back to the 1930s to Hermione Hug-Hellmuth. From Freud’s initial findings, play therapy has since evolved into a specialised field with an organised international association of 4,400 members and two levels of professional certification (Landreth, 2002).
It has been established that as a result of the work of Anna Freud (1928) and Melanie Klein (1932) several adult therapies have since been adapted for use with children. Due to the contributions of these pioneers, play was gradually emphasised and embedded in the therapeutic process of child psychotherapy (Landreth, 2002).

Half a century ago, Piaget (1951:166) noted that “play provides the child with the live, dynamic individual language indispensable for the expression of which language alone is inadequate”. He was one of the first to describe how children’s symbolic play serves a therapeutic function by helping them deal with unconscious conflicts. According to Homeyer and Morrison (2008:212), the phrase “toys are the child’s words and play is the language” support this view. Most children below the age of 11 years lack a fully developed capacity for abstract thought, which is considered as a prerequisite for meaningful verbal expression (Piaget, 1962). Unlike adults who communicate in words, children naturally express themselves through play (Bratton et al., 2005).

It has been reported that Axline “introduced play therapy into the main stream of psychotherapy” (Le Blanc and Ritchie, 1999:19). Bratton et al. (2005) view Virginia Axline’s (1947) application of the non-directive therapeutic principles in her work with children as supporting this assertion. Her writings in the late 1940s and 1950s, the attempt to study the effects of play therapy (Axline, 1949) and her account of play therapy with Dibs (Axline, 1964), are regarded as perhaps the most significant in the development of play therapy as a psychotherapeutic treatment modality for children.

The importance of play for healthy child development has also been observed by the American Academy of Pediatrics (Ginsberg, 2007) and the role of play in development and the need for children’s enrichment opportunities in a sequential manner to address neurological development has also been observed (Stein and Kendall, 2004; Perry and Szalavitz, 2006).

Early in the millennium KAPC, which is a leading institution in counselling training, introduced play therapy at certificate level in Kenya and in 2004, the first group of non-directive play therapists was trained in Nairobi (Hunt, 2006).
1.5. Non-directive play therapy

Axeline (1947) adapted non-directive play therapy from Carl Rogers’ theory of personality. It holds the firm belief in the ability of the child to heal him or herself (Landreth, 2002; Cattanach, 2003; Hunt, 2000, 2001, 2006). Non-directive play therapy works from the premise that the child has the inner resources and power to heal himself across a variety of presenting problems and issues (Ray & Bratton, 2010). Non-directive play therapy is perhaps best characterised as a way of being (Corey, 2009; Robinson, 2011): in therapy, the child leads the way in search of healing (Van Fleet, Sywulak, & Sniscak, 2010). Clients are the ‘magicians’ with the special healing powers (Garza, Kinsworthy, & Watts, 2009); the responsibility for therapists is to provide the conditions under which this magic can operate in therapeutic work with children, who use this ‘magic’ within their natural language, which is ‘play’. “In order to achieve this, therapist must turn loose of their world of reality and verbal expression and move into the conceptual-expressive world of children” (Landreth, 2012:7). It is assumed that the free choice in non-directive play therapy model facilitates a relationship that is a key aspect of the healing process (Bowers, 2009). This view has been shared by Bohart and Tallman (2003:95) who argue “…the presence of a therapist is far more powerful than any technique available”.

1.5.1. Art and Sand as components of non-directive play therapy

According to Moschini (2005:106), “A picture is worth a Thousand Words”. She illustrated her experience of how by using “Art” as a medium of communication, clients were able to symbolize things that were too painful or shameful to verbalize. The power of art is that it does not censor or distort. “In its use the disguise of language is dropped, and in its place a psyche is projected onto a blank piece of paper” (Rubin, 2005:263). Because of its perceived powers in bringing healing, art has been used to help children who have various challenges (Rubin, 2011, 2005). Homeyer and Sweeney (2005) have stated that sand tray therapy can serve in fostering greater levels of
disclosures. Drewes (2009:313) advocates, “The therapeutic road should see more footprints in this sandy path, support this…”

1.6. Play Therapy in Kenya: Our Context

The connection between Kenya and Britain is no accident; Kenya was part of The British Empire until its independence in 1963. It was imperative that the colonial masters of the day dictate the language of use, making Kenya an Anglophone region. Post independent Kenya has continued to enjoy close relations with its former colonial master across different areas of interest to both countries. It is likely that because of these relations, KAPC developed collaborative relationships with universities in Britain, in enhancing and promoting counselling training in Kenya. The first collaboration was with Durham University and, currently, the University of Manchester.

KAPC was borne out of necessity, a need to address the serious psychosocial problems that were facing Kenyans at a time that traditional helping structures were inaccessible as most people had in the wake of modernisation moved to urban areas in search of work and livelihood. Not only was this way of life inaccessible, but most traditional helping structures were broken in the new ways of life (Okech & Kimemia, 2012).

One such problem that had an impact on the trail of counselling was the diagnosis of the first case of HIV/ AIDS in Kenya in 1984 (K'Oyugi & Muita, 2002), following which the spiralling prevalence rates became threatening and by 1990, KAPC was founded by an English man, Dr.Balmer, an alumni of Durham University. By 1999, the government of Kenya declared the HIV & AIDS pandemic as a national disaster (Kenya National AIDS Control Council, 2010). Since then, there have been many initiatives to combat the pandemic, and one of these is the training of counsellors for the mushrooming of voluntary counselling and testing (VCT) centres across the country, a service that is geared toward obtaining demographic information that was required by the funding entities (Okech & Kimemia, 2012).
Kenya is one of the countries worst hit by HIV/AIDS (UNAIDS, 2004) and this has necessitated follow-up intervention for children infected and affected by HIV/AIDS (Nyambedha, Wandibba and Aagaard-Hansen, 2003). The development and expansion of counselling services created a need for professional organisations that could address the professional, training and practice concerns of counsellors (Okech & Kimemia, 2012). During this time, counselling practice became popularised through the Voluntary Counselling and Testing (VCT) initiative by most Non-Governmental Organisations (NGO’s), amongst which KAPC and LIVERPOOL VCT became leading institutions of training. As more families went through potentially tragic transformation due to HIV/AIDS, counselling became more accepted in society (Nyambedha and Aagaard-Hansen, 2003; Nyambedha, 2004).

Socio-political factors have affected the direction counselling has taken in the recent years. For more than four decades, post-independence Kenya enjoyed reasonable peace and stability as a country (Ogot & Ochieng, 1995), until the disruptive post-election violence, which occurred in 2007/2008, following bitterly disputed general election results. This led to acrimonious inter-ethnic fighting leaving several people dead and many more homeless (Kanyinga, 2009). The Humanitarian Policy Group (2008) reported that an estimated 100,000 children were internally displaced in Kenya, with as many as 75,000 living in over 200 camps for internally displaced persons (IDP’s) across the country. The significant role played by local and international volunteer counsellors in response to this traumatic event highlighted the need for more qualified counsellors in the country (Okech & Kimemia, 2012).

Currently, there are two major professional membership organisations for counsellors in Kenya, namely, KAPC and the Kenya Counselling and Psychologists Association (KCPA). KAPC has been actively involved in developing counselling training through the leadership of Dr. Balmer; it is not surprising that KAPC adopted a definition of counselling from the British Association for Counselling and Psychotherapy (BACP). This definition describes counselling as “interventions with clients in a private and confidential setting to explore a difficulty with life, or loss of a sense of direction and purpose” (KAPC, 2009:1).
As the demand for counsellor training grew, KAPC began offering certificate courses in counselling. This paved the way for the establishment of KAPC’s School of Counselling Studies. The institution has graduated students from the certificate level of counselling training to a Masters’ degree level, currently being undertaken in collaboration with the University of Manchester. It also offers specialised training to address the dynamic and complex problems faced by members of our communities, one of which is a play therapy course as a response to the needs for different professionals working with children in diverse contexts.

1.6.1. Has Play Therapy been recognised in Kenya?

In the last 25 years counselling as a profession has developed, as a result of which counsellors can now be found in virtually every sector, with the largest numbers being in HIV/AIDS VCT centres, hospitals, child protection agencies, and primary and secondary schools (West, 2007). This has occurred in the absence of regulatory oversight for either the practice of counselling or the training of counsellors (Okech & Kimemia, 2012). Due to the lack of established registration or certification structures, it is difficult to estimate the number of counsellors in the country; hence, the question of professional credentials, identity, competence, and regulation of the title counsellor is one that continues to pose a challenge in Kenya (Okech & Kimemia, 2012). It is hoped that this situation will change with the recent developments associated with legislature.

It is only recently that counselling gained recognition from the Kenya government through the Kenya Counselling and Psychologists Act (KCPA), 2014. As a young and struggling profession, counsellors and psychologists welcomed this new development alike. The counselling fraternity has consistently engaged in advocacy for the long awaited law for its professionals. This was deemed as a landmark development in the attempt to establish this particular mental health profession. Members are now encouraged to seek and work under supervision. There is institutional accreditation at seven different levels, ranging from Level 1, which is categorised as ordinary membership, to Level 7, which categorises the rank of a senior supervisor (KCA, 2011), which now has official recognition. As a young legal entity which comes in the wake of proliferating
counselling institutions, it is hoped that play therapy will be amongst the specialised areas of the counselling profession that will be accorded space and recognition in the near future to allow for its growth and development.

1.6.2. Training of Play Therapists

The first training of play therapists by KAPC in Nairobi was in May 2004. In 2006 and 2007, subsequent courses were delivered. Course participants in all three cohorts (2004, 2006, and 2007) were invited to learn about play and how to provide therapy using play. The brief training course of 120 hours was based on a child centred model (Axline, 1947) derived from the adult model of person centred therapy (PCT) designed and developed by Carl Rogers (1951, 1957, 1961).

The initial brief training in play therapy was first delivered to 30 Kenyan care-giving professionals, working with vulnerable children, possessing counselling qualifications. Pre-training feelings of inadequacy in terms of meeting the therapeutic needs of vulnerable children using adult style counselling were high (Hunt, 2006). This cohort of trainee play therapists were typical of subsequent trainees representing various professions including teachers and other caring professionals from the fields of medicine, education, government agencies, non-government agencies, religious organisations, social services, the armed forces, counselling and clinical psychology.

The majority of play therapists are currently practicing in schools, hospitals, orphanage homes, religious centres and with private clients. Despite these developments, there are many who view counselling as a service for a clear dichotomy of either a few select wealthy individuals or persons with HIV/AIDS (Okech & Kimemia, 2012).

1.7. Area of Study
This study was carried out in Mombasa, one of the coastal cities of Kenya with a population of over 900,000 thousand people (Kenya Bureau of Statistics, 2009). This region has had numerous attacks fuelled by political instability and ethnic (cultural) differences (Mazrui, 1993). My choice of location lies in the fact that I am interested in the area in which I live and practice. I also subscribe to the thinking that as a practitioner and researcher it is important for me to know the experiences of my fellow colleagues. It is hoped that the findings will enhance the practice of play therapy in this area. These children need the kind of support that transforms and opens new possibilities for both researcher and researched to make sense of the experience in focus (Finlay & Evans, 2009).

However, my choice of location for the research came with the challenges of dual relationship in that my study participants were people that I knew and with whom I had existing relationships. This I feel may have interfered with the way in which we related during the interviews. It may also have affected how I presented material revealed to me especially if it appeared as malpractice. These ethical issues are discussed in detail in the methodology chapter. My other fear is that the research participants may have told me what they imagined I would like to hear or may have shared assumptions of play therapy to support me as a colleague, thus to an extent compromising the authenticity of the research findings. Nevertheless, I had to trust that the anxiety would diminish, since the majority of the participants had previous experience of doing counselling research in their own training and they were familiar with research procedures. I also realised that I needed to trust them, as this is the basis of our practice.

Due to its rich ancestral history of diverse cultures stemming from the outside world of the Arabs, Portuguese, British and our own indigenous coastal culture, I had hoped to get rich data from this coastal city. The other grouping of people I had hoped would be illuminated, was those from other regions of the country, commonly referred to as the mainlanders or “Wabara” (Mazrui 1993). “Wabara” is a descriptive term often used by the local communities to refer to people who are not originally from the coastal region. I belong to this group of people.

The coastal towns have a rich history; many traders attempted to enforce their governance due to the advantageous position, which made them central to trade operations, from the early historical to present day trade. The Arab traders sailed around the coast of Kenya from first century AD and this
remained the centre of the Arab trade in ivory and slaves from the eighth to the sixteenth century. The indigenous people integrating this into their lifestyle, something that continues to date, have absorb their religion and cultural lifestyle. The Portuguese also had their influence on the post and constructed Fort Jesus in the 16th century, which stands to this day. The initial purpose for constructing the fort was for defence during war. Today, it is preserved as the country’s heritage, and is a major tourist attraction and landmark in Mombasa. It is believed that Vasco da Gama was the first known European to visit Mombasa whose purpose of exploration was partly to spread the Christian faith but primarily to establish a direct trade link between Europe and the Orient (Ogot and Ochieng, 1995).

The British built a railway line, which was completed in the early 1900s from Mombasa to Uganda, which facilitated the spreading of European culture over the Kenyan lands. Thus from 1887 to 1907, Mombasa remained the capital of the British East African Protectorate. The British rule ended and Kenya received its independence on the 12th of December 1963 following a supervised self-rule from 1st of June 1961 (Ogot and Ochieng, 1995).

1.8. The context of the problem and its background

Currently Kenya has a population of 39 million people made up of 43 different tribes or ethnic groups (Kenya National Bureau of Statistics, 2010). With the coming of the colonists and the missionaries came the white settlers who by all measures changed the lives of Kenyans by undermining the traditional collectivistic tendencies put in place to safeguard the concept of communal rather than individual goals (Javo, Ronning, & Heyerdahl, 2004). This has continued to trouble us as a people, in that we want to be collectivist, yet we are constantly through learning and experience of society becoming increasingly individualistic.

Opolot-Okia (2004) reports that the white settlers manipulated the communal obligation and responsibility of the indigenous Kenyan towards each other to suit them with a misconception that communal obligations are commonly accepted factor in the daily life of a native village community.
They used this to introduce cheap forced communal labour, which continued to be an integral part of the colonial rule. This forced labour took the men away from their villages on the pretext of search for greener pastures. This experience is captured in the quote:

“… My father died working for a British farmer on the slopes of Mt Elgon…..colonialism drove a wedge between my parents who then separated for quite some time when I was growing up. And because he earned a meager salary…..was unable to pay my school fees…..” (Prof Indangasi, 4 October 2014:19, Standard Newspaper).

This created a sexual dualism and political marginalization of women that continues to be sustained (Aubrey, 2001; Nasang’o and Ayot, 2007): consequently, the empowerment of women is difficult to attain. Nyenze (2002) reports that in Kenya, 10.5 million people, mainly women, reportedly suffer chronic hunger which captures this. It also created a highly individualised model of citizenship for young people, as it encouraged autonomy and competition, alongside political instability in that powerful elites of politicians occupied the areas that had been occupied by the white settlers. This brought in new discourses of regional and ethnic inequalities and high levels of poverty (Kanyinga, 2002). According to the report by Government of Kenya (GoK) (2008), 46%-56% of Kenyans live below the poverty line.

Kenya also, by virtue of being a developing country, has experienced growth in its migration from rural to urban areas (Hope, 2012). Between 1989 and 1999, in-migration contributed a greater percentage of the population of most cities (Ministry of Education, Science & Technology, 2004; Hope, 2012). While rural-urban migration is not unique to Kenya or the African countries, escaping famine, internal conflict such as civil strife, or inequalities in the spatial distribution of social, cultural, and/or political opportunities witnessed more and more Kenyans pushed to the cities in search for better opportunities (Hope, 1998).

Kenyan people are exposed to numerous changes related to globalisation, urbanisation, development, modernisation (Okech & Kimemia, 2012). One change has been an introduction to western forms of education where students can access their study materials, lecturers/ supervisors through the internet as opposed to the traditional ways of sitting in the lecture rooms. The changes also include the rise of the concept of individualism encouraged by the Western world, which has
influenced the Kenyan urban population and conflicts with our traditional concept of collectivism (Sobania, 2003; Mwaniki, 1973). In the coastal region, people have been exposed to and influenced by complexities associated with modernity, which have influenced, altered or superimposed foreign lifestyles onto traditional mores, (Nsamenang & Lo-oh, 2009; Blum, 2006).

Apart from this, there exists generally heightened tensions between Muslims and non-Muslims who are largely Christian, economically and politically powerful ‘mainlanders’ (Wabara). Wabara have been settling in the city in large numbers over the past century. This ‘symbolic violence’ is fuelling a rise in Islamism and coastal separatism as alternative political imaginaries among Kenya’s coastal Muslims (Mazrui 1993; Prestholdt 2011; Seeseman 2007).

One result of such change has been the breakdown of family systems, including traditional ways of childrearing (family formation), because the family support and unifying bonds that extended family provided previously have begun to erode (Okech & Kimemia, 2012). This may have had an impact on youth (Blum, 2006). Traditionally the communities shared the emotional, social, and material costs of rearing children due to the wealth they symbolize for families (Epstein, 2007).

Kenya is one of the countries severely hit by HIV/AIDS in the world (Kenya National AIDS Control Council, 2010) and this has left a mark in the form of the number of orphans left in the country (UNICEF, 2001). There are more than 12 million AIDS orphans in sub-Saharan Africa (UNICEF, 2002). In 1999, the National AIDS Council reported 860,000 AIDS orphans in Kenya (UNICEF 2001: 25). This called for specialised training requirements for counsellors such as play therapy (McGuiness et al., 2001). Though the counselling supervision was given by many agencies, play therapy on the other hand was not given any attention other than in play therapy training, which was adopted by KAPC alone. However, even within KAPC, play therapy supervision seems to have become a neglected issue.

With adult deaths from HIV/AIDS, many children in Kenya are far from experiencing well-being as family structures and configuration have been altered resulting in transformations of gender roles (Oburu, 2011). He goes further to say that these mortalities:
“… have altered family structures and configurations resulting in transformations of gender roles and emergence of non-traditional role shifts and family structures characterized by absentee males and child- or woman-headed households. This circumstance suggests that increased levels of HIV/AIDS related mortalities have likely shifted the power balance in favour of once underprivileged women and children” (Oburu, 2011:153).

This has necessitated the creation of a number of orphanage homes in the country including the existence of child headed families (homes) (Nyambedha, and Aagaard-Hansen, 2003). These children have to deal with losses and grief both from the death of parent(s) and loss of familiar environment when they are moved to the orphanages or moved to live with relatives, a traditional practice upheld by many ethnic groups in Kenya (Ochieng, 2008). They may suffer due to the psychosocial impact of separation, loss, bereavement, illness and caring for ill relatives caused by HIV/AIDS (Ochieng, ibid).

1.9. The need for play therapy

To add to the above problems, children who access play therapy may be stigmatized as many Kenyans have come to associate seeking counselling with the possibility of having HIV/AIDS, and the stigma that is associated with HIV/AIDS carries over to the general perception of counselling (Dixon, McDonald and Roberts, 2002; Grinstead and Van Der Straten, 2000). These children are also robbed of the initial attachment, which according to Bowlby (1988, 1973) is important for the child’s subsequent social and emotional development. It is reported that through this personal experience of attachment the child builds up a mental representation of emotions, and that this is of fundamental importance when it comes to regulating stress (Landry, Simon, Webb, and Mistlberger, 2006).

There is an understanding that play in therapy provides the therapist with an opportunity to enter the child’s world (Landreth, 2012). Play therapy takes this further through developing understandings, exploring conflicts and rehearsing emotional and social skills in children
(Cattanach, 2003), who become empowered through re-enacting and reliving their troubled situations. In so doing healing is experienced (Kottman, 2001). This is where I believe play therapy would fill the gap of knowledge in creating awareness of the need of these children being supported while young.

Luo sayings include “A tree is shaped while young, or when it is grown up it breaks” and “Iron is forged while hot; otherwise you would need extra force to forge it, or it breaks” (Oburu, 2004:155). These sayings suggest that among the Luo, the child and final adult product are a function of parental input into the child’s socialization process. This concept or other similar concepts can be looked at as a traditional way of taking care of children, which spreads or exists among the other Kenyan tribes as well.

1.10. Research Objectives

The aim or the goal of a research is “the desired end product of the research study, which is achieved by attaining specified steps known as objectives” (Fouché, 2005:105-106). The goal of this research study is to capture the experiences of my participants. The research question is - How do non-directive play therapists experience their work with children in the Kenyan context.

In an effort to attain this goal, the following are the objectives of the study:

- To explore experiences of play therapists.
- To ascertain the play therapists understanding of play therapy.
- To establish factors that they think contribute to the success of play therapy.
- To highlight the challenges of play therapy as described by play therapists.
- To establish the impact of culture on practice.
- To make recommendations based on insight from the study that would enhance and enrich the training and practice of play therapy.
The research design is the plan for collecting and analysing data that will answer the research question appropriately (Flick, 2009; Gavin, 2008).

*Diagram 1: Nature and structure of the thesis*

This thesis is divided into six chapters. The present chapter has provided the contexts in which the research evolved, an introduction to the research giving the background to the problem, the research objectives, research question, and the significance of the study. The second chapter provides a review of the literature. Chapter 3 provides an account of the methodological process of the study covering the rationale for adopting a qualitative design, specifically a descriptive phenomenological approach, the methods and procedures of data collection and data explication. Chapter 4 is a presentation of the findings from the participants’ interviews. Chapter 5 focusses on discussion of the findings in the light of existing literature, and includes my reflective statement on
the process of the research. The final chapter covers the conclusion and recommendations that have come out of the study and possible contribution and areas for further research.

1.1. Summary of Chapter One

In this first chapter, I have given the rational of the study, a brief introduction of what play therapy is, and its introduction into Kenya. I have also looked at the context of the problem and its background. The study objectives and the structure of the research are highlighted. Also highlighted is the need of play therapy in the area of study and practice in my opinion.

The chapter introduces the literature review in highlighting the material of interest and key focus in the study, narrowing specifically to the contextual situation within which the play therapy practice exists in Kenya.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction
So far, few studies have been carried out on play therapists’ experiences exclusively (Daniel and McLeod, 2006). This has resulted in a lack of literature addressing this topic to date. This became evident as I was trying to obtain materials for my literature review. Much of the available literature is on research done in the west and covers the experiences of western play therapists. To the best of my knowledge the experiences of play therapists in Africa and Kenya specifically is virgin land that needs exploration as there was no literature exclusively on this topic. This makes my study, whose objective is to capture the rich experiences of the play therapists practicing in the region of Kenya, one of its kind and pioneering in this field of research. In this chapter, I aim to shed light on the current situation of non-directive play therapy in the context of my country, Kenya. I start by guiding the reader through the conception of play therapy in Kenya to the training and preparedness of the play therapists and the practice of play therapy as I review the existing scholarship in terms of previous literature and research (Fouché, 2005; Wilson and Maclean, 2011).

The literature search was an ongoing process. This extended over a range of related and relevant areas, some of which resulted from my findings from the participants’ analysis in chapter four. This resonates with Hart (1998) who views literature as serving two purposes: firstly, to help the development of the research questions and, secondly, to support the analysis of the findings. This research is qualitative aiming to capture the, for instance, potential cultural and individual differences in the subjective experience of the participants. However, I have included quantitative research in this review, which instead generalises experiences and lacks an idiographic emphasis. Quantitative and qualitative research serve different purposes and as such they can be complementary. For instance, quantitative research can provide a general overview that helps reveal patterns and inconsistencies that can be and nuanced as well as challenged via qualitative studies. Qualitative research can provide a strong foundation for quantitative research into its wider generaliseability (Borland, 2001). I have incorporated quantitative research as it can be helpful in setting a wider context within which qualitative research can be positioned and/or understood. Quantitative information on rates of poverty can be important in providing the economic context for experience, as can migration rates point to change within the social context. The provision of such contextual material is especially important to the understanding of the impact of disability according to some models, e.g. the social model of disability. Bratton et.al.’s (2005)
meta-analysis review on the effectiveness of non-directive play therapy, for example, is helpful in providing a backdrop to contextualise the play therapists’ views on the effectiveness of non-directive play therapy. While I am aware that quantitative research lacks a focus on in-depth individual experience and has the tendency to generalise findings and hence potentially simplify them (Finlay, 2006), I present quantitative research here in order to provide background and contextualization for my study.

A child’s wellbeing is crucial. When this is affected, performances and achievements throughout their lives become disturbed as well (Zins, Bloodworth, Weissberg and Walberg, 2004; Suhrcke & de Paz Nieves, 2011). Early detection of any health problem that might cause long-term difficulty may be considered as a preventive measure, contributing towards the children’s general well-being (Allen, 2011). There is an increasing emphasis in the child therapy literature on the need for prevention by early detection before causing long-term difficulties (Robinson, 2011). In this light, it was imperative to review the approach to practice used by my study participants in order to illuminate the effectiveness of this model for the reader. Thus, the review focuses on the non-directive play therapy model as a therapeutic intervention based on the work of Axline (1947). This remains central as it informs the practice of the of my study participants.

Kenyan children, like all children in the world, belong to families. In Africa the emphasis of family goes beyond the nuclear unit to the larger community and for orphans, this traditional philosophy of collectivism aims to ensure their continued wellness through the larger grouping (Mbiti, 1969; Nyambitha, 2004; Mwaniki, 1973). It may therefore be important to understand the family structural background of these Kenyan children. Reviewing the literature around the family structures in the Kenyan context may not only guide the reader in gaining insight into the situations that surround the Kenyan child, and its place within the family structure. I also hope to illuminate the perception and attitudes of adults towards a child’s play within the Kenyan cultures and the child-adult relationships, which may spill over to the therapeutic relationship. Brumfield and Christensen (2011) have observed that children are very perceptive and their affect is often influenced by their parents’ thoughts, including verbal and nonverbal cues about play and its value, which may have a direct impact on what they think about the therapeutic use of play. Understanding this relationship may
highlight the appropriateness of the practice, as well as the challenges facing the play therapists utilizing the non-directive play therapy model, which the participants of this study practice. It was critical that I review the kind of preparation the Kenyan play therapists received and continue to receive to become and remain active and robust play therapists and the knowledge that they may have access to. In studying the literature on training, I hoped that it would help establish the lack of confidence to practice experienced by the participants of the study and exploring what Fairburn and Cooper (2011) have considered as sufficient play therapists’ training in the western world.

According to Wenger (1998), social learning has benefits to professionals and there is need to understand various ways of learning that may be of use in supporting the therapist other than further training, in the absence of any professional support that can be accessed by the therapists in their professional journey (Wenger, 1998; Illeris, Knud, 2004; Barab & Duffy, 2000).

Professionalisation was important in highlighting the current situation for the Kenyan play therapists. It focuses on their struggles in a young profession that is barely known to the general populace and the need to address training and supervision as a critical but non-existent service. In a conducive environment that includes supervision, a practitioner grows from novice to master artisan (Bernard and Goodyear, 2013; Hawkins and Shohet, 2007). The literature attempts to highlight the journey of the play therapist in Kenya. It also highlights the challenge of growing as a professional in a practice, whose membership is fragmented, and lacks the necessary supervisory structure.

I accessed this material electronically using the University of Manchester library, library electronic website search accessing Psych Info database, Kenya Association of Professional Counsellors (KAPC) library, HINARI site, and Advance Scholar Google site. After logging into these several sites. I then keyed in the following; play therapy, experiences of play therapists, development of play therapy in Africa/Kenya, multicultural practices in play therapy, effectiveness of non-directive play therapy, play therapy training and play therapy supervision, social learning and on becoming a professional. When I keyed in play therapy general, it gave me literature on play therapy around the world including Africa and Kenya some of which were relevant in this study.

Then I keyed in the experiences of play therapy and this gave me a few of the studies where play therapy has been reported as having been used successfully. In my search I continued to key in
the experiences of play therapist in Africa/Kenya and the search came up with nothing. I therefore keyed in the development of play therapy in Kenya and found some relevant literature talking about how play therapy came into being and the training of the play therapists. This literature also highlighted the nonexistence of play therapy supervision in Kenya. I then researched social learning which I found in books and via an online library search at the University of Manchester library. I also found relevant and useful articles and books on the cultural practices of Kenya.

2.1. Play therapists’ view on the effectiveness of non-directive play therapy

The process of non-directive play therapy is unique in several ways. Influenced by the work of Roger’s model of the therapeutic environment, Axline (1967:73-74) created eight basic principles of non-directive play therapy emphasizing on the therapeutic relationship and unconditional acceptance wherein the child can feel safe to explore his world. In the safety of this environment, a child feels securely attached to a caregiver and becomes able to develop an inner sense of control which is seen as a contributing factor to the child’s positive behaviour change (Gerhardt, 2004).

It has been argued that a key component in this approach to therapy is turning over responsibility to the child who is viewed as the expert (Axline, 1947; Van Fleet et al., 2010). Ray, Blanco, Sullivan, & Holliman (2009); Bratton, Ray, Rhine, & Jones (2005) further remark that this places a demand on the therapist to take a non-directive stance, leaving responsibility and direction to the child. This places an emphasis on the empowerment of the child in terms of self-awareness, decision-making, and acceptance. It aims at helping the child work through suppressed feelings that may be causing disruptive behaviours (Landreth, 2002). The therapist’s role is to seek to understand the child’s perceptions of their world by making connections with the child’s symbolic play and the child’s metaphor. This working style with the child has been viewed as less intrusive than talking therapy (Robinson, 2011; Kottman, 2003) and has been acknowledged by Garza, Falls and Bruhn (2009:154) as the power of child-centred play in reporting that: “child centred therapists believe in the power of play… Play is a developmentally appropriate medium of communication for children and allows them to process their wishes, feelings, and perceptions via the safe distance of the
playful experience”. Malchiodi (2005) describes this imaginative expression of the child as being like the engine that drives his discovery and his momentum towards corrective solutions to bring about change.

Drewes (2001) suggests that all therapies require, among other factors, the formation of a therapeutic relationship which Hughes (2008a, 2008b) has emphasised in the therapist touching and matching the child’s affect. In the non-directive approach, the play activity between the child and therapist is subject is not directed by the therapist and this has been seen as facilitating a safe relationship, which is considered as key in healing process (Axline, 1967). The attention that a child receives from their therapist and the materials that are made available to the children in the playroom contribute to making the child feel valued. The therapist needs to be accepting and permissive towards the child so that she or he can drop their natural defensiveness, feel understood and so be free to communicate (Carroll, 2002). However, the therapist’s acceptance, being a new experience for the child, may become a source of anxiety, and the child may be unable to tolerate the therapist’s physical proximity (Landreth, 2002). Wilson & Ryan, (2005) are of the opinion that in this relationship the therapist is expected to set limits and boundaries. For children who have been abused and had their personal boundaries crossed without consent, respecting their space is part of providing the safe psychological and physical secure base for therapy needed for the child to create feelings of security. The child responds by testing limits, feeling confused by their unfamiliarity with this type of adult relationship. Within the therapeutic relationship, the child feels valued by the attention that they receive from their therapist, and this sense of feeling valued becomes more pronounced by the free choice of the materials that are made available to the children in the playroom (Carroll, 2002). This requires that the therapist’s whole personality be disciplined towards a consistent, sensitive appreciation of her client.

“… This is your time... We play within the playroom space. ..We are kind to everything in the playroom and we are kind to each other. Otherwise, you can do anything you want to do in this playroom, or you can choose to do nothing... It is your choice” (Robinson, 2011:.p.211)

The therapist’s complete acceptance of the child allows the child to accept all parts of him/herself, including those more destructive and aggressive tendencies and, through the expression of
aggressive feelings or behaviours in the playroom and the presence of an empathic and understanding adult, the child will learn to meet self-needs in a socially appropriate manner (Landreth, 2002). The relationship provides the child with the experience of trusting another, which s/he can then take into other relationships, which means that s/he will go on to anticipate positive experiences of future relationships (Benedict, 2008).

A child-led therapy is seen as a process of discovering, respecting, valuing and giving power to the child, which a child uses to be themselves and do what they want in the playroom, (Robinson, 2011). This power is argued to aid in strengthening the child’s self-concept in the area of decision and choice making (Landreth, 2002; West, 1996). This is different from when play is directed by an adult as children do not experience the freedom to explore and develop; rather they are expected to simply follow adult direction and rules (Ginsberg, 2007), something that most children in the African context are familiar with and used to (Nwoye, 2004).

In Kenya, play therapists trained in the non-directive approach were involved in working with children during what was considered a flawed and disputed general election. Bitter inter-ethnic fighting during the post-election violence (PEV) of 2007/8 (Robson, 2010; Ochieng, 2010) rendered an estimated 300,000 families homeless in Internally Displaced People (IDP) camps (Humanitarian Policy Group, 2008), out of which 100,000 were children (Kanyinga, 2009). Kenyan play therapists involved in therapeutic work with children attributed the positive outcomes to the effectiveness of the non-directive therapeutic approach. The accounts of their experience highlight the perceived efficacy of the non-directive to therapy as captured in Robson (2010:256):

“In addition to research evidence, reports about the usefulness of play therapy in situations such as the post-election violence in Kenya in 2008 provide anecdotal support for efficacy… I work with children, playing, drawing, telling stories, both good and bad, about their lives…. I feel good because these children are lucky to be alive, sometimes the children draw guns and you can see how troubled they are… Children who entered a play therapy program in early January initially drew pictures of houses on fire, people being struck barrows and other disturbing scenes….the younger children played with the toys and the pictures that the older
children drew showed that they had repressed bitterness, anger, fear, desire for revenge and other intense emotions.”

In theory, it is believed that children’s expression through these modalities have as much value as verbal reflection about any experience, and in themselves can provide sufficient therapeutic change (Landreth, 2002). Other therapists believe that they are much more important than verbal reflection and provide the essential tool kit for the therapist working within the therapeutic relationship (Norton & Norton, 2006).

Though non-directive play therapy is a developing and responsive intervention which is widely used by therapists, it has been criticised for lack of adequate research to support this growing base; this limitation is more pronounced in the lack of qualitative research (Bratton et al, 2005). Remarking on the same, Reade, Hunter, and McMillan (1999) reported that there was insufficient evidence to support the practice of play therapy with children who have experienced damaging close relationships. Supporting this opinion, Cambridge Centre for Behavioural Studies, (2001:1) say that "Play therapy is both time consuming and ineffective." They add, "It can have potentially disastrous consequences above and beyond the delay caused by years of ineffective treatment." It seems, therefore, that there are some conflicting opinions about its effectiveness.

2.1.1. Emphasis on relationship:

Rogers, (1986:198) states “the relationship is the therapy and not a preparation for it” and that simply the presence of the therapist is full of healing. Finlay and Evans (2009) support this notion when they say that the relationship with the therapist is the most significant factor in therapy. The therapeutic relationship “sits within a number of other influential characteristics, inter-personal relationships and a wider social context” (Robinson, 2011:209).

According to Rogers (1957:1), the client-counsellor relationship is “necessary and sufficient” for client growth to overcome unhealthy ways of being.
“In 1957, Carl Rogers proposed that constructive therapeutic change could be achieved through six necessary and sufficient conditions: two people being in psychological contact, the client is vulnerable or anxious, the therapist is congruent, the therapist experiences unconditional positive regard for the client, the therapist experiences an empathic understanding of the client’s frame of reference, and the therapist succeeds, to a minimal degree, in communicating to the client her empathic understanding and her unconditional positive regard” (Robinson, 2011: 211)

According to Axline (1969), children are very sensitive to picking up any inconsistencies in a therapist’s attitude or behaviour. Because of this the therapist needs to be congruent. This means that “the therapist is his actual self during his encounter with his client” (Rogers, 1966: 185). This is supported by Robinson (2011), who state that the therapist’s ‘openness to the child, and her curiosity in the child, is vital to the development of a therapeutic relationship” (Robinson 2011:210).

Ryan and Wilson (2000) describe how the therapist needs to prepare herself for entering into the therapeutic relationship by emptying her mind of her world, and being aware of the transferring of emotions and ideas from previous relationships in order to give the child her full attentiveness and view the child as a unique in a fresh way. According to Cozolino (2006), scientifically, memory is stored within specific neuronal patterns within the brain, and present perceptions are concurrently influenced by this existing neuronal architecture. In psychodynamic terms, this might be termed as transference (Dryden, 1989). Though it has been stated that this may be unavoidable, “if the therapist is aware of this, she can self-reflect and distinguish what is past from what is present. She also needs to recognise any heightened anxiety arising from any previous negative experience, lack of confidence or inexperience, because anxiety will interfere with her brain’s capacity to accept incoming information and to think” (Robinson, 2011:209). The therapist needs to be empathic; Kelly and Odenwalt (2008) explain that it is through empathy with the child that the therapist can provide validation of him, and from the safe relationship, the child can replicate this in other relationships.

Of the three core conditions, Van Fleet et al. (2010) consider empathy as the most powerful. Rogers (1957) explained that empathy necessitates the therapist concentrating in the moment on what is happening for the client as he explores areas that are coming into consciousness. This
empathetic understanding require deeper understanding and working with a child at a deeper level (Joiner and Landreth, 2005; Ray, 2004). This is supported in reports of how play shows the emergence of matter from the unconscious to the conscious (West, 1996; Turner, 2005; Wilson & Ryan, 2005; Souter-Anderson, 2010).

Freire, Koller, Piason et al. (2008) have indicated that the power of change in person-centred play therapy does not reside in the expertise, knowledge or techniques learnt. They along with others share the belief of Van Fleet et al. (2010) that the empathic relationship is the key to resolution of aggressive behaviours (Trotter, Eshelman, and Landreth, 2003). In theory when a child experiences empathy from the therapist, this enhances a positive internal working model for future relationships (Benedict, 2008; Kelly and Odenwalt, 2008).

Given the emerging empirical findings of the therapeutic values of counsellors’ self-awareness (Pieterse, Chung, Bissram, and Ball, 2012), the person of the therapist has been widely acknowledged as a critical tool in the provision of effective counselling and psychotherapy and has commonly been referred to as “self as instrument” (Baldwin, 2000; McWilliams, 2004). Although it has been stated that being a successful therapist is not dependent upon personality (Chapman, Tolbot, Tatman, and Britton, 2009), self-awareness is said to be beneficial to the therapist in regulating the impact this may have on their practice (Black, Hardy, Turpin, and Parry, 2005).

Based on the various theories of family therapy, the manner in which the therapist might engage with the client and therapeutic process is based on the relationships and structure of communication within the therapist’s family of origin and other central figures in the formative years (Lim, 2008). This calls for an attitude change for the therapist according to Ackerman and Hilsenroth, (2003). The therapist should pay attention to their emotional reaction, as this may be a reflection of how they respond to the client’s needs that contribute to the therapeutic relationship. It is said that if the therapist is insecure this may negatively influence the therapeutic relationship (Dinger, Strack, Sachsse, and Schauenberg, 2009).

Shirk and Karver (2003) and Karver, Handelsman, Fields, and Bickman (2006) argue that the quality of the established relationship between the therapist and the client is a very strong predictor of the outcome of the work and it is viewed as a means to an end as well as a means in itself (Shirk
and Saiz, 1992). Bowers (2009:184) believes that “the developing bond between child and therapist is an empowering one that gives the child a sense of being able to make choices, create changes, and consequently an improved sense of self”. Axline (1969:209) saw the therapeutic relationship as “offering the conditions within which a child could psychologically grow and change themselves”. This seems to support what had been reported earlier by Chethik (1989) who had suggested that it is not play per se that produces the changes for the child in therapeutic context, but that the therapist’s use of play creates a catalyst for change in this relationship. This is further supported by Russ (2007:15) who is convinced that “indeed there is something about play that acts as a vehicle for change”.

The use of play helps establish a working relationship with children, this relationship is the vehicle that helps the children learn to trust, invest, believe in and create meaning in their lives because it has an organising function in the development of children (Robson, 2010; Schaefer, and Drewers, 2009). Within the therapeutic relationship in non-directive model, is safety, respect and comfort for the child, which the play therapist attempts to provide. It is demonstrated through creation of a safe, non-judgmental accepting and holding environment, which in turn provides the child with an opportunity to work through the traumatic experiences, difficulties, and provides a corrective emotional experience (Baloyi, 2006; Vorster, 2008). It is “a process of discovering, respecting, valuing and giving power to the child so the therapist needs to be accepting and permissive towards the child so that he can drop his natural defensiveness feel understood and so be free to communicate” (Robinson, 2011:211).

As Axline explains:

“Not until she fully realizes the significance of what it really means to be completely Accepting of another person, and has sufficient understanding of all the implications of This term, is she able to be permissive so that the child can be himself, can express himself fully, and she can accept him without passing judgment.” (Axline, 1969: 64).

Theoretically, it seems basic that play therapists would be able to connect with children in a therapeutic relationship; this may not always be the case, because therapists frequently work with children who have experienced damaged relationships. Their ability to damage the play therapy
relationship can be high; some children are skilled in resentful, hurtful, and vengeful behaviour (Van Fleet, 2005) and even the most experienced play therapist can become challenged in working with the child. However, this relationship enables a child to develop new confidence (Schaefer and Drewes, 2009; Drewes, 2005).

“In the safe, emotionally supportive setting of a therapy room, children can communicate nonverbally, symbolically, and in an action-oriented manner, the toys become the child’s words and play becomes his or her language, which the therapist then reflects back to the child to foster greater understanding. The child can play out concerns and issues, which may be too horrific or anxiety producing to directly confront or talk about in the presence of a therapist who can help them feel heard and understood” (Schaefer and Drewes, 2009:4).

Wampold, (2001:81) suggests that those in therapy “acknowledge the importance of the relationship between patient and healer”. In addition, it is important for the therapist to understand the development process of this relationship (Dougherty and Ray, 2007).

2.1.2 Parental Involvement

Even though generally the value of play as a therapeutic tool has been more widely recognised and understood (Landreth, 2001), it may not be well understood by the stakeholders in the children’s lives. It is therefore a requirement that the therapist according to Association of Play Therapy (APT, 2013) undertakes the process of creating therapeutic awareness of play therapy. This resonates with Schaefer (1999), who has stated that play therapy should not be seen as a mystery. The play therapist should have the ability and take time to explain play therapy and its therapeutic powers by involving and engaging those involved in the process of play therapy for a better understanding.

Parent involvement is one of the strongest factors in a child’s well-being (Bornsheuer and Watts, 2008:1). It was also realised that a good relationship with the parents of a problem child was one of the keys to success (Rogers, 1939); especially in filial play therapy when conducted with parents (Bratton, et al., 2005). However, Bornsheuer and Watts (2008) submit that most recent literature on
the topic of parent consultations was added in 2006 (Cates, Paone, Packman, and Margolis, 2006) and that none has focussed specifically on the topic of child-centred play therapy and parent consultation. Considering that parents have influence on the children’s perception of play therapy, it is suggested that it may be of importance to involve the parents (Brumfield and Christensen, 2011; Carmichael, 2006).

Campbell (1993) has noted that in consultations with parents, caution needs to be taken. He is of the opinion that although the therapist may invite the parent to attend the parent consultation, it may appear to be a “summons” for the parent to attend. However, the potential positive outcomes of parental involvement would seem to outweigh the danger of alienating parents (Van Fleet et al., 2010). Israel, Thomsen, Langeveld, and Stormark (2007) are convinced that if the parents are made to feel as partners in the whole process their cooperation would be achievable. Without parental involvement the gains in therapy may be interfered with (O’Conner, 2000) which may come in many forms, one being resistance. Van Fleet (2000) has this to say;

“Parental resistance to therapy can take many forms, expectations of a quick fix of the child. Parents being hostile or passive-aggressive to change, missing sessions, being late for appointments, and noncompliance with treatment or homework tasks are all forms of resistance that the play therapist needs to be aware of and work towards reducing through active listening, empathy, and understanding of the parent’s perspective” (Van Fleet, 2000:37).

Involving parents in the therapeutic process has proven very effective and several different approaches rely on the strength of the parent-child relationship as a significant factor in healing (Homeyer and Morrison, 2008). After a decade of research and practice, filial therapy was developed in 1964. This trains parents in basic child-centred play therapy skills and procedures and during play sessions parents “let the child lead” (Landreth & Bratton, 2006: 203). Guerney, (2000:7-13) identified that a major task of filial therapy is “to identify and utilize strengths and build on them in therapy” and referred to filial therapy as a “remarkably robust approach.” Landreth and Bratton (2006) later introduced a protocol for a ten-session model known as child parent
relationship therapy (CPRT) which also trains and supervises parent–child sessions. They provided the following definition of their approach:

“Filial therapy is a unique approach used by professionals trained in play therapy to train parents to be therapeutic agents with their own children through a format of didactic instruction, demonstration play sessions, required at-home laboratory play sessions, and supervision in a supportive atmosphere” (Landreth and Bratton, 2006:11).

Regarding parental involvement, without mentioning which model of play therapy, Shale (2004) concluded that though parents may recognize the developmental value of play therapy and perceived it as helpful; they were unclear about what play therapy was. As a result, she suggested awareness campaigns to help parents understand for the community she serves by conducting parent education groups about the process of play therapy and the situations that might benefit from play therapy interventions.

Haslam and Harris (2011) are convinced that the attitudes of play therapists is potentially associated with delivery and that the understanding on how these factors impact treatment offers important information for effort to improve care. The therapist’s complete acceptance of the child allows the child to accept all parts of him or herself, including those more destructive and aggressive tendencies (Ray, Blanco, Sullivan, and Holliman, 2009). It is important to note that this happens in the presence of an empathic and understanding adult where it is assumed that in this relationship a child will learn to meet self-needs in a socially appropriate manner (Youell, 2008; Landreth, 2002). It has been stated that the physical containment complements the psychological containment of the therapeutic relationship (Benedict, 2008). However, Ray, Blanco, Sullivan, and Holliman, (2009) have also argued that the therapist’s acceptance, being newly experienced by the child, may become a source of anxiety, and the child could be unable to tolerate the therapist’s physical proximity. Hughes explains that: “Emotional communication that combines nonverbal attunement and reflective dialogue and is followed by relationship repair when necessary, is the central therapeutic activity” (2008b: 2).
2.2. Play therapy in the Kenyan context

Professional counselling was introduced in Kenya because of HIV/AIDS (K’oyugi and Muita, 2002). Similarly, play therapy arose out of the same need to respond to the HIV AIDS pandemic (Nyambetha, 2007). The chief aim was to support the orphans because of HIV/AIDS deaths of their parents. HIV/AIDS orphans operated and still operate as a catchment area for play therapy clients.

According to Drewers (2006) play therapy and the use of play-based therapy is by no means a new school of thought, this may be so in the western world but it is not the same locally. Play therapy in Kenya is in its formative years and the wider Kenyan community has been slow to embrace it. Robson has captured this, (2010:257) he reported that;

“... Therapeutic work with children and young people is in its infancy and where access to training and literature can be severely limited…”

McGuiness, Alfred, Cohen, Hunt, and Robson, (2001:294) have questioned the appropriateness of a western based intervention to countries with varying cultural traditions. They further say that the “beginnings of an answer can be found in the assumptions common among mental health professionals that human beings are human beings regardless of race, ethnicity and culture, theories of counselling are sufficiently culture-free to be applied to anyone, and therapeutic strategies properly used can work for anyone”. The assumption is that theories of counselling are culture-free, and its therapeutic effect can benefit anyone if implemented as intended ethically and competently in the way, they are supposed to be applied (Fairburn and Cooper2011).

Kaplan (2005) have noted that there is lack of therapeutic intervention for children based on treatment models designed for children in Africa. This include cases of sexual abuse in children (defilement) which according to Hunt (2009) is largely accepted without challenge and seen to be a domestic matter, although there are statutory structures to protect children in Kenya. The 2010 Constitution of Kenya and the 1998 Children Act also restate the concept by providing that a child’s best interest is of paramount importance in every matter concerning the child. However, if McGuiness, et al.’s (2001) observations can be applied to play therapy as well, and play therapy is
assumed to be culture free, this then confirms what had been stated by Drewers, (2006) with regard to play and its benefits. This is implying that if play therapy is applied within its therapeutic guidelines then any child irrespective of culture should be helped.

However there are fundamental aspects within a culture that need addressing. For instance, to sufficiently support a child, it would be important to be aware of the place for the Kenyan child within a community. Taking into consideration that both counselling and play therapy practiced in Kenya are based on the western concepts (McGuiness et al, 2001), an important consideration is their appropriateness within the various cultures of Kenya, home to 43 different tribes (Kenya National Bureau of Statistics, 2010). A starting point for a multicultural approach could be provided by Cohen, Hunt, McGuiness and Robson (2000), who argue for the importance of seeing clients as both unique and culturally different. However, it would be important to take into account the service providers; the play therapists who are in as much danger as anyone else of unconsciously carrying bias and prejudice resulting from ethnic and cultural differences (Drewers 2006; Russ, 2007).

How would the needs of the therapists and shortcomings be taken care of? A sense of personal shortcomings was acknowledged by a play therapist here in Kenya who worked with children after the 2007/2008 post-election violence (Robson, 2010). She did not mention where her shortcomings were stemming from; whether it was her inability to put aside her values or cultural beliefs or whether it was the fact that she was working with a group made up of children from various ethnic backgrounds with different cultural values. However, the challenges of working with these children was evident and she concluded by making a case for further specialised training that is sensitive to cultural context. To be able work effectively in a multicultural set up Reinkraut, (2007) demands a conscious understanding of who the therapist is: the therapist needs to have self-knowledge, to understand cultural practices and lay it aside for the benefit of client. Inevitably, “with increasing globalisation the export of western models of counselling needs to be critically examined against the community’s ways of being and needs” (West, 2014:75). For example, non-directive/child centred play does not direct the child, this model of play therapy relinquishes power to the child and recognises and appreciates the individuality in children (Homeyer and Morrison, 2008).
This model of play therapy “promotes values to strengthen individualism and a sense of improvement but at the same time may be confusing with community needs or belongingness” (West, 2014:74). This is opposed to Kenyan traditional ways of life, where what cuts across all the different cultures is the belief that the adult is the custodian of wisdom and knows what is good for the child. Again the teaching and the moulding of children is focused in a collectivist way on belonging (Mwaniki, 1973; Mbiti, 1978, 1969), which could be perceived us an authoritative way of dispensing knowledge from the viewpoint of somebody from outside this community.

Consequently, the need for counsellors to become culturally competent is argued, which would involve counsellors developing the cultural awareness, knowledge and skills to be able to address the needs of diverse societies appropriately (Robinson-Wood, 2009; Collins & Pieterse, 2007; Flowers and Davidov, 2006).

2.3. Family structure and culture in Kenya

In Kenya the family is guided by kinship based on blood and betrothal. It is what controls social relationship in a given community, governs customs and determines the behaviour of one individual towards another. Respect towards the older generation from the children is a command and not negotiable (Mbiti, 1969). Children’s’ up bringing is a collective effort and puts emphasis on teaching children that they are an organic part of that unit (Mwaniki, 1973). The individual in a traditional African society does not aim to master himself or other things but instead aims to accept a life of harmony with other individuals. This emphasis on group membership is likely to foster and maintain a strong collective concept of the self (Ma and Schoeneman, 1997); as a result, children are oriented towards collectivism in their upbringing.

Collectivism has been described thus:

"Individuals for whom collective self is more salient when responding to a self-description are said to have a collectivist, ensemble, or interdependent conception of self as defined in terms of relationships to others and the collectivist identity: The self-other boundary is fluid,
that is, it extends to and overlaps with the selves of others in important social groups. Each person’s most significant attributes are public roles, statuses, and relationships. Collectivists generally do not differentiate between personal and group goals, and if this distinction is made, collectivists tend to sacrifice personal goals for the good of the collective” (Ma and Schoeneman, 1997:262-264).

Mbiti 1969) emphasises this by saying that the children belong to the cooperative body of kinsmen and that belongingness in a kinship is demonstrated in all areas of life within kinship. Whatever affects one member affects all the members and whatever affects the kinship affects a member. He goes further to state that:

“In traditional life the individual does not and cannot exist alone except corporately. He owes his existence to other people, including those of past generations and his contemporaries; he is simply part of the whole. The community must therefore make, create or produce the individual; for the individual depends on the corporate group. Physical birth is not enough; the child must go through rites of incorporation so that it becomes fully integrated into the entire society. These rites continue throughout the physical life of the person, during which the individual passes from one stage of corporate existence to another. The final stage is reached when he dies and even then he is ritually incorporated into the wider family of both the dead and the living…” I am because we are; and since we are therefore I am” (Mbiti, 1969:108-109).

This demonstrates the collectivist concept of the Kenyan as a people in which children and child upbringing is within the script of the community members and that “what is considered infant development is not independent of the cultural goals, values and resources that guide mothers in their child rearing practices”(Levine et al.,1996:143).

Although the "talking cure" is hardly new among Kenyans, the contemporary western concept of counselling is (McGuiness et al, 2001). In our cultural ways, “counselling” or teaching by an elder has clear structures of authority and hierarchy with gender roles clearly defined (Nwoye, 2004). Within tribes and extended families, specific people were designated to assume leadership and decision-making roles and offered advice on a range of issues as the notion of consulting with a
stranger about personal or family problems was an unusual concept and even frowned upon (Okech & Kimemia, 2012; Nyambedha, Wandibba and Aagaard-Hansen, 2003b). Traditionally if a family member was experiencing interpersonal issues that needed attention, he/she would seek the help of a well-respected relative or a clan elder. In more serious cases concerning sexuality, such as child defilement, rape or incest, traditional healers within the kinship were consulted as a way of protecting the family name and reputation. The success of this process was societal structural stability that resulted from geographical location and proximity (Okech & Kimemia, 2012). However, as the AIDS epidemic took its toll in the country, the social infrastructure that provided a safety net in times past was fragmented and HIV deaths have altered family structures and configuration resulting in transformations of gender roles (Oburu, 2011).

Looking at the practice of play therapy in the Kenyan context in relation to poverty, according to Kabubo-Mariara, Araar, and Duclos (2013), poverty should not only be measured in terms of deprivation of economic means but welfare as well. The colonial legacy of segregation and inequitable distribution of resources and the unprecedented pace of global change characterised by, among other things, the continual relocation and displacement of populations, have created significant socio-economic inequities in Kenyan society. The political instability and tribal tension in Kenya have brought in new discourses of regional and ethnic inequalities and high levels of poverty (Wainaina et al., 2011). 46%-56% of Kenyans live below the poverty line (GoK, 2008). The unemployment rate stood at 40% in 2009, with job opportunities concentrated in urban areas (Kiringai & Fengler, 2010). This has resulted in high level of rural-urban migration in search of employment opportunities (Ministry of Education, Science & Technology, 2004; Hope, 2012). Moreover, the new lifestyle encourages autonomy and competition, resulting in the growth of individualism amongst the young, which may have created another problem (Otieno, 2002).

2.4. On Becoming a Professional

There has been very little research on the assessment of therapist competence and therapy quality. Therapist competence in this context may be defined as “the extent to which a therapist has the
knowledge and skill required to deliver a treatment to the standard needed for it to achieve its expected effects” (Fairburn and Cooper, 2011:374). According to Homeyer & Morrisson, (2008:218) “it is each country’s national professional association to establish minimum training standards” and play therapists must be responsive to their client’s culture. In America, the specific training of beginning play therapists often occurs within a wide spectrum of master’s degree programmes, ranging from a single elective course to a programmatic focus on play therapy (Joiner & Landreth, 2005; Ray, 2004).

2.4.1. Training Needs in Kenya

In Kenya, what is present in the form of counselling and psychotherapy is a western model of counselling as part of the colonial legacy. (West, 2014:76). The counselling training programmes in Kenya vary both in terms of curriculum and duration depending on the institutions that offer training. Provision varies from three week training for Voluntary Counselling and Testing (VCT) counsellors to a Doctorate in counselling studies offered by both colleges like the Kenya Association of Professional Counsellors and universities colleges like Daystar University, Kenyatta University and Moi University. In view of this the training that the counsellors receive is not regulated or standardised (Okech & Kimemia, 2012; West, 2007).

Play therapy training in Kenya is based on a non-directive/ child centred model developed by Axline, (1947), with the duration of the 120 contact hours, and most play therapists are initially generic counsellors (Hunt, 2009). Elsewhere, like in America, the specific training of beginning play therapists often occurs within a wide spectrum of master’s degree programmes, ranging from a single elective course to programmatic focus on play therapy (Ryan, Gomory, and Lacasse, 2002). So in order to demonstrate and bring forth the effectiveness of play therapy which is strongly influenced by the person of the therapist (McWilliams, 2004), the therapists need to be well prepared and to understand how their own identities might influence the therapeutic process (Collins and Pieterse, 2007; Hill, Sullivan, Knox, and Scholler, 2007).
Though, Gladwell (2008) states that success is based on the quantity of experience as opposed to training, Fairburn and Cooper (2011:373) have stated that to deliver quality services “therapists should be trained to the point of competence”. However, Schwenk (2006) believes that training is a continuous journey in a counsellor’s life, and provides an outline for a programme of continuing professional development based upon and grounded in counselling practice. She suggests four stages a counsellor will pass through on this journey; Novice, Apprentice, Journey person and Master Craftsman.

According to Turner, (2007) most counselling is learnt in practice and not through lectures, and self-development or personal development is regarded as an important component of counselling training (BACP, 2010) which requires the trainees to work on their issues that might reduce their effectiveness. This self-development may occur at any time (Donati and Watts, 2005) as it is not an event but a process that is life and career long, and viewed as necessary in the facilitation in the client development (Turner, 2007). This is tacit knowledge and cannot be taught but can be learned or acquired if relevant opportunities are provided (Polanyi, 1969).

2.5. Professional Development

Personal development and professional development have been described as:

“...the two strands that constitute the broad process of counsellor development while professional development is primarily concerned with the acquisition of skills and knowledge, personal development embraces ‘everything else which facilitates being a practicing counsellor …. [It] has also been referred to in terms of a range of specific activities directed at the maintenance and development of therapeutic effectiveness, such as basic and further training, attending conferences and workshops, keeping abreast of developments within the field, having regular supervision and sustaining ethical practice”(Donati & Watts 2005:476).
Therapists are argued to be ethically responsible for ensuring their own continued professional development and maintaining good standards of practice and care for the benefit of clients (Joyce and Sills, 2007). This requires professional competence and observing of professional ethics (Joyce & Sills, 2007; Melnick & March Nevis, 2005; Neukrug, 2007). With reference to professional development, Landreth (2012) has suggested that all play therapists should be engaged in a process of never-ending self-critique. Hill, Sullivan, Knox, and Scholler (2007) in examining the development of counsellor trainees found that trainees’ experience of professional growth included increased awareness of their reactions to clients. This self-awareness has been equated with personal therapy, which is regarded as a significant building block in training, along with personal development group work and practices such as reflective journaling (Wright & Bolton, 2012). It is also considered as an essential part of training, which facilitates working at depth in a challenging and containing relationship (Macaskie, Meekums, and Nolan, 2013).

2.5.1. Supervision: Ethical implications in therapeutic practice

Much of this development takes place in the life of therapists’ journey of practice and through supervision, which Wheeler and Richards (2007) cite as a psychotherapy practice that is widely promoted in the United Kingdom as an aspect of professional development. It is seen as an essential aspect of ethical and effective therapy and as the cornerstone of continuing professional development. Not seeking supervision is viewed as unethical for any practicing therapist. Ethics can be understood as morals and ideas or ideals about what is right and wrong for any profession (Ecclestone, 2003). All counsellors who are members of the British association for Counselling an Psychotherapy (BACP) are required to have regular and on-going formal supervision as an ethical requirement. Failure of some work contexts to offer on-going supervision leads some counsellors to feel unsupported (Scaife, 2004). Burnout may be lessened and harm to clients may be prevented by effective supervision (Corey, 2005; Van der Westhuizen, 2009). The demand placed on the counsellor to ensure that the ethical commitment to clients is fulfilled means that they need to actively participate in supervision and remain open to learning as part of continuing professional
development. In supervision, knowledge of development, theories of change, self-awareness and continuous assessment become integrated into clinical practice (Landreth, 2002). The frequency and type of supervision is said to vary according to the therapist’s level of experience, including the need of the therapist and the therapeutic setting (Neukrug, 2007).

Supervision having been regarded as an important component in the counsellor’s working life, this also requires a supervisor to be knowledgeable and experienced in supervisory training (Bernard & Goodyear, 2013). At the same time, the supervision should meet the needs of the novice therapist according to Bernard and Goodyear (2013) in that it should be theory based, developmental, social, experiential and integrative.

Some of the benefits of supervision have been highlighted. For example, Vallance’s (2004) qualitative analysis of trainees’ experiences of the impact of supervision revealed that discussing the dynamics of counselling in supervision led to an increase of self-awareness for the counsellors, and that this positively influenced their work with clients. Such findings have resulted in the incorporation of self-awareness into models of supervision. For instance, Stoltenberg (2005) articulated an integrated developmental model of supervision, in which trainees move through various stages in their development and stated that at a more developed stage (Level 3), trainees are able to focus on the client while increasing their awareness of their own feelings, thoughts and behaviours regarding the client.

The tasks and functions of supervision are to set up a learning relationship, to teach, to evaluate, to monitor professional ethics, to counsel, to consult, and to monitor administrative aspects. Moreover, the functions are understood as being educative (formative), supportive (restorative), and administrative (normative). Supervision can be applied in exploring the supervisee’s experience and countering blind spots within a therapeutic relationship (Carroll, 1996). Kirk, (2010: 293) argues that:

“….a good supervisor can help identify blind spots in your understanding, possibly those associated with unhelpful beliefs of your own; and to help you to become aware of gaps in your skills and knowledge. They can also be invaluable in providing you with support and reassurance if you are dealing with distressing and difficult materials”.

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Ray (2004) discusses supervision for play therapists and believes that supervision should fit the therapeutic process and that the supervisor should be trained in and knowledgeable of the specific play therapeutic orientation of the play therapist. It has been suggested that given the nonverbal nature of play therapy, supervisees may benefit from exploring supervision issues through nonverbal means like the use of symbolism, metaphoric play, and art would be appropriate, if not the standard (Homeyer and Morrison, 2008). In addition, it is argued that that experiencing these same dynamics in the supervision process would lead supervisees to a greater depth of understanding than they could get from words alone (Ray, 2004). Hawkins and Shohet (2007:5, 28-29) are of the opinion that without supervision therapists can begin to feel ‘stuck’ and become rigid in their approach to therapeutic work. The quality of therapeutic work can deteriorate and the therapist may experience feelings of guilt and inadequacy, which when accompanied with the normal stress of therapeutic work can lead to burn out.

Supervision is then seen not only to be beneficial for therapists throughout their careers as “the foundation of clinical development,” but as being beneficial for the personal and professional growth of all therapists as well, whether they are newly qualified or having many years of experience (Resnick and Estrup (2000:121). Supervision according to Aveline (2007:536) “offers practitioners the chance to stand back and reflect on their work, to engage in a search for new knowledge and skills and to receive support and affirmation”. In this regard, Resnick and Estrup (2000:121) are of the opinion that “supervision is one of the most important and influential processes in enhancing the personal and professional growth of the practitioner and lies at the foundation of professional development”. Corey (2005) observes that supervision can provide less experienced therapists with the opportunity to discuss their feelings of anxiety in relation to work and to practice skills and techniques. According to Van der Westhuizen, (2009) the therapist who makes regular use of supervision resources remains current and continues to develop professionally and personally, while reduces work related stress and avoids burn out.

Supervision is well established in most western countries. In Kenya, the counselling profession is growing but the supervisory structures are largely absent. It is only recently that the Kenya Counsellors and Psychologists Act was signed. However, in the absence of a play therapy body or
any play therapy supervision, play therapists are totally dependent on peer supervision in an attempt to support the play therapist. This supervision is usually a less formal method of supervision, and may take place as a one on one meeting or as a group meeting. A disadvantage is that peers may not be disciplined enough to focus on discussing needs arising from the therapeutic setting. However, an advantage is that peers have the same level of work experience and encounter similar problems and so provide an opportunity for the release of tension and built up negativity (Hawkins & Shohet, 2007).

2.6. Social Theory of Learning

In the absence of play therapy body or play therapy supervision, exploring other supportive theories of learning is important. According to Macaskie, Meekums and Nolan, (2013:359) therapist education "is not one way but joint enterprise; a mutual dialogue in which tutors gain insight from trainees through valuing their life experience and wisdom. It involves the inculcation of mutual respect and recognition, a humility that avoids the kind of knowing that forecloses but sustains curiosity towards the potential to learn from each other".

The Social theory of learning stipulates that learning is a social participation, which calls for active participation in any given activity. It should result in constructing our identity and the meaning we make from what we learn from this activity (Wenger, McDermott, and Snyder, 2002). Rather than being taught, the social learning entry point is that many individuals learn more effectively when they have the opportunity to observe others (Wenger, 1998).

This is similar to group affiliated identity (Carter, 2003, 2005), where students participate in an experiential activity in which they learn from each other how each student understands his or her reference group identities (e.g. racial group, ethnic group, religious affiliation, etc.). Similar to the social theory of learning, members work together in the quest for a viable identity in a community of practice, which is an integral part of our daily lives: hence the theoretical construct of communities of practice (Lave & Wenger, 1991; Wenger, 1998, 2001; Wenger et al., 2002). It is grounded in an
anthropological perspective that examines how adults learn through everyday social practices, rather than focusing on environments that are intentionally designed to support learning. Social learning take social interaction into account and places emphasis on the interpersonal relations involving imitation and modelling and observation becomes a source of learning (Bandura, 1977).

A community of practice is defined as “a group of people who share an interest in a domain of human endeavour and engage in a process of collective learning that creates bonds between them” (Wenger, 2001:1). This theoretical framework proposes that it is in these communities of practice that people learn the intricacies of their job, explore the meaning of their work, and develop a sense of professional self. The original concept of communities of practice addressed learning that took place in face-to-face situations such as apprenticeships of Mayan midwives in Mexico, work-learning settings of United States Navy quartermasters, and among non-drinking alcoholics in Alcoholics Anonymous (Lave & Wenger, 1991). A key characteristic of a community of practice according Barab and Duffy (2000) is that it provides newcomers with a forum for learning and construction of identity. The more experienced practitioners through the social process of sharing stories and examples help the newcomers to understand and learn various aspects of the practice. Barab and Duffy (2000) claim that telling and retelling of individual stories does more than pass on knowledge; it contributes to the construction of their own identity in relationship to the community of practice and reciprocally to the construction and development of the community of which they are part. A community of practice also provides a forum where members can negotiate the meaning of their work through the everyday on-going actions of the community. Wenger states, “in our communities of practice, we come together not only to engage in pursuing some goals but also to figure out how our engagement fits in the broader scheme of things (Wenger, 1998:162).

Communities of practice are a system of informal learning and consist of people with a shared domain of expertise who voluntarily learn together about practices that matter to them (Lave & Wenger, 1991). Wenger’s (2001) framework suggests that there is the potential for professional associations to facilitate and enhance informal learning by providing opportunities for the development of problem solving. The members can learn together and continue to shape not only their own identity as practitioners, but the identity of the practice itself (Wenger, 1998). The systems
are self-organising with multiple levels and types of participation, where the members help each other by learning and by interacting with one another. In addition, they share information in a discussion venture by individuals’ engagement and contribution to the practices of their communities. People are known to learn more effectively in a group where they are able to complement each other.

Within this membership is fluid. The interplay between experienced members and newcomers is an important dimension of passing on knowledge and facilitating the creation of new knowledge and insight on how to be and do. It is stated that through participation we learn not only how to do but how to be (Wenger, 1998). Wenger goes further to say that through these interactions, members build relationships and form a community where they develop a shared collection of experiences, stories, best practices, and ways of solving problems. This shared repertoire of stories and case studies becomes a common knowledge base on which they can draw when facing new situations (Wenger, 2001). Such communities address not only the technical acquisition of skills required by a specific practice, but also the informal and social aspects of creating and sharing knowledge, in a community of practice: individuals learn to function and become acculturated into that community’s practices, language, viewpoints, and behaviours (Wenger, 2001; Wenger et al., 2002).

2.7. Summary of Chapter Two

This chapter illuminates the scope of my literature review and gives a brief focus on the development of play therapy from its foundations to the current situation in Africa and Kenya. Throughout my experience of this chapter, I realised that the existing literature is mainly that which has been documented in the west. As such, there exists very little documented evidence of literature on the African and closer to home, the Kenyan professional situation. This may point to the need for documented evidence related to the Kenyan situation in the form of further research.

The literature has also highlighted the impact of the relationship between client/therapist/parent and the need for awareness creating and parental involvement. Literature covering multicultural
practices point to the need for culturally sensitive models or integration of other models, which would respond to some of the "taboo" aspects like child defilement and power dynamics in therapy. It might also explore the involvement of significant others in the child’s life, which may cause tension on how the play therapists work using non-directive play model. The need for the play therapist to work with the larger community of play therapists or related fields has also been revealed.

Finally, the knowledge gap surrounding training and the regulation of such training has been reviewed and the need for supervision discussed, highlighting the dangers of not seeking supervision. In the absence of a play therapy body or play therapy supervision within Kenya, the literature review has reviewed other avenues of learning, specifically social learning as a way of professional development, growth and support for the therapists.

CHAPTER THREE: RESEARCH METHODOLOGY

3.0. Introduction
In the world of research practice there is quantitative research at one end of the continuum and qualitative research methodologies at the other end of the continuum, with mixed research methods in the middle (Onwuegbuzie and Johnson, 2004). This chapter presents the methodological considerations which according to Etherington (2004:72) should be “… about what I need to do to discover what I want to know”. This includes an evaluation of the options considered, why certain choices have been made, the philosophical reasoning behind the decisions made (McLeod, 2001) and how this has informed my research. Lennie and West (2010) refer to the importance of understanding the positioning of the researcher, which needs to fit with their methodology, methods and the area of their research. Remarking on the same, Wilson and Mclean (2011), Parahoo (2006) and Patton (2002) have stated that the research approach chosen should be the one best suited to fit the study and one that will provide data to answer the research question and help to advance knowledge. Further, Ramazanoglu and Holland, (2002) hold the view that methodologies should rely on the ontological and epistemological stance of the researcher.

Prior to this research a pilot study was done to test the appropriateness of the descriptive phenomenological approach, which was then adopted as the methodology of choice and the lessons learnt are presented in this chapter. As the study is phenomenological in nature, I maintain a stance on embracing both relativism and realism, as I believe that my participants’ realities are from their own perspectives (Finlay, 2011).

Alongside discussion of the methodology and methods adopted, I also discuss the ethical issues of trustworthiness, confidentiality and nonmaleficence, and examine issues surrounding validity. A summary of the methodology chapter is followed by the conclusion of the chapter

3.1. Rationale for the methodology

This research is about capturing the experiences of play therapists practicing in the coastal part of Kenya, which could potentially draw from both quantitative and qualitative research methodologies (Finlay and Evans, 2009; Mellor-Clark and Barkham, 2003). To help in capturing these experiences,
it was important for me as the researcher to identify a research methodology and method that acknowledges the differences and diversity of each participant with a hope of improving practice (Finlay and Evans, 2009). As a researcher with the knowledge of the complexity of the participants’ experiences, I knew that such experiences would be difficult to measure or quantify (Fitzpatrick and Finlay, 2008). Hence, I was drawn to qualitative research as a more favourable method of working, since qualitative research aims to describe experience and offers the possibility of hearing the perceptions and experience of service users (Finlay, 2011). This is opposed to quantitative research, which emphasises numerated specifics and tests hypothesis with an aim to prove or disprove scientifically (Finlay, 2006).

It has been reported that the qualitative descriptive phenomenological approach, while respecting individuality, focuses on the phenomenon and not solely on the individual experience (Giorgi, 2008a, 2008b). This resonates with my aim in this study to present these experiences in a way that individual meanings are captured and presented within a more general presentation of the experience of the phenomenon (Finlay, 2011; Langdridge, 2007). Because of this, I see my findings as holding a promise of being able to give the reader the ‘what’ and the ‘how’ of the experiences of play therapists’ experiences (McLeod, 2011).

Within qualitative research methodology, I settled for a phenomenological approach as opposed to grounded theory, which I considered as a possibility, where a researcher is expected to generate a theory that makes sense of the phenomenon being investigated based on the data collected (Corbin and Strauss, 2008; Charmaz, 2006). In grounded theory, this theory is derived from codes, which lead to concepts, which are then categorised by ranking to make a theory (Glaser and Strauss, 1967). My challenge as a researcher would be categorising of words (Glaser, 1992) in capturing and describing feelings of the participants’ experiences.

Grounded theory’s emphasis on theoretical sensitivity and abstaining from reading the literature on the topic being investigated prior to collecting data is similar to the descriptive phenomenological process of bracketing. However, in grounded theory emphasis is put on not having any pre-conceived idea on the topic when collecting or analysing data (Glaser & Strauss (1967). I questioned how this would be compatible with my subjectivity about the research topic since I am
an insider. In some approaches to grounded theory, the researcher is a detached observer and the researcher's reflexivity is not highlighted and the collaborative working alliance between the researcher and the participant is downplayed (McLeod, 2011). Grounded theory may be a powerful way to draw meaningful conclusions and a way of challenging existing theories (Allan, 2003). However, considering my position as an insider, bringing presumptions and past knowledge of play therapy, it would be unrealistic on my part to expect to be objective and detached from my study. I needed to be fully engaged in an open way to what may appear (Giorgi, 1985) and this is what a phenomenological approach offered.

Grounded theory aims to uncover the basic social processes that underlie behaviour to generate a theory (Corbin and Strauss, 2008; Charmaz, 2006). My aim however was not to discover cause and effect but to get to the essence (essential general meaning structures) of a phenomenon. This involves bringing back all the living relationships of the phenomenon by describing in detail what the participants have told me, while being aware of my previous knowledge of play therapy as a way of discovering the world (Finlay, 2011; Langdridge, 2007; Husserl, 1970). Because of the reasons discussed above, I decided that grounded theory was not the best fit for this study.

3.2. Ontological and Epistemological Statements

For the reader to appreciate my choice of research approach, it is crucial that I make my ontological and epistemological statements. Ontology is theories about the nature of reality, while epistemology is theory about the nature of knowledge and how it is known. Hence, both ontology and epistemology are theories about the nature of reality and knowledge (Braun and Clarke, 2013). Within ontology, there is realism on one end of the spectrum and relativism on the other, with critical realism in between.

“Realism believes in the existent of a pre-social reality that we can access through research, Relativism on the other hand believe that reality is dependent on the ways we
come to know it while critical realism believe that a pre-social reality exists but we can only ever partially know it” (Braun and Clarke, 2013:26).

I place myself between the camp of relativism and realism because I believe that the reality of my participants is from their perspective, it is multifaceted and partial (Finlay, 2011; Silverman, 2010). This also reflects my professional beliefs of co-construction of realities and truths, which De Jaegher and Di Paulo (2007) have described as a plurality of truths from a variety of perspectives. It is fluid and continually co-constructed through embodied participatory sense making. “Other people are not simply the objects of our desires, fears, identifications and projections, but embodied subjects in themselves and in relation with us” (Macaskie, Macaskie, Meekums and Nolan, 2013:353).

Finlay (2011) places phenomenologists between realism and relativism, with an argument that it is possible to capture some meanings about how the world is experienced but these are emergent, partial and contextual according to Finlay (2011). In this study the participants’ description of experiences is according to their context, how they see it. Patton (2002:96) states that “...the world of human perception is not real in an absolute sense, but is “made up” and shaped by cultural and linguistic constructs.” (Patton, 2002:96). My ontological position is that of critical realist leaning towards relativism. Critical realism sits between relativism and realism and reflects the belief that authentic reality exists and is subjective and socially influenced (Braun and Clarke, 2013). It can only be partially accessed (Mandill et.al., 2000). In my study I believe that what my participants are describing as their experiences is according to their reality on their own terms and that this reality has been shaped by their social interaction with others and they only tell me what they have decided to tell me.

As phenomenologists, we respect our participants’ realities by accepting what they share in research is their own understanding (Finlay and Evans, 2009). We also believe that these realities are not based on a single experience but are intertwined with the world we dwell in which is culturally influenced and can only be understood within a context (Burr, 2003). However because the descriptive phenomenological approach that I subscribe to aims to get to the essence of a
phenomenon, I would need to take all these variables into consideration in producing the structural essence (Finlay, 2005) as discussed below.

Epistemology is concerned with whether reality is discovered through the process of research or created through the process of research (Braun and Clarke, 2013). The knowledge of this study is constructed, fluid and contextualized (Burr, 2003). This knowledge can only be explored through interaction with the participants (first person's accounts), which the descriptive phenomenological approach advocates, by the use of language in dialogue. Phenomenologists also appreciate that the words we use to describe our experience play a part in the construction of the meaning that we attribute to such experience (Guba and Lincoln, 2008; Rohlerder and Lyons 2015). They believe that language is a medium through which we constitute our ideas and constructions of the world and reality.

At the core of the phenomenological approach is deep respect for the uniqueness of human experience, highlighting the “complexity, ambiguity and ambivalence of participants’ experiences” (Dahlberg, et.al. 2008:94). On the other hand, the slogan “going back to the things themselves” (Husserl, 1970) describes how the descriptive phenomenological approach aims to transcend everyday understandings or the ‘natural attitude’ in order to access or uncover the essential nature of the participants’ experiences. How then do I marry my stance of multiple realities, and the notion of essence? I aim to bring back all the living relationships of experience (Merleau-Ponty, 1962).

Following Husserl’s ideas of epoche, and imaginative variations would bring out each participant’s unique experience within a community (Freeman, Hayes, Kuch, and Taub, 2007). This would become part of a unique picture of the whole experience of play therapy and its meaning within this community, whose uniqueness is no longer singular or exclusive to the individual (Paley, 2005). By exposing the phenomenon to Imaginative variation, looking at the participant’s experiences from different perspectives so the essence may come into view (Langdriddle, 2007). I was aware of the need for me as an insider researcher to be receptive by being open and to pay attention to the smallest detail from each participant’s perspective of play therapy without assuming anything (Mortari, 2008; Finlay 2008) with a hope of finding “something new” as stated by McLeod, (2003:38). Although as a descriptive researcher, I seek to describe a general structure of the
findings, at the same time, I do consider a group of play therapists as a unique group in itself and would consider its situated nature.

What will be presented will be a collective of essential structures of all the participants within the general structural essence, highlighting all the participants’ experiences in all their complexities; having worked out each participant’s individual essential structure and describing them as closely as possible as given without interpretation. This way each participant’s reality of experience will have be taken into account, respected and valued. This demonstrates the flexibility and openness of the phenomenological approach, which is its greatest strength (Garza, 2007). At the same time, the meaning that comes out of the research will be based on the data and achieved through a systematic process of analysis suitable for psychotherapy (Zayed, 2006; Giorgi, 2006). The researcher will remain faithful to what has been given, to whatever reveals its presence and exposes its original profile to our gaze (Motari, 2008; Finlay, 2009).

3.3. Phenomenological Approaches

Phenomenology is a family of approaches whose philosophical foundation were laid down in the early 1900s with the work of Edmund Husserl (1859-1938), as a reaction to quantitative research methods on human beings. It is a human science, which discloses, transforms and inspires the phenomenologist to describe in rich detail what it means to be human in the world (Finlay, 2011).

Phenomenology “can be defined as the description of things as they appear to consciousness” (Moran, 2000:6). It is a way of seeing, “the unprejudiced, descriptive study of whatever appears to consciousness, precisely in the manner in which it so appears” (Moran 2002:1). As Wertz (2005:175) describes it:

“Phenomenology is a low-hovering, in-dwelling, meditative philosophy that glories in the concreteness of person-world relations and accords lived experience with all its indeterminacy and ambiguity, primacy over the known”.
Phenomenological researchers focus on a phenomenon as it is “concretely lived” (Finlay, 2009:6), which has made it popular in education, nursing, and psychology researches (Langdridge, 2007). The approach is existential in that it “relates to the experience of existence...” (Finlay, 2011:19). Phenomenology is open, respectful, non-instrumental and relationally orientated, where both myself as a researcher and my participants relate in inter-subjectivity (Finlay and Evans, 2009). In the descriptive phenomenological approach, the research is rigorously descriptive and inductive, uses the phenomenological reductions, explores the intentional relationship between persons and situations, and discloses the essences of meaning in human experiences using imaginative variation (Giorgi, 1989).

Phenomenology is descriptive, meaning it seeks “to reveal the essential structure of an experience, leaving a side our previous knowledge, all theoretical, psychological interest in order to see phenomenon as experienced” (Husserl, 1970:262). It is also an Inductive approach which aims at looking for patterns and asking the what and how questions related to description and understanding associations derived from observations of the world (Finlay, 2011). Phenomenological reduction involves “a radical self-meditative process where the philosopher “brackets” the natural world and world of interpretation in order to see the phenomenon in its essence” (Finlay, 2008:2). Finlay (2011:37) describes the intentional relationship as referring to how “we are always conscious of something in the world”. She considers essences as the “description and structural analysis of consciousness as it is given how it appears... in experience, how things show themselves to us.” (Finlay, 2011:44). Imaginative variation has been described as a process of looking at a phenomenon from various perspectives in order to distinguish essential features of an experience, which is crucial in uncovering the essence of a phenomenon (the structure underlying that experience), which is “purified of preconception” (Finlay, 2011:47).

In my study, in order to capture the experiences of the participants in all its complexity, it was important to reveal the essential structure of a phenomenon. This required me to adopt the phenomenological attitude. I needed to be present and focus on what was being described by the participants, without applying ontological claims of existence or hierarchy of meanings. While being aware of my previous understanding of play therapy, I needed to describe what appeared in my
consciousness in detail without hierarchies of meanings (Finlay, 2011; Giorgi, 2009; Langdridge, 2007). This was focussed on accessing the essence of a phenomenon, or bringing “back all the living relationships of experience” (Merleau-Ponty, 1962:15). To be able to access the essence of the experiences of my research participants, I needed to work with the data by running it through imaginative variation, while looking at the phenomenon from various perspectives of the participants to be able to establish what counts for the essence of their experiences.

Turning to my research question, “how do non-directive play therapist experience their work with children in the Kenyan context”, as a play therapist researcher I came into this study with past knowledge about play therapy. From my past experience of play therapy I was aware of the existence of some of the experiences that my participants would be describing. Being an insider researcher, I was aware of what had led me to the research topic, which was the doubt I had about my ability to practice. I had therefore set out to confirm if my fears were founded: this I had hoped to establish by exploring my fellow play therapists’ experiences. Lincoln (2008:278) has described this as a “conscious experiencing of the self as both inquirer and respondent as teacher and learner, as the one coming to know self within the process of research itself.”

So unless I attempted to practice phenomenological reductions, i.e. to hold in abeyance past knowledge and any existential claims (Wertz, 2005), it would be a challenge to concentrate and be fully present to what the participants were describing. Their experience would be likely to evoke my experiences and might lead to one sided understanding. Even though I appreciate my counselling training in preparing me in dealing with my values and working with my beliefs, I needed to be aware that counselling is different from doing research because they each have different goals (Polkinghorne, 2005), and manage the boundaries between counselling and research well.

When choosing the phenomenological approach, my reasoning was also informed by the parallels between the skills of doing research such as openness, a non-judgmental attitude, empathy, listening, trusting relationship and warmth (Finlay, 2011:77-78) and the skills I use in my counselling practice. This is informed by the person-centred theoretical framework, based on the work of Carl Rogers whose approach to practice is characterised by non-directiveness and the non-imposing of values or views (Rogers, 1951). This is similar to the phenomenological attitude in the
phenomenological approach. Maintaining an empathic attitude in research, being open to the other without any preconceived ideas and with respect and trust in order to be able to see the world from the point of view of the participant (Finlay and Evans, 2009; Finlay, 2008) is comparable to the use of empathy therapy. While empathy can be criticised as reflecting the “natural attitude”, or our everyday way of thinking (McLeod, 2011), it is assumed that in research this natural attitude can be held in abeyance. Instead the phenomenological researcher adopts the phenomenological attitude of openness through bracketing (Finlay, 2008).

The phenomenological attitude has been described as a “dance” between reduction and reflexivity, bringing together the holding of an awareness of our subjectivity and preconceptions while attending to what is being described (Finlay, 2008). The fact that I shared the experience of play therapy with the study participants made it important for me to consider the issue of subjectivity, which has been highlighted as having potential negative consequences on the data (Drapeau, 2002). This notion is shared by Chew-Graham, May & Perry (2002:288) who talked of the danger of the research relationship becoming “a case of shared conceptual blindness allowing the interviewer’s own feelings and opinions about the field to govern the dialogue and interpretation.”

This seems to have been confirmed by Denzin and Lincoln (2005) who have stated that reflexivity is essential to the trustworthiness of research. Having adopted the phenomenological attitude which is one of the characteristics of the descriptive phenomenological approach, there is a high possibility of being able to empathically enter and reflect on the lived world of other play therapists in order to access the meanings of the world as they are given in “the first-person point of view” (Husserl, 1962). Important to this is bracketing, also known as epoche, which means that “One simply refrains from positing and looks at the data with relative openness” (Giorgi, 1994:212). Bracketing helps the researcher to remain vigilant to the ways in which their personal intellectual baggage might distort the description of the phenomenon. Critical attention is given to the present experience solely for the purpose of allowing description to be carried out in as undistorted way as possible (Ashworth, 1996). Epoche in phenomenological research, according to Patton (2002) is a process whereby the researcher attempts to: “…become aware of, prejudices, viewpoints or assumptions regarding the phenomenon under investigation” (Patton, 2002:485).
Morrow (2005:254) notes that:

“In order to deal with biases and assumptions that come from their own life experiences or in interactions with research participants, which are often emotion laden, qualitative researchers attempt to approach their endeavour reflexively”.

Similarly, Etherington (2004:46) writes:

“I explain my interest in the topics and how I had gone about trying to discover new knowledge. By doing so, you as reader are provided with information about the values and principles that underpin the way I conduct research and you can use that knowledge to judge its rigor and validity. ‘Biases’, ‘assumptions’, and ‘validity’, though, are perhaps words associated with the explanatory paradigm, in which researchers might strive for an objective understanding of their topic.”

The application of epoche (bracketing) requires disengagement from everyday understandings or the natural attitude. According to Moran (2002), this involves temporarily attempting to set aside our presumptions and prejudices. It concerns temporarily putting out of action previous understanding or reducing the field which commands one’s special focus of attention (Giorgi, 2009) in order to look at the phenomenon from different perspectives. This, Husserl (1970) says, requires a transformation and orientation of the natural attitude, and helps in bringing out our participants’ subjectivity. According to Ashworth, (1996) the natural attitude reflects a belief in an objective reality, which enquires the causes of the phenomenon rather than the appearing of the phenomenon.

It is important to note that Ashworth (1996) has stated that what cannot be put out of action are a shared focus and shared cultural meanings. What is bracketed is theoretical understandings and any scientific explanation of a phenomenon and refraining from any value judgments and empathically focusing on what the participant is sharing (Finlay, 2011). Building on this, it is stated that one is able to be open to a participant’s experience as it appears in the consciousness by “reading the text with a sense of discovery, avoiding the temptation to impose meaning by engaging in the phenomenological reduction” (Mortari, 2008:6).
Phenomenological reduction is critically purifying oneself of bias and prejudices and entering a new being (Finlay, 2011). Although I have claimed to be a descriptive phenomenologist in my choice of research methodology and working methods, purifying of my past understanding about play therapy is a challenge being an insider. I found it more realistic to work with my presumptions as a source of insight (Finlay, 2008). Recollecting and interrogating my past understanding of play therapy, even as I listened to the participants describe their own understanding of the intervention, helped me to understand their understanding of play therapy.

So, recollecting and interrogating my past experience of play therapy and how this contributes to my study enhanced my present understanding of the intervention model in question. For example one of my presumptions is ‘that play therapy is effective’. By critically interrogating this against what the study participants were describing as their perception on the effectiveness of play therapy, I was able to establish what influences my opinion rather than assume its veracity. This resulted in me gaining insight (Finlay, 2011). I became aware of my passion for children and their wellness: just to be able to see a child happy and full of life was enough to convince me of the effectiveness of play therapy. I became aware that this might lead me to assume that the client had made positive therapeutic change and therefore the intervention must be effective, without considering other variables that may have contributed to the positive effect or if indeed the model is effective. This experience when exposed to the workings of descriptive phenomenological may very well expose, bring to light the essence of the effectiveness as experienced (Langdrige, 2007).

This notion of working with my past understanding to gain insight may appear problematic with my alignment to bracketing. But, as Finlay (2011) and Ashwoth (1996) argue, what is bracketed is theoretical understanding, value judgments and any scientific explanation of a phenomenon, I was able to acknowledge my presumptions of play therapy and work with these experiences. I was also relieved that Giorgi (2009) has stated that bracketing is not forgetting the past but heightening the present. This seems to concur with what has been stated by West (2009), in that in doing research there is a level of subjectivity involved, and that we always need to know who did the research and their background as none of us can truly bracket our culture as researcher, which forms part of the process.
Within phenomenology, I considered using Interpretative Phenomenological Analysis (IPA) as a method of choice. In IPA the analyst interprets participant’s understanding, which is referred to as “double hermeneutic” (e.g. Smith and Osborn, 2003). IPA is inductive, grounded in the data and aims to explore in detail participants’ personal lived experience and how participants make sense of that personal experience (Smith, 2004). This is similar to the descriptive phenomenological approach. However, IPA does not use the Husserlian technique of eidetic variation (generalisation), instead focusing on idiographic (individual) analysis (Finlay, 2009). Eidetic variation, also termed as eidetic intuition, “is the process of moving from the individual to universal” (Langdridge, 2007:20). This entails moving from the description of individual experience to a description of universal experience. Again, rather than search for essence, IPA focuses on differences as well as similarities in experiences and does not advocate for bracketing in the same way the descriptive approach does (Smith, 2007; Langdridge, 2007).

It has been reported that with interpretation the analysts “thinks what the participant is thinking” (Smith, Flowers, and Larkin, 2009:80). Being an insider this would be a challenge and I stood a high chance of presenting my own thinking rather than the participants’ thinking. This made IPA unsuitable for this study because being an insider researcher I needed a method that would enable me to give a rich description of people’s experiences as given (first person’s accounts) without interpreting the experience. With interpretation, there was a risk of my own presumptions of play therapy slipping through, making the findings my own agenda. This is something that I needed to be constantly aware of and work with. I therefore settled for descriptive phenomenological approach, which aims for the presentation of description of experience as closely as possible and heavily advocates for bracketing (Husserl, 1962).

According to Finlay (2009) each phenomenological approach places emphases depending on the philosophy that informs it and what it aims to achieve. In this respect, I chose descriptive phenomenological approach which “seeks and aims to describe and clarify the nature of the phenomenon being studied as given in our consciousness without attempting to interpret meanings by bringing external theory to bear” (Giorgi, 2009:127).
3.3.1. Descriptive Phenomenological Approach

The Descriptive Phenomenological approach is the most traditional and classically Husserlian approach to phenomenological psychology. It is closely connected with the work of Amedeo Giorgi in the 1970s and places the philosophy of lived experience centre stage (Finlay, 2008). This approach is also known as the Duquesne School in America. There are other ‘schools’ which have emerged, e.g. the Sheffield School in Great Britain (Ashworth, 2003, 2006). Inspired by Husserl’s philosophy, the slogan of the descriptive phenomenological approach is to “return to the things themselves” by applying epoche and the psychological reduction to a phenomenon (Husserl, 1970).

It has been reported that researchers who take a stance of realism with a belief that there exists an objective reality that is separate from human practices and understanding that can be studied or accessed through research might adopt a quantitative research methodology because they hold the view of a single reality that can be objectively measured. Researchers who identify more with reality as subjective and relative and only to be understood within context (Braun and Clark, 2013; McLeod, 2011; Finlay, 2011) would tend to be attracted to qualitative research methodology.

Taking into consideration my philosophical stance and my research question, I settled for qualitative research methodology, specifically a descriptive phenomenological approach, with an aim to improve my practice. Being an insider researcher, I do acknowledge the complexity of the interaction between the researcher and the researched (Brandbury-Jones, 2007). So, in order to enhance transparency and trustworthiness to this study, I chose a descriptive phenomenological approach which aims to describe the structure of experiences in the manner in which they are given in consciousness, meaning that “it does not attempt to interpret meanings by bringing in external theory to bear” (Giorgi, 2009:127).

3.4. Research Sample
Sampling is used to choose a representation of the population appropriate to answering the research question (Strydom and Venter, 2005; Bordens and Abbott, 2011). According to McBride (2010) choosing the appropriate method of sampling is important in any research study. In this study, I settled for purposive sampling, which is where a researcher seeks out participants who are likely to contribute rich data concerning the phenomenon being investigated (Groenewald, 2004).

My stance is that data are contained within the experiences of the participant. Based on this, my inclusion criteria involved experience in terms of years of practice, which was at least three years as a prerequisite for the play therapists to qualify to participate in this study. I assumed that after a minimum of three years of practice, the participant therapist would have gained enough experiences to be able to articulate these experiences and provide rich data, taking into consideration their varied cultural practices within their communities.

I chose to recruit six participants. This is within the parameters of sample size advocated within the approach (Halling, 2008). The six practitioners were trained, practicing play therapists and their experience ranged from six to twelve years. The reason for confining this study to therapists with at least three years of practice experience was that, since my aim was to understand the meaning of a phenomenon from a perspective of the participant, it was important to select a sample from which most can be learned. Due to their experience of practice, the above participants were seen as having the potential to offer a richness of information directly pertaining to the purpose of the investigation at hand (Ziomeck-Daigle and Christensen, 2010; Gay and Airasian, 2003).

Invitation letters were sent out to eight out of the twelve play therapist in this area and the intake of the research participants was on a first-come basis. Once the number six was attained, recruitment was closed and I politely declined those who responded later. This is in line with purposive sampling. The research participants were four females and two males, all of middle age but from different ethnic and previous professional backgrounds. They professed different religions, although they were all residing and practicing in the area of this study.

When it comes to sample size, the descriptive phenomenological approach, being a qualitative research methodology, recommends a small sample size because of the vast data produced (McLeod, 2011). It has been suggested that from 1-10 participants is an appropriate sample size for
descriptive phenomenological research (Halling, 2008). Giorgi (2008a:37) has recommended recruiting at least 3 “participants” in order to come up with a typical essence when subjected to imaginative variation by looking at the experiences of play therapy from different perspectives of the play therapist. It has also been reported “even one single case may provide sufficient access to a phenomenon depending on the epistemological goals of the project” (Finlay, 2009:10). For this study I concluded that six participants were sufficient to obtain the different experiences of play therapy, considering my intention to put to use imaginative variation to be able to access various aspects of the experience of play therapy. In the descriptive phenomenological approach, like all the other qualitative research methodology, the aim is quality and not quantity. I believe that the words that make up qualitative analysis represent real people and events far more concretely than numbers (Finlay, 2009). I therefore settled for six participants, which I deemed as sufficient taking into consideration the vast data resulting from interviews.

Morrow (2005) is of the opinion that an adequate amount of evidence is not decided by a greater sample size, even though sufficient numbers of research participants are important for verification, as each individual is unique with a creative ability. In the case of this study, almost all the participants came from different ethnic groups, and the makeup of these participants varied in terms of religion, personal experience, level of education and professional background. They also varied in terms of social status and the categories of the children they had worked with, which I believe played a role in shaping their perspectives on life experiences. I therefore assumed that they should provide rich enough data to produce the essence of a phenomenon and a contribution to knowledge in play therapy (Morrow and Smith, 2000).

3.5. Participants’ training background

The participants were four females and two males whose ages ranged from 45-60+ years. They were all family people with children of different ages of between 18 and 28 years. They were all holders of a certificate in play therapy after a 120 hour long brief play therapy training by the Kenya
Association of Professional Counsellors. Their training was based on the child-centred model, which is rooted in Rogerian psychotherapy and developed by Axline (1947). Their other qualifications ranged from Diploma to MA in Counselling studies and previous professional qualifications in related fields (i.e.) teaching and clinical medicine. These play therapists were currently practicing in education, social services, religious bodies and health centres and were seeking ways to help and support hurt children they came across in their daily working lives.
<table>
<thead>
<tr>
<th>Code</th>
<th>Age</th>
<th>Ethnic Group</th>
<th>Gender</th>
<th>Marital Status</th>
<th>No.of Children</th>
<th>Education Level</th>
<th>Practice</th>
<th>Yrs of Practice as a Play Therapist</th>
<th>Religion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant One</td>
<td>45</td>
<td>Kikuyu</td>
<td>Female</td>
<td>Married</td>
<td>3 Grown up Children</td>
<td>MA Counselling Certificate in Play Therapy</td>
<td>Teacher Counsellor, Play Therapist</td>
<td>6 Years</td>
<td>Christian</td>
</tr>
<tr>
<td>Participant Two</td>
<td>60</td>
<td>Kikuyu</td>
<td>Male</td>
<td>Married</td>
<td>4 Grown up Children</td>
<td>Dip. Clinical Medicine MA Couns Cert. Play Therapy</td>
<td>Retired Clinician Counsellor Play Therapist</td>
<td>8 Years</td>
<td>Christian</td>
</tr>
<tr>
<td>Participant Three</td>
<td>30</td>
<td>Asian</td>
<td>Female</td>
<td>Married</td>
<td>3 Grown up Children</td>
<td>Dip. Special Education Cert. Play Therapy</td>
<td>Teacher Counsellor Play Therapist</td>
<td>6 Years</td>
<td>Christian</td>
</tr>
<tr>
<td>Participant Four</td>
<td>65</td>
<td>Arab</td>
<td>Female</td>
<td>Married</td>
<td>2 Grown up Children</td>
<td>Dip. Early Childhood Education Cert. Play Therapy</td>
<td>Retired Teacher Counsellor Play Therapist</td>
<td>5 Years</td>
<td>Muslim</td>
</tr>
<tr>
<td>Participant Five</td>
<td>65</td>
<td>Kikuyu</td>
<td>Female</td>
<td>Married</td>
<td>3 Grown up Children</td>
<td>Bed. Dip. Counselling Cert. Play Therapy</td>
<td>Teacher Counsellor Play Therapist</td>
<td>6 Years</td>
<td>Christian</td>
</tr>
<tr>
<td>Participant Six</td>
<td>40</td>
<td>Girima</td>
<td>Male</td>
<td>Married</td>
<td>2 Young Children</td>
<td>Bed. MA Counselling Cert. Play Therapy</td>
<td>Teacher Counsellor, Play Therapist</td>
<td>6 Years</td>
<td>Christian</td>
</tr>
</tbody>
</table>

Table 1: Participants’ Profile
3.6. Pilot Study

A pilot study can be defined as a small study that acts as a ‘trial run’ to test research protocols, data collection, instruments, sample recruitment strategies, and other research techniques in preparation for a larger study (Sampson, 2004). The purpose of this study was to test the data collection and analysis tools in a descriptive phenomenological approach, which was undertaken after the research proposal approval, three months before the commencement of the interviews of this study. Having done an MA course several years before this study, it was refreshing to undertake the pilot study. It helped me reconnect with my experience of using a phenomenological approach as part of my MA programme.

Data generated by interviews in a descriptive phenomenological approach study is vast (Finlay, 2011). My experience of this while undertaking the earlier research study helped me to decide to keep the number of participants in the study to a manageable number of six. Smith and Osborn (2003) view working with small numbers as a characteristic of the phenomenological approach.

Some questions in a study may need to be modified, while others may remain the same. On the basis of the pilot study I adjusted two questions:

a) Having realised from the response by the participant of the pilot study that some of the questions were closed, I rephrased my questions to allow for greater exploration.

b) When the participant talked of his encounter with cultural practices, this was very insightful and it made me question myself on the impact of culture in our practice. Supporting this, the Association for Play Therapy Standards of Practice (2000) states that “Play therapists will actively participate in the providing of interventions that show understanding of the diverse cultural backgrounds of their clients, by being cognizant of how their own cultural/ethnic/racial identity may influence interventions and therapeutic philosophy” (p.2).
This led to the formulation of interview question where I sought the participants’ opinion about the impact of culture on their practice and how they negotiated the same. However, the opening statement did not need to change as that could have changed the whole focus of the research.

Lastly, the process of doing the pilot study was helpful in that it gave me the experience of being a researcher as an insider (Miller and Glassner, 2004); of testing out the research method and self as a researcher (McLeod, 2003). This is the first time of researching on an area of interest that touches on my own practice. The role played by the researcher’s subjectivity and reflexivity in facilitating awareness of my biases and working with them helped me view the play therapy practice afresh from the participants’ perspective, gaining insight.

This helped me think about my assumptions about play therapy, which were that:

- Play therapy as mode of intervention works
- There are cultural differences in the perceptions of children, play and play therapy.
- The therapist’s attitude, belief and culture influence therapy.

The list above contained my preconceptions about play therapy, which I brought with me in this study. Drawing up this list of assumptions helped act as a point of reference as I applied reflexivity throughout the research. I continued to read the transcripts to uncover layers of meaning without ranking by repeated reflection of the phenomenon which, it is said, can only be achieved through phenomenological reduction (Langdridge, 2007). As I read, I attempted to render myself as neutral as possible with no moral judgment while being aware of my previous understandings, past knowledge, stake and assumptions of play therapy. I reflexively attempted to work with them to the best of my ability in order to focus on the phenomenon in its appearing as described by the participants (Finlay, 2008).

### 3.7. Data collection

Semi-structured interviews were chosen as the data collecting method. The purpose of data gathering in research is to provide evidence concerning the experience it is investigating (Polkinghorne, 2005). In addition, it aims to find a way to enable rich description of the phenomenon
(Finlay, 2011). In the descriptive phenomenological approach, data serve as the ground on which the findings are based, which is later analysed by the researcher to produce a core description of the experience (essence) (Langdridge, 2007).

In this study all, the participants were sent a letter giving them detailed information about the aims of the study and the interviewing process. (See appendix 1)

Once the consent forms were signed, the individual, semi-structured interviews proceeded. The aim of using semi-structured interviews in this study was to obtain a description of the research participants’ lived experiences with regards to using play therapy in their work with children. I also kept in mind my ontological and epistemological stance that knowledge is created through the process of research and that what is true and real differs across time and context. I used a loosely semi-structured interview approach in order to provide flexibility to my questions and to provide more depth in the experiences described by the participants. The interview questions were open ended and I felt this allowed them to describe their world in as they experienced it.

Though the questions were open ended, giving the participant room to describe their experiences in their own terms, I experienced a desire to establish if they really understood what they were doing. Being aware of what I was experiencing, I was also aware of the need to work with this rather than to try to deny it or bracket it (Finlay, 2008; Langdridge, 2007). Working with my preconception made me a co-producer of the findings as the participants described their experiences, being a play therapist myself, I was able to empathize with their experiences and in my opinion understood them better even probably more than had the researcher been an outsider. I experienced myself both as an inquirer and as the respondent. This confirms what Lincoln (2008) say about reflexivity that it is a conscious experiencing of the self as a teacher and learner.

According to Finlay (2003) reflexivity is a process continually reflecting upon both our experience and the phenomenon being studied. It involves an immediate critical self-awareness (Finlay and Gough, 2003). As I carried out the research I was constantly reflecting on my experience of play therapy and being aware that because of our shared assumptions with the research participants I might miss the obvious that an outsider would notice as familiarity is a partial block to full engagement in the research process (Chew-Graham et al., 2002).
During the interview I listened attentively and empathically to attune myself with my participants’ experiences. This also allowed my presence to be felt by them in that when I am empathically attuned with my participant the inter-subjectivity between me as the researcher and the interviewee is felt (Finlay, 2010, 2005; Todres, 2007; Evans & Gilbert, 2005). This is described as embodied attunement by McCluskey (2005).

According to Wertz, (2005:168):

“Epoche allows us to recollect our experiences and empathically enter and reflect on the lived world of other persons in order to apprehend the meanings of the world as they are given to the first person point of view, by investigating their original sphere of experience...allows access to the experiences of others”.

The technique of paraphrasing was used for further clarification on the participants’ responses whenever necessary. There were questions that were more refined during the interviews because of the response of the participants, and this helped in producing more focused information gathering. For example, with one participant who had reported being very successful with the children, I inquired to what she attributed her success to. After her description in response to my question, I realised she may have understood me as asking how she was able to get so many clients yet what I really wanted to know was how she was able to help so many children. I was therefore able to rephrase my question to obtain what I wanted. (This information is from the transcript Participant Wanja 2.).

I sometimes used a more directive style of questioning during the interview when I required clarifications, in case there was something that was not clear as illustrated above. This therefore means that the number of questions did not remain constant; it varied from one interview to another. This is in line with the descriptive phenomenological approach way of working, in that “questioning does not take shape in advance, but it emerges from hearing the other” (Berguno, 1998:9). The responses were recorded on audiotape with the full knowledge of the participants. The participants were given a chance at the conclusion of the interview to add anything that they felt had been missed out.
Another way of achieving adequate depth and richness apart from semi-structured interviews is to have multiple interviews with each participant as recommended by (Polkinghorne, 2005), using the first interview for rapport creating. However, in this study I had only one interview with each participant since he/she was already known to me. It was therefore assumed that a rapport already existed. Despite that, a few minutes were spent in exchanging greetings and generally inquiry into each other’s wellbeing, which is a gesture of non-hostility and a cultural practice of connecting into each other by being concerned about each other’s welfare.

In some cultures during this exchange, inquiries are made not only about that particular person but also about the whole family including domestic animals. This demonstrates love and acceptance for one another. A fundamental aspect in the African culture “collectivism” (Mbiti, 1969; Mwaniki, 1973). Aspects covered in each interview included the participant’s perception of Play therapy, the role of ‘culture’, professional skills/support.

During the interview our interaction was delivered in our culturally accepted manner and expression in that we both started by enquiring about each other’s condition. Because our place in society is gauged by age or a common activity in our lives, this makes us equal within a particular group in the community (Mbiti, 1969). As being a play therapist served as a common denominator, during the interview there was general feeling that we were all equals (Freeman, Hayes, Kuch, and Taub, 2007).

Being an insider, I did not take anything for granted. After the interview, I would write my experiences of the interview, which were very useful later when going through them while listening to the recordings (Caelli, 2001). This helped in identifying my presumptions. Being a therapist I had the advantage of having practiced listening skills, so I listened to the recordings with openness, receptivity and curiosity with a hope of discovery so that I could see the world of play therapy anew (Willis, 2010; Finlay, 2008).

The giving back of the interview transcript to the participant is referred to as member check in the phenomenological approach (Groenewald, 2004). The aim was to confirm if what they had described was captured well. The rationale behind this was that as the participants were already known to me, they may shy away from criticising me to my face. Giving them the transcript would
give them the time and freedom to look at it and make changes without feeling coerced or pressurised.

3.8. The transcripts

I transcribed the interviews by listening to the recordings several times in order before writing in order to immerse myself in the data and to gain a sense of it in preparation for analysis as stated by Finlay, (2005, 2003). (See appendix two). As an “insider” and having the knowledge that my presumptions, expectations, values and experience may influence the analysis of the data (McLeod, 2010), I attempted to apply epoche by being fully engaged in and concentrating on what was being described by the participants. First, I concentrated on becoming aware (critical self-awareness) of my presumptions and how my inter-subjectivity, process assumption and interest may influence this study (Finlay, 2008). What I was bracketing specifically was the scientific and theoretical understanding of play therapy (Finlay, 2011). I was reflexive throughout the research and worked with my presumptions of play therapy, referring to my research journal and giving the interviewees a chance to add whatever they felt needed to be added at the end of the interview and giving back the transcript to the participants for clarification. Also in my presentation of findings, I used participant’s quotes, which acted as checks and balances, which I put in place to ensure validity of this study.

3.9. Data Explication Process

The descriptive phenomenological analysis model based on Giorgi and Giorgi (2003) was chosen as the analysis method for this study because it allows for the researcher’s description and presentation of an experience to stay as close as possible to participant’s description (Langdridge, 2007).

The process includes the following processes:
• Reading and rereading the transcript while applying epaneche (bracketing) and phenomenological reduction. Reading the transcripts for their meaning rather than for evidence relating to one’s personal expectations (Ashworth, 1999), with a sense of discovery (McLeod, 2011).

• Delineating units of meaning, which is to identify the discrete units of meaning, while adopting a psychological attitude of being open and attempting to see the world freshly in a different way.

• Clustering units of meaning to form themes of psychological significance, i.e. an experience with psychological significance in the context of the study. For example, in this study, the number of children worked with was not considered as being of psychological significance in the experience.

• Extracting general and unique themes from all the interviews and making a composite summary.


3.9.1 How I worked with the data

Diagram 2: Process of data analysis
Step1. Having transcribed the interview tapes, in order to familiarise myself with the data, I read the entire transcript a number of times while listening to the audio recorded moving back and forth from the transcript and back to listening to the recording, with an attitude of openness being open to whatever meanings emerged (Finlay, 2008, 2005). This was done in order to elicit the units of general meaning and to develop a holistic sense of the interview as indicated in (Appendix 4 step 1). This was repeated until I felt that I had a good understanding of what was being expressed in the data. This process was repeated for each interview. At this point I was aware of the need to dialogue with my presuppositions on play therapy by practicing epoche (bracketing) and reflexivity as a means of reducing the temptation to impose meaning to the text. What this means is that I needed to be aware of my presuppositions by identifying and articulating my assumptions about play therapy (Langdridge, 2007). Some of assumptions I have about play therapy have been mentioned in the list of assumptions earlier.
Another way of taking care of the issues to do with my own preconceptions about play therapy was by keeping a journal. I had kept a reflexive research journal from the inception of the study within which I listed all my presuppositions about the research topic that I was consciously aware of. I also kept referring to what I had written, to help free me to be as open as possible to what was coming from the participant and to try to understand it from their point of view (empathically).

**Step 2.** The second step involved discrimination of meaning units within a psychological perspective while adopting a psychological attitude towards the text. Phenomenological attitude here means reading the text with an eye for where the experience relates to issues appropriate for psychological investigation. I focused on where the experience relates to issues appropriate for psychological investigation within context and highlighting them into meaning units. I was constantly referring to the research question; ‘How do play therapists experience their work with children in the Kenyan context? In order to determine whether what the participant has said responds to and illuminates the research question. This breaking of text into meaning units was useful in making the data manageable in the following step thereafter (Finlay, 2011; Langdridge, 2007). (See appendix 4, step 2).

At this stage, I approached the data with openness and went over every word, phrase, sentence, paragraph while addressing the research question to them in order to elicit the participant’s meaning and the relevance to the research question (Finlay, 2008, 2009). This was put in place to the best of my ability. I constantly moved back and forth from reading and rereading (Langdridge, 2007; Wertz, 2005) while being aware of my personal assumption and going back to the transcript with an aim of determining what an experience means for my participants who had undergone it.

**Step 3.** The third step was assessing the meaning units highlighted in step 2 for their psychological significance in relation to the experience while engaged in phenomenological reduction. This was to enable me to look at the text without ranking the meanings. These units of relevant meaning were then examined for any common themes and essence related to the context with imaginative
variation in mind. I came up with cluster units. Then out of the clusters of units came the theme that captured the whole experience (see appendix 4 step 3).

**Step 4.** In this stage I was concerned with producing an individual structural description. This involved synthesizing the psychological units of meaning by identifying the key elements for the phenomenon by going back to meaning units in step three with the research question in mind. Out of the clusters of units I came up with the theme that captured the whole experience for a particular participant and came up with individual structural description. (All the participants’ transcripts were subjected to this process).

**Step 5.** At this stage, I looked at all the individual structural descriptions to identify common and unique themes. I then wrote one composite summary for the study, capturing what had been described in each individual structural description.

### 3.10. Ethical issues

The Ethical Framework for Good Practice in Counselling and Psychotherapy (BACP, 2002:3) states that the ethical principle of beneficence ‘directs attention to working strictly within one’s limits of competence’. According to Ritchie and Lewis (2003) any research study raises ethical considerations. Building on this Kvale (1996:110) writes, “Ethical decisions…arise throughout the entire research process”. As a way of conforming to this, I therefore considered ethical issues before, during and as I carried out the research while at the same time remaining open to any ethical issues that might have arisen. The ethical issues that arose in this study were: 1) Informed consent. 2) Confidentiality, and 3) non-maleficence.
3.10.1. Informed consent

The study proposal for this study was reviewed and permission to continue was granted by University of Manchester research committee before starting my research. (See appendix 5). In line with the University of Manchester’s ethics policy. I gained informed written consent from all the participants who decided to take part in my research after a detailed explanation of what the research was all about without deceiving them, participants were informed about the purpose and the method of the study and were given time to ask any questions concerning the study.

They were informed that participation in the study was voluntary, and that they could withdraw whenever they were not comfortable without repercussion. An introductory letter and the University of Manchester –approved ethical guidelines of the study was also presented to the participants, finally all the participants who agreed to take part were asked to sign a written consent as an indication of agreement to the terms of the research. Haverkamp (2005) advises that informed consent be conceptualised as an on-going, mutually negotiated process of which I adhered to.

The same question was asked to each participant at the outset of the research interview to allow fairness (BACP, 2011). Each interview was terminated when a ‘natural’ ending was evident as determined by participant and myself by asking the participants if there was anything that they wanted to add as a sign of respect.

3.10.2. Confidentiality / Anonymity

Christians (2000:39) notes that, “Despite the signature status of privacy protection in research ethics, watertight confidentiality has proved to be impossible.” As Etherington (2004:64) points out, ‘It is notoriously difficult to disguise a person’s identity because personal stories highlight the uniqueness of a person’s life”. In this study, the participants were assured of anonymity. This was discussed in the invitation letter describing the study and the process involved and the methods of
confidentiality in that, the data will be handled only by the researcher and will be kept under lock and key only accessible by the researcher and destroyed five years after the completion of the study. I also attempted to ensure confidentiality for all participant therapists by carrying out the interviews in a safe and private environment and by avoiding using real names or revealing distinguishing information about them in my research report. Also in an attempt to maintain confidentiality, because the play therapists are few within the area of study. I avoided giving the name of the study location.

3.10.3. Non-maleficence

A further ethical problem was linked to the ethical principle of non-maleficence, which states that research participants should not be harmed though this may be unavoidable. Bond (2004b:1) notes that all researchers in the field of counselling and psychotherapy ‘are expected to have given careful consideration to any risks arising from the research’. These risks were communicated to the participants and they were informed that in the event that a participant indicated distress, I would offer to terminate the interview and offer to provide the contact details of the counselling services. As there was no distress indicated by or observed in the participants, the counselling services were not required.

Bond (2004b:17) has outlined in a number of ethical considerations which appear to be absent in most other texts. He notes, for example, “A researcher should be supported by regular and ongoing supervision”. In line with this, I attended regular supervision meetings with my academic supervisors throughout the period in which I engaged in the research presented in this thesis. During these meetings, I was given the opportunity to talk about my experiences of doing research. The insight from these meetings was that the struggles and challenges of doing research and being an adult student was not confined to me but was a shared experience within my fellow students as well.

West (2002) raises an ethical issue. He notes that researchers should ‘avoid the possibility of research being experienced as what has been called 'hit and run” (West, 2002:264). In ‘hit and run',
a researcher gains deep and personal data from a research participant, then leaves without attempting to close down the interview process. To avoid this, after carrying out my interviews, whenever possible, I chatted informally to participants, asking how they had experienced the interview, and answering any questions they had, for as long as seemed necessary.

3.10.4. Validity

The ‘acid test’ in qualitative research is whether the conclusions being drawn from the data are credible or defensible (Giorgi, 2002; Yardley, 2007). Building on this McLeod (2011:268) has stated, “the credibility of research is determined by the process the researcher uses to collect and analyses the data it presents”. The discussion of validity is further discussed by Giorgi (2008a) who has insisted that when it comes to applying his method which is descriptive phenomenological approach the criteria associated with scientific rigor need to be completely respected. Any discerned meanings that come out of the research need to be based on data and achieved through a systematic process of free imaginative variation, which allows a kind of internal validity check. In the descriptive phenomenological approach, applying imaginative variation to the participant’s descriptions serves as a validity check because the findings would be from the participant’s description.

Groenewald (2004:21) seems to share this opinion by saying that “conscious bracketing off by the researcher during the interview and during the transcription of the interview allows for better understanding in terms of the perspectives of the participants interviewed about a phenomenon being studied which counts for truth. The most common technique used by Husserlian researchers to ensure that rigor is not compromised due to the researcher’s bias is to “identify and articulate assumptions prior to data collection and analysis”. Having done this throughout the study process, my assumptions is that since the techniques of bracketing, phenomenological reduction and imaginative variation were applied to the best of my ability in this study, this should contribute towards the credibility of this study.
In this study, I reflected upon my own perception about play therapy, and employed the process of member check at the beginning soon after producing the transcript. Though member checking in phenomenology is regarded as one way of ensuring validity, in descriptive phenomenological approach this concept has been criticised very strongly by Giorgi (2008a). He stated that the participants are in the natural frame of mind or attitude at the time of description. He has argued that they thus “cannot confirm the meaning of their experiences nor do they have the relevant phenomenological skills or disciplinary attitude necessary to adequately judge the analysis” (Giorgi, 2006:358).

Being a committed follower of Giorgi’s philosophy of descriptive phenomenological approach, I am in agreement with Giorgi’s argument for disregarding the participants’ validation as unreliable and not to be taken seriously. Because of this, I decided to use only the first member check because at this point the focus of member check is not validation but simply a confirmation of accuracy of data collected, while refrained from utilising the second member check (see appendix 4). This may sound disrespectful to participants and their experiences. However the stance I have taken as a researcher of respecting the participants’ views and perception of their experiences and giving them time to describe these at their own pace during the interviews demonstrates my respect. Again, by being actively involved and responding with prompts I communicated that I was present and interested in what they were sharing. The interviews were relaxed and the questions were open ended to allow the participants to share freely without coercion.

3.10.5. Generalisability

As Lincoln and Guba, (1985:110) indicated “the only generalization is; there is no generalization…the trouble with generalizations is that they don’t apply to particulars.” This is an opinion held by researchers from different research approaches but within the descriptive phenomenological approach, it is believed that, with regards to generalisability, reliability and validity, if the small number even illuminates to some significant degree the “worlds” of the participant then that in itself is valuable information about human beings in general (Giorgi, 2006:355). The idea is not so much whether another position with respect to the data could be
adopted but whether “a reader adopting the same view-point as anticipated by the researcher can also see what the researcher saw, whether they agree with it or not” (Hycner, 1985:295). Considering that this is the first research of its nature in the country, this knowledge can be used to enhance practice not only in Kenya but also to larger parts of Africa for the benefit of the African child now. However, out of this research another researcher or the same researcher for he/she can take up any hypothesis generated later further.

3.11. Summary of Methodology

I have in the above chapter tried to explore and demonstrate ways of doing a qualitative research study and how I as an insider researcher have put to use the tools recommended and developed by Edmund Husserl and Amedeo Giorgi. They helped me deal with preconceived ideas about a topic of investigation and this helped me to analyse my data to the point of presenting the findings. I have also demonstrated how I negotiated ethical issues in this study. Being an insider I was aware of my influence on this research. To enhance transparency and the trustworthiness of this study, the checks and balances I put in place were; 1). Being aware of subjectivity and being reflexive of them and account my role in the creation of the findings. 2). Using participants’ quotes in my presentation of findings. This research has also created hypothesis that there may be a need of integrating non-directive play therapy with other forms of supporting children for better therapeutic outcome for the Kenyan child.
CHAPTER FOUR: FINDINGS

4.0 Introduction

In this chapter, I present the fourth stage of the data analysis process, which gives a detailed individual structural description of each participant’s experience of play therapy as described in their perspectives. This individual structural description is a product of data, which have been analysed using the descriptive phenomenological analysis process based on the work of Giorgi (1971, 1985) and Giorgi & Giorgi (2003). The data was collected into psychologically significant meaning units using key words from the individual participant (see Appendix 2). I also present a general analysis of the whole. This takes the form of a thematic analysis and a general structural description of the study findings capturing a “holistic” experience of the research participants as related to the research topic. The thematic analysis is presented first, followed by the individual and then general structural descriptions.

To maintain the naturalness of data and their given meaning by respondents’ descriptions, I considered it fit to present the respondents’ voices and quotes. This is in line with the phenomenological philosophy of ‘return to the things themselves’ (Giorgi, 1970). A sample giving the whole process is given in Appendix 1. The participants I call Okinyo, Wanja, Mugoa, Raha, Kazungu, and Kamau (pseudonyms). A brief description of each participant is given at the beginning of each individual structural presentation of findings. At the end, a brief summary of this chapter is given followed by a summary of the key findings.
Experiences of Play Therapists

Therapists feeling Unsupported and Unprepared
- Supervising
- Refresher courses
- Regulation of consultation fees
- Training

Challenges
- Parents perception, intrusiveness and demands
- Lack of trust
- Fears
- Frustration and pain
- Disrespect/ unappreciated
- Lack of understanding of play therapy
- Play material

Understanding developed
- Lack of public awareness
- Experienced non-directive play therapy as effective
- Child's family life
- Role of conducive environment

Impact of Kenyan culture on practice
- Ethical issues
- Decisions making
- Impact of cultures

Recommendations
- Need for more researches
- Need for more play therapists

Rewards
- Fulfillment
- Interesting
- Encouraged
- Successful
- Pleasurable
- Cherishes the Change in children
- Appreciative
- Good feeling
- Excitement
4.1. Description of Findings

Having used Giorgi’s concept of explication (Giorgi & Giorgi, 2003), I went back and forth from the interview transcripts to the individual key words for each participant. I then looked at all the individual key words together taking note of anything that is unique or common in all the interviews in order to get the sense of the entire interviews and to give the sense of the whole experience. The aim was reconstructing the inner world of the experiences of play therapist by coming up with general themes, which I believe captures the phenomenon of the study.

I have attempted to the best of my ability to stay true to the literal statements and meanings given by the participants by using the exact words of the participants in the quotes. I have also in my own perspective, attempted to categorise the themes that came out of the respondents’ interviews analysis in the table above. As a result, I came up with a central theme that describes the essence of the phenomenon as being “lack of confidence to practice”.

4.1.1 Therapists feeling unsupported and unprepared

The findings reveal that despite the play therapists conviction of the effectiveness of play therapy, their understanding of the helpful elements is limited and they feel that this needs improvement in the form of further training, refresher courses and/or supervision. This lack of better understanding of how play therapy works was not limited to the play therapists only but to the society. This is a handicap on how the play therapists perform in their practice because it came with the feeling of inadequacy, frustration and incompetence. One therapist was bothered by the fact that he can believe in something that he does not understand how it works. The illustrations below demonstrate the feelings of play therapists about their preparedness in terms of training and the need for supervision.

One would argue that without training the participants would not have considered themselves as play therapists in the first place. Therefore, training has a very important aspect of any profession.
What are expected from training are a theoretical aspect and a guideline specifying on how particular professionals ought to carry out their work. After qualification from training, this ought to have given one the confidence that one needs in their professional life.

The participants appreciated the training they had on play therapy, as it has been very useful so far though they all felt that it was brief. However, there is also an understanding among the therapists that no training can be sufficient, and that it is up to the individual to update themselves academically through reading of latest journals and attending refresher courses. However, the general feeling was that they needed more training to sharpen their skills. The participants were of the opinion that with further training they would learn more like in dealing with multicultural issues and being able to work with a child’s metaphor, which they felt, lacked in their earlier training. Some participants in turn saw this as a way of helping them become more confident as play therapists. One participant said that lack of confidence hindered her from standing up for what she believes in. Because she did not feel confident enough as a play therapist, she could not charge for her services and continued volunteering her services which she felt was being taken for granted. Another participant feared that this assumption may have caused other play therapist not to practice and may kill play therapy as a profession.
However, some of the ways of tackling this as seen by the participant(s) was having refresher courses and regular supervision where the therapist could share their challenges.

Regular supervision is a requirement for any practicing therapist. However in this case supervision was viewed not only as a requirement by the counselling bodies i.e. BACP, KCA or any other; but the participants also regarded supervision as an avenue where play therapist could be supported with their various challenges. Because most of the participants felt that they were not adequately prepared for the task ahead of them, they saw supervision as a place where the therapist could meet to support one another and learn from one another to remain competent and relevant.

4.1.2. Challenges

The therapists reported incidences of challenges and frustrations they experienced and attributed them largely to lack of knowledge or not being aware of what play therapy is supposed to be and how it works. Either the challenges came because of the expectations of the parents or because of the helplessness the therapists felt in certain situations. All the participants described their frustrations at various points of practicing play therapy as being lack of knowledge about play therapy, because of this the parent's expectations and mistrust were challenging to the therapists.

My experiences have been good in most cases though in some cases I was not able to see the end. Either the parents feel that six sessions...I should have talked to the child and finished... (P2:3:#1)

...I find this so frustrating in that you are left hanging, the child is withdrawn and you are not given any explanation......confusion and a feeling of inadequacy....you are left feeling helpless and sometimes very angry....(P1:1#10)

... I must talk of my many challenges and frustrations......what I found frustrating was the lack of trust from parents ....mainly whites......this really frustrated me...and interfered with therapy...(P6:3#19)

.....most teachers are referring these children to psychiatrists thinking that these children are mad......(P2:3#19)
The parents did not seem to understand the least number of sessions, which may be beneficial for the child. In some incidences, the referring agents wrongly diagnosed the children, and some children were withdrawn from therapy without the knowledge or explanation to the therapist. Another participant felt frustrated by the mistrust demonstrated by the parents from other cultures and felt that this greatly interfered with the outcome of therapy. These created frustrations and feelings of helplessness and the therapists were sometimes overwhelmed. The illustrations above demonstrate the need of awareness creating about play therapy for harmonious working relationships between the child, referring agents and therapists.

4.1.3. Understanding Developed

From the participants’ responses, it was evident that all the participants acknowledged the need to make play therapy known to all stakeholders being parents, teachers and orphanage administrators as this would do some good to play therapy. This discovery came to light that even though play therapy has been practiced for a numbers of years both in the country and locally especially, its intervention is still relatively new, there is lack of public awareness and its functions may not be well understood. The opinion created in the participants was that children might be more harmed than helped whenever a wrong diagnostic is made which has created the need to make play therapy known and understood by the society.

The quotes below give the opinion of the participants about awareness creating.

...if their emotional components were taken care of by involving parents I believe everybody can actually blossom.....I guess in creating awareness....so they can understand what play therapy is and how therapists work could help (5:4#23)

Sometimes I am drawn to have group play therapy because of lack of understanding of play therapy of the people involved hence the need of creating awareness (P1:1#14)

.....I also feel that the therapeutic relationship between the therapist and the child, where the child feels accepted has been great for me.....empathy the child feels understood also was key to my success..... (1:1#5)
Also the feelings of the participants was that, had there been the awareness of play therapy and how it works existing amongst the society, the work of the therapists would have been made easier with the support of the significant others in the children’s lives and this may have lessen the suspicions surrounding play therapy. This in turn may make the work of therapists easier with the support of significant others by enhancing the trusting relationship between the parents and the therapists.

The role played by relationship in therapy is something that was acknowledged by all the six participants who attributed their success to the trusting relationship that existed between them with both the children and parents with exception of some cases. One of the participants even felt that it was an honour to be trusted by the child’s parents.

The participants saw this kind of relationship as being ‘key’ to positive therapeutic outcome and felt that this could make their work easier because in this trusting therapeutic relationship the therapist communicate empathy to the child and in turn the child feels accepted and understood.

4.1.4. Experienced it as effective

... at the age of 12years she was out there looking for a job as a maid, when in employment she would steal from her employers and she was ... handed over to the child officer who decided to bring her to me for counselling before being taken to children’s court... you know this child has changed.....she is through with her secondary education... (P2:3#3)

... Case was this child ... whose father and mother went their separate ways... this child had turned violent. After being involved in play therapy, the child slowly started to come up....the child is top of his class...(P5:4#9&#10)

It is amazing how play therapy helped her heal. If the children are provided with an environment that is conducive... P4:2#12)
The play therapist affirmed the effectiveness of play therapy with excitement when one participant talked of her conviction of the role played by the environment, which according to her when put in place therapeutic movement took place. Again, because the parents have an influence over the children, these children pick the relationship that exists between the therapist and their parents, where if this relationship is positive and has trust, the children will most likely emulate and work with. One participant reported that the therapy could be made better with corporation from the significant others in the child’s life. This participant was referring to a case where the mother of the child was supportive while the father of the child was non-cooperative and the therapist felt that she was being entangled in family issues and was frustrated by the child’s regression.

One participant was amazed by the healing powers of play therapy as she reports that she did not have to do much except just being there for the child and the child healed herself.

According to reports given by all the participants is that there were many revelations in play therapy. The children’s themes of play and art drawings spoke volumes. The therapist was able to get to the source of the children’s problem through play, this adds to the positive attributes of play therapy as an intervention for children. The participants also seem to acknowledge the role played by the conducive environment.

From the above illustrations even though the participants did not come out strongly to claim that they understood what play therapy is, but what they can all vouch for is that it works based on their many successful cases, how it works or the curative elements within play therapy, they may not be sure. However, some were convinced that their cultures in general sometimes interfered with how they worked.

4.1.5. Impact of Kenyan culture on practice

From the participant’s responses, it was quite clear that some participants consider culture as something ‘sacred’ and not to be talked about, to some it is something that can be integrated and
worked with to enhance practice, yet to some it is not anything to be given much thought depending on one’s background. Does one do away with it or integrate it?

...the therapy might have come from the west ... But it is relevant to our children...the songs children sing in their mother tongue in therapy has meanings in the children’s lives (P3:1#15)

......the challenge that seem to come up is the one that pertains to ethics especially when after you have worked with a child in a session the parents demand that you tell them what the child has shared with you…. (P6:3#16)

My client having been sexually abused.... I found myself at a conflict ......taking any action without the consent of the parent ..... to some extend touches on our culture as Africans where the head of the home’s decisions supersedes any other decision... it takes a lot to reflect how my culture would interfere with how I work with children there is a lot of taboo and stigma connected to sexuality ..... parents would like to protect the image of the family by handling things quietly in a cultural way (P1:1#11)

Culture perpetuates the social values of the specific community that ensures the survival both physically and mentally. The indigenous ways of child upbringing was left to the grandparents and were structured to accommodate the entire families according to their age groups. The methods used in traditional child therapy were songs, dancing, storytelling and imitating others in both play and eventful activities; this signifies group participation and involvement. It helped them to fit in the society. The society no longer places importance on the practices that took place within traditional society. There may be a need for play therapists to strive to replace the grandparents in feeling the vacuum functionally.

4.1.6. Ethical issues in play therapy

Working ethically is not negotiable in any profession. However, there are times when the ethics are not upheld because of lack of knowledge, and /or lack of confidence or cultural practices of the land. One of the participants felt that the therapist had to possess certain qualities to be able to understand children especially when it came to ethical issues on dealing with parents. In Kenya,
traditionally it is taken that the adult is the custodian of wisdom therefore knows what is good for the child so at times keeping to ethics became a challenge especially with older clients where after a session a parent(s) would demand to know what the child has shared in therapy totally disregarding the autonomy of the child.

Despite the different opinions held by different participants, some participants realised how cultural beliefs and practice affected their practice when it came to decision-making in that, despite knowing the right thing to do yet they had to follow what the culture dictated. In the particular incidence where a child was sexually molested in school, the therapist was aware that this was a criminal offence and she would have wanted to see justice done by taking the offender to court, an opinion not held by the father of the child. The father was uncooperative. Therefore, for the therapist, there was the ethics on one side and culture on the other, considering that according to Kenyan culture, the head of the home’s decision superseded any other decision.

This is a clear manifestation of the conflict that the play therapist faces and struggles with while using a western or foreign-based model. Its application may not be fully utilised based on practicability. This may lead us in finding a way of integrating cultural practices with the modern ways of practicing play therapy for the benefit of the Kenyan child. Despite the challenges, practitioners reported play therapy to be rewarding to all the play therapists participants.

4.1.7. Rewards

When the therapist talked of fulfilment, it was either because of the positive therapeutic outcome or because of what they perceived as their successful case studies. This effectiveness of play therapy was gauged by the positive behaviour change in the children observed by the therapist. All the six participants reported that they found play therapy to be effective with different categories of children. They all reported that there were many successful cases of children from dealing with psychological issues to emotional issues. In addition, some delayed grief to those who had behavioural issues. The participants reported that these children changed both at home and at school, which came as a surprise to the significant others in the children’s lives. Witnessing this
change in a child gave feelings of excitement, fulfilment, satisfaction and joy to the therapists as illustrated below.

(P5:4#12, 5) testifies to the power of art and amazed by the effectiveness of play therapy and had the privilege to observe them change from what they were at the beginning. (P6:3#3, 12 &13) this has been fulfilling for him to observe children change, and affirms that play therapy works; he was convinced that it was the play therapy intervention that brought out the positive therapeutic change. (P2:3#3) was able to observe the positive change in children becoming more constructive rather than destructive, this gave her a feeling of fulfilment. (P: 5:4#2, 10) was amazed by the children’s activities and resilience; after engaging a boy in play and art therapy the boy after a while changed. While (P3:1#1) finds play therapy flexible and effective even though she finds nondirective model insufficient.

As they were describing the feelings, it seemed to possess a force behind it. This could be observed from their tone of voice. This demonstrates their maturity as parents and their professionalism as play therapists. One male participant reported that he was passionate about children and was ready to support them at any cost which I would equate as being ready to go to any length to help the children.

One participant even considered it a privilege to have had a chance to work with children. The foregone highlights demonstrate not only the effectiveness and curative powers within play therapy but also how this intervention had be successfully applied in various situations, and the fulfilment this brought the therapists. The feelings of fulfilment and satisfaction seem to bring excitement to the participants whenever the participants were describing positive therapeutic change. This was observed in their tone of voices.

Working as a play therapist gives me a sense of joy and satisfaction having helped a child to be constructive rather than distractive... there is nothing as fulfilling as that (P.2:3#3)

My client’s mother way very supportive and collaborative for the benefit of the child and this made play therapy effective and rewarding...(P.1:1#6)
When I talk of the rewards that the participants experienced in practicing play therapy, I would also like to report the categories of the children they worked with. The suffering of the children was acknowledged by the therapists. All the six therapists reported having worked with traumatised children at some level. One participant discovered that patience is a virtue to play therapists.

4:2. Presentation of Findings

In the analysis above, I have presented the themes that have emerged from the analysis of the participants. The themes, which illuminate the experiences of the therapists, are on the same level, which demonstrates the importance accorded to them as being the same. At the lower level, I have mentioned some themes, which came out of the analysis, which I did not consider as being experience, i.e. recommendations and referral agents. Below each theme, I have given sub themes, which describe a particular theme and general description in my own understanding aiming to capture the general meaning of that particular theme.

4:3. Presentation of individual structural description

Individual structural description of the experience of play therapy is the product of psychological significance of the description of experience for each participant. Each individual structure starts with pseudonym for participant, followed by the number allocated to each participant and the day of the week the interview was done i.e. 1: stands for Monday, 2: stands for Tuesday, 3: stands for...
Wednesday, 4: stands for Thursday, and 5: stands Friday. For example, Okinyo was the first client and interview done on day one (Monday). I have also included relevant participants’ quotes to with an aim of staying as close as possible to the participants’ description of experiences.

4:3:1. Respondent. Okinyo: 1

Okinyo is a middle-aged woman, belonging to the Kikuyu tribe of Kenya. She is a single parent of three grown up children two having graduated from the University. She was a paediatric nurse before training as a counsellor and then as a play therapist. During the interview, I experienced her as a serious, eloquent and thoughtful person, when she talked of her child clients her face lit up and I sensed her engagement with them and the joy that working with these children brought her. When she spoke of her difficulties around child protection her voiced dropped and her face registered the pain she clearly still felt.

Thank you, my experience has been not without goodness, and also not without some level of challenges… play therapy was very effective and could have been made better with the cooperation of the adults in the children’s ’lives… guess that it is this joy that keeps me going…

Okinyo’s experience of using play therapy has been of mixed feelings of both fulfilment and challenges, to a point of frustration and a feeling of helplessness. Having trained as a play therapist, Okinyo discovered the limitation of the effectiveness of play therapy especially with older children, and the need for integrating this model with other intervention for effective support of children became obvious to her. An observation on Okinyo’s part was that play therapy could be enhanced with the cooperation of the significant adult in the child’s life. After years of practicing play therapy, Okinyo at times found it difficult to establish what was helpful but attributed the success to the trusting relationship that existed between her and the children.

: with the youngest one I think that is where I would like to start I must appreciate that it was difficult for me to say what was helpful but I strongly feel that the establishment of safety based on this case study the trusting relationship was quite effective…….
The challenge came when presented with a difficult decision to make regarding her client, even though she was concerned about her client’s wellbeing, she allowed culture to rule instead of sticking to the ethics of her practice. Her not being able to stand for her client’s wellbeing, resulted in her feeling of incompetency coupled with fear of failure and lack of confidence.

Okinyo: … this to some extent touches on our culture as Africans where the head of the home’s decisions supersedes any other decision……. also I felt that I was getting entangled in the family wrangles yet my concerns were my little client. I did not know what to do at this point ………What was also even more frustrating was the helplessness that I felt ….. seeing my client in a position of helplessness that I was ……..she had to continue going back to the same school yet the offender was there, no action had been taken. This frustrated all my efforts of trying to help my client

Sexual defilement was singled out to be the most challenging and a cause of anxiety by Okinyo, especially because of cultural practices which surrounds the offence that make it an abomination and should be handled by elders only not discussed publicly. She came to the realisation that because of this culture and stigma connected to these cases, this had an impact in her practice when it came to decision making concerning a child who has been sexually abused. This clashed with her way of training and her working ethics.

This led her to feel that the cultural perception of children and their activities may have been the main cause of non-appreciation of play therapy as an intervention, and lack of respect for her work as a play therapist.

… of lack of understanding of play therapy of the people involved……hence the need of creating awareness……. some of them dismiss play therapy as a child’s thing without much attention this also touches on our cultural values and perception on children and their activities… not worth paying for in this light the therapists should volunteer their services…..My fear is that this assumption may have caused some play therapist not to practice ….. if this trend continues play therapy as a profession may die totally.

This according to Okinyo may have resulted in deterring other play therapist from practicing and could very well be the source of death for play therapy as a profession in the future. Despite
Okinyo’s feeling of anxiety, she draws her strength and joy from her passion for play therapy and is of the opinion that further training, supervision and awareness creating of play therapy to the significant others in the lives of children could be of benefit to the children. Looking at play therapy through the lenses of a therapist with all her expectations of a positive therapeutic outcome, when a child is withdrawn from therapy, Okinyo sometimes experiences a feeling of void, which she described as “you are left hanging”. This feeling of void damaged her professional self-esteem.

4:3.2.Respondent Wanja: 2

Wanja is a middle-aged woman from the Kikuyu tribe. She is married with four grown up children with two grandchildren. She first worked as a high school teacher, and then trained as a counsellor before training as a play therapist. I experienced Wanja as a serious, energetic and firm “nonsense” mother/teacher. She seems firmly grounded in her Christian beliefs, which seem to come through in her counselling. This was observed from her tone of voice of disgust and her facial expression during the interview when she talked of some of her discoveries in her work. Her Christian belief could not be concealed as she became judgmental when she was describing what was going on in one of schools where she worked with children.

….nowadays I feel there is a cultural conflict being experienced by children…..[pause] like recently I was invited to a school where in this class the students age was about 8-9 years had formed groups where the girls would run to the toilet one by one from the same group remove their panties and finger each other practicing lesbianism/ tone of voice was disgusted. ……..apart from the traditional culture which we have to deal with which has brought about a lot of cultural confusion yet there is no role models to look up to because the parents are just as confused even more than the children…..

For Wanja, the experience of play therapy has been that some sessions were with challenges and some without. She experienced play therapy as successful, and was able to observe the positive change in children becoming more constructive. This gave her a feeling of fulfilment and she voiced
working as a play therapist gives me a sense of joy and satisfaction having helped a child to be constructive rather than distractive …… there is nothing as fulfilling as that……

She was privileged to work with a child experiencing aggression and discovered that children displayed their troubled emotions in play. Wanja also discovered that traumatised children preferred to use sand trays and art and benefited within the six sessions. Being a therapist and aware of the role of a relationship in any therapy session, she attributed her success to the relationship that existed between her and her clients. In the midst of all that, she was convinced that some parents and teachers had no knowledge of child counselling and advocated for play therapy awareness creating. For Wanja these adults had other expectations and even gave wrong diagnosis of children even sending some children to psychiatrist and doctors on the assumptions that these children are mad or have learning disorders.

…though some parents do not understand what child counselling is. They bring a child wanting you to talk to, even the head teacher but it takes them by surprise to realise that I am not going to talk to the child directly but the child talks to me through play…both the teachers and the parents do not know that there is something known as child counselling/ play therapy…..something that can help the children…

Wanja was challenged by her limited knowledge about play therapy and acknowledged the impact of culture in her practice in the way the children’s activities were viewed or valued. She observed that sometimes when they come and see the playing materials, some parents do not see that need to bring the child back for therapy. She is convinced that improvement through training would make her more competent, add value to play therapy, and enhance the way she worked with children.

4:3:3.Respondent Mugoa: 3

Mugoa is middle-aged woman. She practices the Christian faith. She is married with three grown children. She started working as a teacher working with children with special needs. She then trained as a counsellor then as a play therapist. I experienced her during the interview as energetic,
and as somebody who wanted to see some changes take place in play therapy being practiced in this area.

…there should be a follow up on the trainees you know holding a certificate from a certain organisation is very important for the organisations there should be a follow up……

For Mugoa, having been trained in the non-directive model, she sometimes found this model insufficient and had to improvise with what was available. She sometimes used sand and sticks.

In her practice, she has worked with severely traumatised children and observed that working with children in different environment using sand to be useful in bringing change. Mugoa is convinced that when the therapist understands of play therapy is better then, it is effective and rewarding.

… Yes play therapy does work but you really need to understand play therapy is a different world, and know that children do things for a reason…

She has discovered that a lot is revealed by children in therapy if given time and is convinced that all children enjoy play therapy and that if the therapist is patient can learn a lot of things about their clients. However even though she finds fulfilment in play therapy she also has found it challenging and felt overwhelmed by the children’s questions at times and the parents intrusive expectations and demands. Mugoa also acknowledged that culture affects the way she works with children and feels obligated to educate the parents on play therapy.

She finds pleasure in the confidence entrusted to her by the children and cherishes the change that this brings to children.

….. it has been rewarding though when you see the child looking at you …….., and them trusting you without looking back if somebody was hearing because I was told not to tell, yes this kind of trust can be very rewarding……

Mugoa appreciates her training, recommends supervision, and feels that this would be beneficial in play therapists sharing their experiences and challenges. She fears that play therapy may not be taken seriously by some therapists because of the general attitude, and feels that the Kenya Counselling Association (KCA) should regulate the consultation fees.
Yes I feel that my training prepared me really well, ........, I also feel that the play therapist should meet regularly. Maybe once in three months once a month could be too much for me but in three months or in six months would be good for me. This way the play therapists could share some of the challenges that we faced........ I am happy to have been given this opportunity and I hope that when you are finished with your research I would be able to read it, and know some of the challenges that other play therapists have been experiencing and that I have contributed

However, she expressed her pride in being part of this study and hoped that her contribution would add some value to the study.

4:3:4. Respondent Raha: 4

Participant Raha is a middle-aged Muslim woman from Arab origin. She is married with several children and grandchildren. She started working as Montessori teacher then trained as a counsellor and later trained as a play therapist. During the interview I experienced her as Intelligent and composed and chooses her words very carefully as she speaks. She came across as somebody who values and promotes family bonds. When she talked of dysfunctional families her voice went down almost to a whisper, as if it was something secret. In contrast, when she talked of the fulfilment she gets in seeing children change, her face lit up and her tone of voice rose in excitement. This told me of her commitment and engagement with children that she works with.

For Raha, the experience of play therapy has been a pleasant opportunity to represent the children who she considers the voiceless in coming out with positive results. Raha experienced good feelings and excitement whenever there was positive therapeutic outcome. With non-directive play therapy, Raha was able to get to the source of a child’s problem and was shocked by the revelation that happens in therapy.

............it is amazing how play therapy helped her heal… if the children are provided with an environment that is conducive and the presence of a play therapist it was an amazing feeling really!
[Excitement in the voice].....all I did was to be there for the child and the child healed herself and the feedback I got from the parent was amazing....... 

However she was fearful and spoke in a low tone almost to a whisper as she wondered how to disseminate these discoveries to the people concerned for the benefit of the child. Raha was encouraged and pleased by the positive responses she received from parents, which made her very excited. This excitement was evident in her tone of voice, which changed from a whisper to a high pitch, The positive responses convinced her that a good relationship with the parents was responsible for a good relationship with the children. If the therapist was patient with children, the children would trust them and in turn these children would blossom.

Raha was convinced that the existence of play therapy was still limited and advocated for the creation of awareness in both schools and hospitals and saw this as being beneficial to terminally ill patients (clients). She was exhilarated by the trust bestowed on her by both the children and parents.

.....you see I was trained as a Montessori teacher is what made me into the confident teacher that I am today, I feel that further training in play therapy may also do the same, make me into a confident play therapist [pause] and that would also give me the confidence to charge for my services and not continue working on volunteer bases.......though I have never really had a child who was so traumatised. I would feel ill prepared to work with a child like that...

Raha suspected that her confidence as a teacher might be because of the way she was trained. With play therapy, she did not feel confident enough to even charge for payment for her services since she felt that she was not well prepared due to the brief training. This made her thankful that she never came across a severely traumatised child, as she would not have been able to handle it. She however found fulfilment in helping children change through play therapy and advocates for further training and supervision for the betterment of both the children and play therapy as a profession.
4:3:5. Respondent Kazungu 5

Kazungu is a middle-aged Giriama man, married with two young children. He started working as a high school teacher before training as a counsellor and then as a play therapist. During the interview, I experienced him as a highly intelligent person, energetic, and outspoken. When talking about his clients his face lit up and his tone of voice changed to a high pitch, full of excitement. He enjoys play therapy and finds it most interesting and he has a passion for children. This tells me on how committed he is in helping the children.

For Kazungu, the experience of non-directive play therapy in the Kenyan context was most interesting; he was amazed by the children's activities and resilience and how different children responded differently to the toys.

: ....my experience of using play therapy has been most interesting, children always seems to bounced back on top of things ...I have been amazed by children’s resilience and their response to different toys and how creative they can be in using these toys......

In his practice, he had worked with severely traumatised children, some with cancer and some dealing with fresh losses of parents. He had the privilege to observe them change from what they were at the beginning. However, there were times when he experienced frustrations and pain when he did family home visits because of the cultural bureaucracy. Nothing happens before clearance from the head of the family i.e. grandfather, father, in these homes despite the suffering that the children were undergoing.

........ There were times when I experienced frustrations........ In this particular home the children were stigmatised because their mother was HIV+ so the whole family was isolated and I had to wait for one and a half hours for the head of the family to come where we were before I could start to work with the boy, this was very frustrating for me........

He once again worked with a boy who was aggressive because of being abandoned by his parents,. After engaging this boy in play and art during play therapy sessions, the boy after a while changed. He was not sure what brought about this positive therapeutic change but attributed it to
the relationship he had with his clients. He testified to the power of art and was amazed by the effectiveness of play therapy. As a result, he is convinced that play therapy works.

.. I have been really encouraged by finding out that somebody can move from being whoever he or she were to express themselves in play.

Kazungu was very pleased with the way some of the children welcomed him to join them in their play through which he had learnt a lot of children’s games and songs. This made him feel encouraged and he is convinced that although play therapy is challenging it can also be interesting. He lamented that:

...I think that our cultural practices sometimes interfered with our work ...I was obligated to follow the cultural ‘norms’ before I could commence my sessions........

Kazungu sometimes experienced challenges with the children’s metaphors and felt that he needs to do more in terms of further training. He felt that his previous training of teaching prepared him better than play therapy training. He feels more confident as a teacher than as a play therapist and would also appreciate on-going supervision for support. He is concerned about the lack of psychological support in public schools and advocates for awareness creating in schools, churches and even madras (mosques). Kazungu feels that children are traumatised yet have no access to therapy because of lack of knowledge about play therapy. He was convinced that the awareness of play therapy would benefit everybody in the society and that we would have a healthier people. He advocated for more research because he was convinced that there is a lot to learn from both the African and the Western ways of doing things that would benefit the African child.

You see my play therapy training was brief, so sometimes I feel that I need to learn more like being able to work with the children’s metaphors....when a child asks you about something and you are not able to work with like in a metaphor ....it becomes difficult so I need to learn more to be confident... I would like to see more researches because I am convinced that there is a lot to learn from both the African and the Western ways of doing things that would benefit the African child.

Kazungu summarises his experience of play therapy as that he has an overwhelming passion for children and was ready to support them at whatever cost.
Kamau is a middle-aged Kikuyu man, married with four grown up daughters and several grandchildren. He started work as a clinical officer before training as a counsellor and then as play therapist. During the interview, I experienced Kamau as a serious and quiet person. He answered his questions with long elaborate answers giving full detail of any of his experiences. Despite his middle age he came across as energetic and committed to his counselling work. When he talked about his clients’ suffering his voice changed to a deep tone, giving an indication of the pain that he still feels.

For Kamau, the experience of non-directive play therapy in the Kenyan context has been one of discovery that play therapy is effective with children with various issues such as trauma and unacceptable behaviours. His observation was that at first these children were fearful of the toys, but later, as the relationship develops the children change and enjoyed playing with them. This has been fulfilling for him to observe. At the same time, he was fascinated by the revelation that came out of the children’s play. He was able to connect what it was like in these children’s lives outside therapy, He realised that some children were voiceless out there and were expected to be submissive.

: Ah if I can pick up a case generally “silence” eeh where I found play therapy to be effective. I had one of my clients who came with a reason of non-performance and ..eh .. and this caused him to be moved from one school to another and it was as the though the parents were the key players yet the child was …..to be very submissive… a family set up. But what was fascinating was as if the family was in a parade …eeh. When I explored the meaning of that I discovered that the father is an ex-military man and I came to realise that in that family it was orders and orders. So the boy could not be seen, his voice could not be heard, he was lost he did not exist…… My experiences - I find play therapy to be effective especially with children who are living in dysfunctional family [tone changes to a deep voice] they come for therapy in fear of parents and initially eeh when you put them through therapy initially they are not free.
He confessed that he was not sure what was effective and wondered if it had anything to do with the relationship he had with these children. However, he was sure that he had been very patient with his clients and gave them space and time not rushed them to do anything. Kamau came to realise that working with children required patience and understanding. When he got down to their level these children changed, enjoyed the sessions and were happy to come back. He was bothered by the thought that he did not understand play therapy yet he affirmed that play therapy works.

Some of the challenges that I have had to deal with is transiting from working with adults to working with children .. hmmm ..This requires a lot of understanding from the therapist to be able to understand how cognitive set up of the child works.

Looking back on his success, he shared two cases, one of a little girl who had refused to eat and another one of a boy who was aggressive, these children changed. He was convinced that it was the play therapist’s intervention that brought about the positive therapeutic change. However, Kamau was convinced that the therapist needs to possess certain qualities to be able to understand children, especially when it came to ethical issues on dealing with parents. He has observed that most parents do not respect the autonomy of children or the children’s rights. These parents expect to be told what went on in the session. Kamau acknowledged that the parents have a right to know what is being done to their children; however, he felt that the parents should be educated on the boundaries. He had the privilege to work with cross-cultural clients, but was frustrated by the mistrust demonstrated by the parents from other cultures. He advocated the need to create awareness on how play therapy works.

... in my practice I was dealing with cross cultural children considering where my practice was located . This was an up market area, so there were many white children, children from Asian or Arab community while I am black. And what I found frustrating was the lack of trust from parents not trusting you with their children ......You see I have two rooms, one is the reception area and the other one is where I hold the play sessions…. Even after explaining to the parent how I work at the reception and once I take the child to the next room and closing the door - after a few minutes you hear a knock on the door and before you get a chance to respond you see a head peeping in.
He was deeply concerned about children and their suffering. He felt that therapists are responsible for the children’s wellbeing. He thought they should make sure that they stay relevant and competent by reading latest journals and updating their skills by doing further training. He advocated for supervision and refresher courses and acknowledged that no training can be sufficient: it has to be a continuous thing.

… Yes though my training was brief but I believe that no training can be enough eeh it is up to me to keep u dating my knowledge by reading journals and keeping practicing to gain more confidence. We also need to have play therapist to keep updating their skills because play therapy and children can be very dynamic. My biggest question is are we as play therapists able to move with the time, update our skills and knowledge and accompany that with supervision, ensuring that you remain competent - competent here I mean even personal therapy so you don’t end up offloading your issues on the child. And also up dating yourself academically so as to remain relevant and also in term of research and also to remain healthy.

Kamau was appreciative of the opportunity accorded him in this study to be able to share some of his challenges.
4.4. The general structural description

In this section, I move to extracting general and unique themes from all the interviews and making a composite summary. I move from depicting an individual’s meaning units to presenting a more general essential structure of the experiences of play therapists.

What is salient from the participants’ responses is that the play therapists have a passion for children and are committed to working with these children despite the various challenges that they face in practicing play therapy. This is reflected in their responses by the words they used to describe their experiences like fulfilment, joy, rewarding, privileged to work with, good feeling and excitement, satisfaction in seeing the children change positively after being involved in play therapy. These emotional words describe the deep feelings that the participants have towards the children they have worked with. This demonstrates and speaks volume of their level of commitment towards these children. It seems to point out that, for these play therapists, practicing play therapy came more out of their desiring to alleviate the suffering of children than a means of personal or financial gain in a form of a job or profession.

The participant’s experiences of play therapy were a mixture of fulfilment and challenges, flexible, effective, interesting and rewarding. This is an expression of emotions which are intertwined with their perception of using play therapy (Radcliffe, 2008). When working as a child counsellor irrespective of the mode of intervention, the aim is to support, a troubled child regain their “robbed” childhood. The aim is also to bring hope and development (Mwiti, 2006:18-19). So to experience fulfilment in itself is a feeling of an accomplishment, it is a reward, which results from a job well done, and joy manifests itself and is experienced as a result. This may speak for the effectiveness of the intervention, with all its limitations and whether it is well understood or not, in bringing the desired outcome. It is assumed that when therapy is successful play themes change towards more
positive development (Wilson & Ryan, 2005). The positive therapeutic movement was observable by the change in the children and good feeling.

Fulfilment can also be experienced when the job is interesting because the intervention is flexible, it gives you room to manoeuvre and you do not feel cornered. You experience freedom to be who you are especially when the model acknowledges the child’s autonomy within some gently, but firmly set limits. The therapist needs to provide respect, safety, non-judgmentalness and an accepting environment that allows the child to feel secure enough to express his or her deepest emotion. It grants children the permission to be themselves by allowing the children to choose their own focus of interest and pace of change (Axline, 1969; Ryan, 2004), creates these.

This is what the participants experienced as they engaged with the children in a non-directive play therapy sessions. They did not have to do anything, only their presence was enough. This presence created a trusting relationship and conducive environment, within which both the client and the therapist felt safe to be themselves (Giorgi & Gallegos, 2005). A positive relationship between the parents and the therapist brought some encouragement and a sense of weight being lifted from the therapists’ shoulders. Conversely, the mistrust from some of the parents led to a lack of confidence or ability to perform, which in turn interfered with the therapeutic outcome. The child clients’ activities and resilience was amazing, and as stated by Landreth, (2012), the success or failure of therapy rests on the development and maintenance of the therapeutic relationship.

Rogers (1957) viewed a therapeutic relationship as a place for growth, in which he hypothesised the necessary and sufficient conditions (core conditions of empathy, UPR, congruence) as the basis for quality of the relationship. Rogers, (1951) that the success of therapy was based on the quality of the relationship. The therapists experienced this relationship as rewarding. The challenge came when fear was experienced. A challenge can be because of lack of understanding. Fear may be the evidence of loss of control. For the therapists, this resulted in feelings of discomfort and confusion mixed with hopelessness and frustrations. This renders one helpless and confused accompanied with a feeling of worthlessness. With lack of knowledge, misdiagnosis can be created that may lead to harm: this calls for awareness creating. When there was no form of support offered
not only the confidence was threatened, but also this lack of confidence was replaced with fears of failures.

Further training or supervision and engaging in research can improve this lack of confidence. Non-direc
tive play therapy involves art and sand tray work, which can be one way of communicating uncomfortable issues. Where a change is experienced, a child becomes more constructive as healing takes place. Being a western concept, there is a possibility of it clashing with cultural ways of doing things, rendering the therapists ineffective.

4:5. Summary of Chapter Four

In this chapter, I have applied the descriptive phenomenological approach way of working based on the work of Giorgi, which remains faithful to Husserlian philosophy and as such involves a search for essence of a phenomenon following epoche and a phenomenological reduction (Langdridge, 2007:105-106). I have provided an individual structural description for each participant, a general structural description for all the participants and a presentation of the highlights from the data while applying imaginative variation. The data was collected through semi-structured interviews which were audio taped, transcribed and taken through the five stages of the descriptive phenomenological method of Giorgi which are reading and re-reading for overall meaning, identifying meaning-units, assessing the psychological significance of meaning-units, and synthesizing meaning-units and presenting a structural description. This was followed by a table of themes and a descriptive presentation of the findings together with quotes from the participants' own words in an effort to remain as close to the meanings given to phenomenon as described by the participants with recommendations as suggested by the participants.
4.6. Summary of Key findings

Participant therapists feel that they are unsupported and unprepared and lack confidence to practice. There is need for further training and supervision support.

Participant therapists are of the opinion that though nondirective play therapy is effective, but its awareness is limited.

Participants are challenged by lack of understanding of play therapy.

Participant therapists feel “culture” affects their practice and interferes with their ethical decision-making.

There is need for further research for better support for the Kenyan child.

All these seem to point to lack of confidence to practice.
CHAPTER FIVE: DISCUSSION

5.0. Introduction

This chapter discusses the key findings of this study under the following subheadings:

- **Play therapists doubt their competence:** - the discussion around participants’ lack of confidence in their practice and factors that may have contributed to this. Participants have indicated their challenge in use of self in therapy and the struggle to involve parents. These aspects are discussed with regard to their contribution in how participants lack confidence in their practice.

- **Training and preparedness:** – the view held by the participants on their training and how this prepared them for their practice is discussed. Participants voiced the challenges of culture to their practice and wondered if this has to do with their learning in training or the relationship between therapist and client, both of which have been a focus of the discussion in this segment.

- **Professionalisation:** - There is need for continuous Personal and professional development and supervision for the play therapists in Kenya. The lack of a regularising body and its impact on practice continues to threaten the survival of the play therapists.

- **Social learning:** - In the absence of supervision the exploration of other learning avenues as support for the therapists.
The chapter continues with a discussion of the implications of the findings. These findings and their meaning to the study are illuminated in this segment. I conclude this chapter with what this research has revealed and this is followed by a summary of chapter five and a reflexivity statement, which is both personal and epistemological.

The results of this study indicate that:

1. Therapists feel unsupported and at the same time, unprepared
2. Therapists experience challenges by lack of understanding of Play therapy both from them and the significant others.
3. The participants developed understanding of the effectiveness of the intervention.
4. Culture has impact on practice and this generates ethical dilemmas
5. Participants felt fulfilment and rewarded
6. In view of therapeutic support for the child, this study has revealed gaps to future research.

These factors have greatly contributed to the participants’ feeling of confusion in practice; questioning their competence and leading to a lack of confidence in their work. This lack of confidence to practice forms the fundamental argument around which my discussion vigorously revolves. As a researcher, I challenge myself to remain vigilant of the self as therapist and how this may have influenced the analysis in the area under investigation.

In the discussion, I do not lose sight of the central question to my study which is:

“How do non-directive play therapists experience their work with children in the Kenyan context?

In their love for children, they have found passion in their work, but in the context of this work, participants have developed a lack confidence, which may have led to confusion.
5.1. Play Therapists doubt their Competence

The study participants are all primarily generic counsellors by training in the person centred approach. Some of them possess other knowledge related to child development from earlier training in other caregiving professions such as teaching and nursing. This notwithstanding, therapists still portray a lack of confidence in the practice of play therapy. One wonders if this lack of confidence is isolated only to play therapy or if it spreads to general counselling as well.

Fairburn and Cooper (2011) argue that competence is gained through training and it plays a role in the quality of service provided by the therapist. Participants of this study have all been trained in the non-directive play therapy approach and have stated their success in their practice. Despite this they confess that even though experience has taught them that therapy is effective, they are still confused. One wonders how it is that they continue to doubt their competence.

Gladwell (2008) says that successful therapy can be attributed to the quantity of experience, a journey that, according to Wheeler and Richards (2007), the therapist takes in practice while receiving supervision support. It is in supervision where knowledge of development and theories of change as well as continuous assessment become integrated into clinical practice (Landreth, 2002). Supporting this view, Joyce and Sills (2007), reason that therapists involved in continued professional development remain open to learning as part of maintaining good standards of practice.

Findings of this research indicate that neither supervision nor professional development is readily available to the participants. Might this be the source of continued confusion experienced by the therapists?

At this point, I attempt to differentiate the understood from not understood elements: What is it they clearly seem to understand and what possibly do they not understand?

Kamau; Reports that the relationship is therapeutic with children although he is not sure how. This, he continues to say, makes him feel frustrated, a feeling that may contribute to his lack of confidence in practice. Okinyo holds similar sentiments in saying:
“...... I must appreciate that it was difficult for me to say what was helpful but I strongly feel that the establishment of safety based on this case study the trusting relationship was quite effective” (Study participant (April 2015).

Rogers (1957), emphasises the centrality of the therapeutic relationship in which the therapist experiences the core-conditions of acceptance, genuineness and empathic understanding towards the client, which he proposes as “necessary and sufficient” for client’s growth. The assumption is that the non-directive play therapists are familiar with the safety of this relationship. In it, the therapist places no expectations or demands on the client; instead offers presence, which will build trust to help clients share deep emotions and concerns to make sense of their world and build wellness (Dougherty and Ray, 2007). The quality of real presence is at the heart of therapy (Mearns & Cooper, 2005). Having been equipped with this knowledge in training the assumption is that it will be put into practice.

By deduction, this experiential knowledge goes beyond lecture halls and has been found to be effective, which can amount to the competence of a therapist. However, like most of the other participants both Kamau and Okinyo cannot identify how this effectiveness takes place. They clearly understand that they do not seem to know, through experience, what contributes to the effectiveness. It appears that they possess tacit knowledge which Schon (1995) suggests to exist in practice albeit not well understood by practitioner. It would appear that these factors breed the confusion in participants in spite of training. However, how is this so?

Jones and Larner (2004:21) explain, “Training does not seem to result in high ratings of confidence and competence”, and Gladwell, (2008). is of the opinion that success is based on the quantity of experience as opposed to training. These views seem to suggest that a therapist’s competence is not defined by training alone. Experience contributes to building the knowledge base for the therapists, who acknowledge that it has taught them that play therapy works. The old adage, “experience is the best teacher” perhaps makes reasonable sense.

Through my years of practice across the diversity of my land and my people, I have experienced this success that has been proposed by Gladwell (2008), and have also learnt that if therapists understood well what they were doing, there would be no doubt in their performance unless the
argument is that success cannot be equated thus. They would demonstrate competence and the result would be success. Supporting this perception of success in therapy, Mugoa (P.3:1), speaks of play therapy as effective and rewarding especially when the individual’s understanding of it is better, a field she qualifies through experience thus:

“by better I mean, after the training there were times I was confused and did not understand what I was doing, or if play was working…..but now I can say that I have a better understanding of play therapy…..(Interview participant P3:1. May 2012).

But this experience is different for most participants of this study to who, like Mugoa, the prerequisite to participate in this study was 3 years of being in practice, a period in which I had thought they would have negotiated the developmental milestone of the novice stage. It would appear based on their confusion that this period of practice may have no bearing to the number of children they may have worked with within these years, which would make up for ‘quantity’ of experience.

This concurs with what Garza et al, (2009) have said that the building of skills will come through practicing. Is there a possibility that the participants have not gained the quantity of practice that could have facilitated the confidence aforementioned? For this study, I chose to work with Jones and Larner, (2004) theory and assume that training does not seem to yield competence. However, this continues to raise the question of how the study participants would acquire confidence and competence to practice.

Fairburn and Cooper, (2011) on the other hand have stated that for the therapists to deliver quality services, they should be trained to the point of competence. Is there a point of competence? In the present Kenyan education system, of which I am a part of and I assume worldwide, one such measure would be an individual’s qualifications, which often speak for them. However, Gachutha (2006) is of a different opinion that there is no connection between qualifications in training and developmental stage of a counselling practitioner, and the length of training does not equal growth. Turner, (2007) supporting this view and that of Jones and Larner (2004) argues that much of counselling is learnt in practice and not through lectures. What then ails our practitioners? The Kenyan play therapists are struggling with difficult terrain, considering contextual issues such as
sexuality in relation to culture, poverty and HIV & AIDS where secrecy and conspiracies rock family support for children. The level of poverty is very high and most clients hail from this socio-economic group. As such sustaining a child in therapy for most people is difficult. In my experience, most of the children from low-income clients’ families often have difficulties in follow up on therapy because they are generally prepared for one session in which they often believe as adequate in finding a solution. Lack of a regularizing body and the hostility that has faced counselling in general in Kenya compound the situation (Okech & Kimemia, 2012).

Although these factors are central, Haugh & Paul (2008) argue that there are other reasons that affect and erode therapists’ competence and confidence respectively. They also outline age, gender, personal experience, previous experience. For Raha 4:2 to compare teaching with play therapy training unfavourably, arguing that the latter did not prepare her well. This is an expression of her feeling of incompetence and anxiety over losing grip on the therapeutic practice as her confidence dwindles. There are several possibilities to this. On one hand, one may claim that her years of service in the teaching profession may outweigh her time of practice in play therapy; a further argument may be that as a graduate teacher, the length of training was longer and she was qualified at a higher level. By these arguments, her comparison of play therapy and teaching in relation to competence might most likely remain discouraging to her and the rest of the participants. Finally, like most participants Raha felt challenged in her work with clients. With no place for professional care, her confidence may fade or die. We might never conclude what it is for her and the others; but from her findings, Hunt (2006) concluded that the training done in Kenya was perceived as beneficial in increasing the confidence, knowledge and skills of the course participants. What can possibly be concluded? and where does this leave the play therapists? This argument is beyond the scope of this research. However, it is arguable as to how aware the therapists are of the self.
5.1.1. Therapist use of self

The emerging empirical findings of the therapeutic values of counsellor’s self-awareness indicate that they are significant in play therapy as a developmentally responsive intervention widely used by child therapists (Pieterse, Chung, Bissram & Ball, 2012), which Haslam and Harris, (2011) have reported that are potentially associated with delivery. The person of the therapist has been widely acknowledged as a critical tool in the provision of effective counselling and psychotherapy. In addition he/she has commonly been referred to as “self as instrument” (Baldwin, 2000; McWilliams, 2004). It has often been suggested across literature on therapist use of self that of all the various ‘schools’ of psychotherapy the person-centred approach makes the heaviest demands upon the therapist. While the use of self is instrumental in therapy the effectiveness demands personal Interaction (Reinkrut, 2007). This interaction places a demand on therapist to “know” the self in order to “use” the self.

What in my understanding, does a Kenyan therapist need to “know”, to effectively “use” the self? As a practitioner, experience has exposed me to the knowledge of the context within which we practice. This knowledge in my opinion is fundamental and difficult for us to realise as it is achieved through being on the ground in practice a competency on its own. I say this with the confidence of an original Luo by ancestry; who though well-schooled and thoroughly urbanized over the years, can testify to the fact that our beliefs, feelings and reactions as different peoples across our diversity and in the contexts of culture, ethnicity, religion, socio-economic and political divides, strongly influence our practice.

As such, our competency is challenged. Rogers, (1957) was keen to emphasise on the attitudes of and personal characteristics of the therapist and client as prime determinants of outcome of the therapeutic process and constantly relegated to a secondary position therapist’s knowledge and skills, provide for this knowledge of use of self. It is clear from the above that participants need to be equipped with three areas of competencies to survive the tough Kenyan play therapy terrain: theoretical knowledge, self-knowledge and knowing context.
However, Kamau is convinced that counsellors must have certain qualities; is aware of his person and the influence in therapy: came to realise that working with children required patience and understanding. “...I gave them time and space...,” Raha is aware of the basic tenets of therapeutic success:

\[Raha: \ldots it is amazing how play therapy helped her heal... if the children are provided with an environment that is conducive and the presence of a play therapist it was an amazing...\]

While Kazungu is clearly aware of the cultural context and how this influences therapy:

\[Kazungu.......I think that our cultural practices sometimes interfered with our work, ...I was obligated to follow the cultural ‘norms’ before I could commence my sessions........\]

In spite of the knowledge these participants portray across context, self and training, they still struggles with lack of confidence. They have each demonstrated a particular aspect of the said competencies individually, is it possible they are not consciously aware of their ability to practice? Perhaps they know as experience has taught them, but do not understand. They might also, consistent with Kirk, (2010);Black et al.,(2005), be struggling with identifying which of their blind areas are associated with unhelpful beliefs about their capability to practice. However, one thing stands out clearly, that if collectively they demonstrate the knowledge of self, of context and of training, which in my opinion are the competency they need to raise their confidence, then I can conclude that they live in isolation as practitioners. Largely this explains the sense of apathy and the frustrating feelings around diminishing confidence in practice.

The call for unity of practice by Mugoa who is confident of her training competence is timely. She says:

\[Mugoa – Yes I feel that my training prepared me really well... I also feel that the play therapist should meet regularly... would be good for me this way the play therapists could share some of the challenges that we faced.\]

According to Wenger, (1998), many individuals learn more effectively when they have the opportunity to observe others. The social learning approach postulates that members serve
together in quest for a viable identity in the community of practice, which is an integral part of their daily lives, (Lave & Wenger, 1991; Wenger, 1998, 2001; Wenger, McDermott, & Snyder, 2002). Its anthropological perspective examines adult learning through everyday social practices rather than focusing on environments that are intentionally designed to support learning.

This practice would benefit the Kenyan play therapists, in using the self to involve the significant other, the parent. The participant expresses the gravity of the matter:

*Okinyo “……of lack of understanding of play therapy of the people involved…….. if this trend continues play therapy as a profession may die totally.”*

### 5.1.2 Parental involvement

Being a therapist and aware of the role of a relationship in any therapy session, Wanja attributes her success to the relationship that existed between her and her clients. In the midst of all that, she was convinced that some parents and teachers had no knowledge of child counselling and advocated for play therapy awareness creating. Agreeing to the same, Okinyo is of the opinion that:

“……*Play therapy was very effective and could have been made better with the cooperation of the adults in the children’s lives.*”

It appears that parents are not sufficiently aware of the service. What is the confusion around this particular context? In working with a child, Neil (2004) remarks that often therapists have not understood ‘who’ the client is. Useful questions like is the child mine alone, or ours with referrers, or is the parent, family, the client? When family is the client, it can be problematic because they usually do not think so, and are often shocked to hear so. Most of the participants appeared to lack this awareness. This lack of understanding of their work may have led to play therapy being a mystery, which should not be the case (Schaefer, 1999).
The therapists should be in a position to explain to stakeholders what play therapy is if they understood it well, I would like to refer to this as “awareness creating”. However, if they struggle with this competency, how is it possible for them to create in another? The stakeholders are the significant others in the children’s lives who could be involved in the joint agreement in supporting the children in what has been termed as parental consultation by (Brumfield and Christensen, 2011; Carmichael, 2006). Nevertheless, my concerns would be how parental involvement would enhance the therapists’ confidence in practice.

It is my assumption that if the therapists had acquired the above competencies, they would be in a better position to confidently explain and involve the stakeholders in the process of therapy. This would confirm what Falender et.al. (2004) has talked about that the knowing is in the practitioner’s action, this action would then affirm the competence. I am aware that my training is similar to that of my participants. I am also aware that for a while in my developmental journey through practice, I struggled with parental involvement for lack of capacity. Neil (2004); Landreth and Bratton (2006) mentions filial therapy as the parent education component in child centred play therapy. To this effect, understanding how to involve parents cannot be assumed as a regular interpersonal interaction. Mearns and Thorne, (2004) sees a clear correlation exists between the level of self-awareness, communication and efficiency in therapy. It is a possibility that therapists may not be aware of this.

 Might it be possible that they struggle with these competencies to the extent that confidence to involve parents is eroded?

The other side of the coin of parental involvement would be the non-cooperation of parents which can be as a result of resistance from parents and/or counselor (Van Fleet, 2000), which he has defined as an attitude, belief, or behaviour that derails or slows the therapeutic process. He continues to state further that:

“Parental resistance to therapy can take many forms, expectations of a quick fix of the child, parents being hostile or passive-aggressive to change, missing sessions, being late for appointments, and noncompliance with treatment or homework tasks. All these are forms of
resistance that the play therapist needs to be aware of and work towards reducing through active listening, empathy, and understanding of the parent’s perspective” (Van Fleet, 2000:37).

The parental resistance was experienced as source of frustration as voiced by one participant who said that at times she was uncomfortable, frustrated, mixed with confusion and helplessness. She found it so frustrating in a case where the child was sexually abused, this child was withdrawn with no explanation and she was left hanging and very angry not knowing what to do next. This left her feeling uncomfortable, frustrated mixed with confusion, helplessness, and feeling of inadequacy. My question is if this participant had known that there was a forum to let out her frustration would she have felt the helplessness that she experienced maybe, maybe not?, we will never get to establish this in this study.

However, taking into consideration what has been said by Campbell (1993) - about what might be perceived by parental invitation for consultation as being a summon - how would the therapists negotiate a balance between the non-directive model of play therapy which seems to suffer from lack of literature on parental involvement (Bornsheuer and Watts, 2008) and the traditional ways of being which is authoritative when it comes to children’s modelling (Mbiti,1978,1969)? On the other hand, should it be assumed that both the parties would agree? Traditionally in Kenya, the teaching / counselling of the children was done by grandparents (Nyamedha et al., 2003) within the confinement of the family and not by strangers especially with regards to anything touching on sexuality.

This came from a standpoint that the custody of knowledge lies with the adult (Mbiti, 1978, 1969). Hence if a parent perceives consultation from this perspective, this involvement of the parent or caregiver would most likely contribute to therapeutic success. However, if parents perceive the consultation as threatening, the counsellor may experience resistance from parents especially from the traditional standpoint; invitation for the parent to attend the parent consultation may appear to be a “summons” for the parent to attend (McMahon, 2009). It has been suggested that the therapist should acknowledge and be sensitive to the anxiety and discomfort that may be experienced by parents, these parents may experience stigma and criticism on their parental skills, which may result in threatening their parental role (Bradley et.al., 2005; Steinberg, 2005). Traditionally a
parent cannot be summoned for the sake of a child by just anybody; protocol is such that this can only be done by an elder (Okech & Kimemia, 2012; Nyambéda et al. 2003).

Most traditional structures are broken and no longer exist to function as they did in the original settings in which they were created (Okech & Kimemia, 2012). However, it is clear, even from my own standpoint as a cultural woman, that these beliefs exist and are deeply coded in the minds of people. This is probably what parents present in fear of summons. Yet the structures have been replaced differently; the custodianship of knowledge has shifted from the traditional setting of the villages to new ‘villages’ in form of schools, churches and other identified groupings or systems; including a proliferation of other information sources such as media and technology. Teachers and religious leadership have assumed the roles of grandparents to most of the children whose parents are often too busy making a livelihood. This new shift is tough for both the therapist and the parent as the two have unconscious struggles.

One of the research participants was of the opinion that our cultures as Africans were such that the head of family’s decision supersedes any other decision and that sexual offenses were considered taboo and domestic affairs that should only be handled by the elders who in her opinion down played the children’s activities. This is despite structures that have been put in place to protect the children (Children’s Act, 2001). This has been a concern even to the therapists and it has been suggested that it is imperative that legislation can be enforced through its law enforcement agencies (Hunt, 2009). This is often challenging for therapist as most of the time, as they have portrayed, they do not seem to understand how to deal with this.

In Kenya parental consultation may take on a whole new twist considering the entry point of play therapy into the country. Counselling and play therapy is associated with HIV/AIDS (Okech & Kimemia, 2012), so stigmatisation cannot be ruled out, added to the traditional ways of being which have been mentioned above. This on the part of the parents to some extent may explain the withdrawals of children from therapy in cases of sexual abuse, which have been reported by some of the therapists. Can this also explain the confusion of the therapist, taking into consideration that the therapists recognised that they are in danger also of taking their fundamental cultural beliefs and values to therapy (Drewers, 2009; Russ, 2007)?
Reinkrut, (2007) has demanded a good foundation of self-awareness of the therapists in order to facilitate the laying aside of values for the benefit of the client. This is theoretically taught in the non-directive play therapy model in training, but its practicability is left to chance. Again, it would be important to note that the therapist’s training does not spill over to the parents. For the sake of this study I would like to assume that this laying aside of values for the benefit of the client might have been taken care of during the training for the therapist trainees, but what about the parents? It would have benefited all round if the therapists’ training attempted in some degree to take into consideration therapists’ traditional values. It is my considered opinion that it may be a cause for confusion for the therapist on how to integrate the two cultures of working which may contribute to the lack of confidence.

The views on the need for awareness to the parents and society are consistent across all the participants. They felt that parent’s perception of therapy was affected by the lack of knowledge of what play therapy is and this in turn challenged the practice. The knowledge by the minority coupled with lack of finances is another contributor and finally arrogance and ignorance of those who both know and can afford therapy for their children yet seem to place little value on the intervention probably because of traditional cultures. This seems to have been voiced by one of the study participants when she said;

Okinyo: ……of lack of understanding of play therapy of the people involved because this way children can be seen as just playing something that is acceptable generally. Hence the need of creating awareness. Some of them dismiss play therapy as a child’s thing with no much attention. This also touches on our cultural values and perception on children and their activities….another hindrance is the assumptions that children things are childish therefore taken for granted and not worth paying for. In this light the therapists should volunteer their service. People need to understand that play therapists need to have economical gain from their practice. My fear is that this assumption may have caused some play therapists not to practice…… if this trend continues play therapy as a profession may die totally…….
This is distressing for the therapists. From my experience as a generic counsellor, I have experienced supervision as supportive and have known it can help prevent therapist outcomes such as loss or inappropriate use of a skill or the apathy which therapist may experience.

For Kenyan play therapists this specialised field, like most others in the counselling practice, becomes challenging to concentrate on, especially in terms of the lack of awareness coupled with the economic state in the country. Kenyans struggle with high levels of poverty (Kanyinga, 2002) and almost 50% of the population live below the poverty line (GoK, 2008). This certainly has impact on services rendered to the public and especially when the parent is fully responsible for the cost of their child’s therapy.

Some children are sponsored by different agencies and organisations and can have the luxury of several sessions. From a personal experience, my only consistent play therapy clients are those who are sponsored by Non-Government Organisations (NGOs). These children qualify to be put in such programmers by virtue of being HIV/AIDS orphans and have no other support for livelihood, so such Organisations come to their aid. Organisations like Compassion International, being foreign bodies, are aware and appreciate psychological support for the children under their care and hence they will pay for such services. Yet well-to-do parents have brought their children for therapy and one wonders what causes them to withdraw their children. Parents may introduce a child because of difficult behaviour, says Neil, (2004), and withdraw interest when, through the outcomes of therapy, they are invited for consultation. The anxiety of feeling accused may exist, especially with the affluent population as the discussions may touch on styles of living that may have created the problem, which the parent is unwilling to address. The shift to modernisation has generated reasonable confusion, much of which affects the children very directly as well as indirectly.

The majority of parents will pay for the child’s therapy and most find the financial burden too heavy. Most parents complain about the amount of hard-earned money that goes to waste, and fail to appreciate the experience of the child, which may often be minimised. In a recent case of truancy because of being bullied at school a father argued that his son “...should have removed his shirt and fought like a man (in school) instead of waste my money (in therapy)!” and continued to say the son needs to be ‘fixed’. This is common for many parents to feel as if therapy is a waste of time and
hard earned resources for a situation that can be handled ‘easily’. Therapist encounter scenarios of frustration similar to this one regularly in practice and it takes patience on the therapist’s part to explain the need for collaborating with the parent in the therapeutic process.

Thus, as much as the Kenyan play therapist would want to continue practice in this specialised field, this may become almost impossible, as working professionally as a play therapist alone is not economically sustainable. For the play therapists to continue to survive they generally have to continue by combining working with both adults in general counselling and children in play therapy. The interchangeable roles between counsellor and play therapist, may have contributed to the confusion and lack of understanding for the play therapist. While this is not unethical, it may generate dilemmas that need to be addressed. One of the study participants voiced this:

Kamau – Some of the challenges that I have had to deal with is transiting from working with adults to working with children - hmmm- this requires a lot of understanding from the therapist to be able understand how cognitive set up of the child works.

Alternatively, participants may practice in roles other than either play therapy or general counselling, such as teaching. The majority may also get confused by the different other roles they find themselves in as they work with children. For example, teachers may find it hard to adjust to non-directive play therapy in terms of appreciating that the child leads. Moreover, practitioners are Kenyans who live within similar contexts to their clients across the diversity.

5.2. Training and preparedness

The participants’ responses point to the fact that they believe they were not well prepared by their training except for Mugoa. Some of them who were professional teachers previously or currently even combining their training and competency as teachers with being play therapists. However, it would be interesting to note that teaching is behavioural and our education system is not person-
centred. So at what point would one even begin to equate the two professions? Are these some of the struggles that the former teachers who are now play therapists or switching between teaching and practicing play therapy have to deal with - being a teacher who is authoritative in class and being a nondirective play therapist who has to follow the lead of the child? This might lead to struggle with the therapeutic condition of empathy (seeing things from the child view).

The play therapist trainees had voiced the need for further or higher training in 204, 206 and 2007 respectively, so is this a Kenyan thing of equating competence to the level of education therefore clouding their perception and influencing their performance? All the training course cohorts requested that further training be made available to them at diploma level and possibly, to degree level, They continued to say that there should in addition be training for play therapy supervisors (Hunt, 2009). All the participants of this study are in counselling at higher levels. This notwithstanding, they feel inadequate and lose confidence in that they consistently claim to not understand the practice.

As a researcher, it seems to me that the understandings acquired through training are theoretical while those gained through working experience are practical, both of which most of the participants possess. This point to two things: firstly, a play therapist's confidence does not necessarily stem from training or years of practice alone. Secondly, the success of therapeutic outcome is not solely dependent on understanding of therapy alone. Yet this understanding seems to be crucial to the participants. Is higher learning a solution? Alternatively, is it a mind-set that persons that are more educated understand better? Is there anything more to understand? Perhaps through tacit knowledge (Schon, 1995), they know all they need in the immediate to practice effectively. Perhaps they need to know more in terms of establishing what works and what does not.

Kenyan play therapists, since they have not had any supervised practicum experience according to what they have voiced, can be viewed as lacking developmental feedback. On the other hand the participants are possibly simply overwhelmed and feel unsupported and stuck; which could be termed as burn out (Gathutha, 2006). Interestingly, no documented evidence is available confirming the counsellors' experience of supervision or of their confidence in practice. Could this be the missing link to play therapy practice for the participants?
5.2.1 Tension between Training and Culture

Is there any tension between the training of the therapists and their traditional practices of beliefs and values, and does this contribute to the confusion and lack of confidence to practice for the therapists? The need for competency in cultural counselling has been reported (Robinson-Wood, 2009; Collins & Pieterse, 2007; Flowers & Davidov, 2006). A study by Hunt, (2007) identified the professional developmental needs and future direction of newly trained play therapists in Kenya but failed to spell out what the needs were and whether they included competency in cultural counselling. Was this an oversight on the part of both the trainees and the researcher or was this part of the colonial legacy (West, 2014) of exporting a new method of working which does not take into consideration the cultural values which should have been included in the training curriculum in the first place. Because of this, the training failed to evoke and challenge the emotional reactions of the trainees (McWilliams, 2004), and how this may affect their work process. Although the participants may be well grounded in their cultural beliefs (Reinkrut, 2007) but how to work with this knowledge for the benefit of the client may be a challenge and may as well be a source of confusion and incompetency.

The participants were trained in non-directive play therapy, which aims to increase a child’s level of wellbeing (Hunt & Robson, 1999) by surrendering all the power to the child in therapeutic relationship (Axline, 1947; Hunt, 2000, 2001), while traditionally the adults are the custodians of wisdom (Mbiti, 1978, 1969). Non-directive play therapy model encourages individualism (West, 2014) while tradition is focused in a collectivist way of belonging (Mbiti, 1978, 1969; Mwaniki, 1973).

My experience is that Kenyans are still a people who try to hold on to their cultures despite the urbanisation and modernisation. Our cultural values and beliefs have shaped our perceptions on various aspects of life, socially, politically or otherwise (Ancis, 2004; Holdstock, 2000). In my experience, these have been passed down from generation to generation and run deep within us, which may not be appreciated at face value or understood especially by an “outsider”. By an
“outsider” here, I mean anybody outside the little communities where each Kenyan belongs as a tribe or ethnic group.

Although these cultures are assumed to belong to the last century, especially in relation to child upbringing, as Kenyans, our views of people and especially the care of children are still influenced by our traditional cultural beliefs (Nyambedha et al., 2003). Focussing on cultural sensitivity in counselling practice, where does this leave the non-directive play therapist?

From a personal experience, despite my non-directive play therapy training and my vast experience in practice, I still harbour the traditional belief that adults know what is good for the children that children should learn by imitating the adults. This confirms what was talked about related to the dangers of unconsciously carrying different viewpoints resulting from ethnic and cultural differences by (Drewers, 2009; Russ, 2007).

While this may be so, it does not explain the therapist’s feeling of incompetence in relation to sexual abuse cases. Could the therapist be stuck because of her own pain? The therapist having been equipped with child centred values through the training process, in practice may be faced with cultural values, a tension that may reflect in the therapeutic relationship. She or he may find it difficult to function and work ethically which renders this particular therapist helpless as Hunt (2007) has indicated.

5.2.2 Relationship between therapist and client,

Talking therapy is not new (Okech & Kimemia, 2012), neither is play (Drewers, 2006) but play therapy is (Robson, 2010). Relationship is the central of non-directive play therapy model which as far as Rogers (1986) is concerned is the therapy itself, is the relationship part of the confusion talked about in West (2014;74 ). Based on the various theories of family therapy, it has been reported that the manner in which the therapist might engage the client and the therapeutic process is based on the relationship. In addition, structure of communication within the therapist’s family of origin and other central figures in the formative years shape the nature of the process (Maddock et
al., 2009; Lim, 2008). Both the child and the play therapist hail from the Kenyan structural and cultural set up, where socialisation is authoritative. Freeman et al (2007) state that in the therapeutic relationship, communication is informed by both the personality and culturally accepted expression of both the client and the therapist. Traditionally, the emphasis is placed on the children respecting the elders; the play therapist on the other hand by virtue of being older than the child is socially oriented to be wiser and know what is good for the child (Mbiti,1969). Theoretically in non-directive play therapy mode, the child is the expert in therapy (Axline, 1947). Clearly these two differing views create tension for both the child and therapist in the exposure they experience in therapy.

Yet play has been reported to be culture free (Drewers, 2006) regardless of its values or presentation, which might vary (Sutton-Smith, 1974, 1999). Similarly, McGuiness et al. (2001) view play therapy as an intervention that is presumably culture free and can be applied diversely across culture. However, having in mind that therapists are also cultural beings, they may be struggling with putting aside their values, which may be inconsistent with their training which holds the assumption that they apply this knowledge within the training period (Drewers, 2009; Russ, 2007). Are both the child and the therapist able to join and appreciate a therapeutic relationship that may bring healing (Wampold, 2001)?

Of all the core conditions, Van Fleet et.al. (2010) considers empathy as the most powerful of Rogerian skills. At the same time it may be the most challenging to put to use for the therapist, taking into consideration traditional ways of being, Yet it the assumption is that in the empathic relationship a child will learn to meet self-needs in a socially appropriate manner (Youell, 2008; Landreth, 2002). Ultimately, if the outcome of therapy is dependent on the quality of this relationship (Shirk & Karver, 2003; Karver et al., 2006), is it surprising that the therapists are confused and lack the confidence to practice?

It would seem that apart from the therapist being knowledgeable about this process (Dougherty and Ray, 2007), they should have the ability to cascade this knowledge to the significant others in the children’s lives by creating awareness (Shale, 2004). This confirms the need for parental involvement, which was voiced by the study participants
Okinyo -……...but play therapy was very effective and could have been made better with the involvement of the adults in the children’s ‘lives……”

Raha-I had children from different cultures and religion and they trusted me rarely did anyone come up with anything like don’t do this with my child that in fact I feel honoured to have been trusted by these parents

This also confirms the opinion of Van Fleet et.al. (2010) and Israel et al. (2007) that if the parents were made to feel as partners in the process then the therapy would be successful. I would like to assume that the specific techniques that are associated with the nondirective core conditions (Rogers, 1957) are sufficient to bring about positive therapeutic change in a therapeutic relationship, if the therapist communicates them to the client and the client is able to perceive them.

Again, the non-directive model makes no demands on the client, who is accepted unconditionally. This may require a change of attitude especially from the child and significant other and to an extent, the therapist; who may also need to feel secure in this relationship (Dinger et al., 2009). It is therefore assumed that the free choice in non-directive play therapy model facilitates a relationship that is a key aspect of the healing process (Bowers, 2009).

5.3. Professionalisation

The participants of this study have gone through a brief training of 120 hours. Can it be considered as a formal training especially as it has been stated by Mearns and Thorne (2000) that there is no evidence that either years of experience or duration of training have any strong bearing on therapeutic outcome. A crucial component to the development of adequately trained play therapists is each country’s national professional association establishing minimum training standards and that these credentials professionalise the play therapy field and protect client welfare (Homeyer and Morrison, 2008). However, with no body to regulate this in Kenya, where does this leave play therapy locally? The fact that not all the participants of this study or the other play therapists practicing in Kenya are at masters’ level, could they still be recognised as play therapist or do they
fall in the category of professional skilled helpers? Does this have an impact in the understanding and/or confidence in practice?

**5.3.1 Personal and professional development**

Personal and professional developments are ethical issues for the therapist in maintaining a good standard of practice and care for the benefit of clients (Ecclestone, 2003). But it is also a responsibility that puts a demand on the therapists for their own professional competence and personal growth (Joyce & Sills, 2007; Melnick et al., 2009) which they can use as a corrective means in time of distress to enhance their professional growth (Wiseman and Shefler, 2001).

Self-development is a process which is career long and may occur at any time (Donati and Watts, 2005) and facilitates in the client’s development as well (Turner, 2007). Hence, the therapist should be open to learning and continuously engaged in a process of self-critique (Bolton, 2005; Landreth, 2012). On examining the development of counsellor trainees, Hill et al. (2007) concluded that through trainees’ experience of professional growth, there was an increase of awareness of one’s reactions to clients. This is an assumption that professional growth is taking place. However, in a situation where personal growth or professional development is questionable, as in the case of the Kenyan therapist, can such claims be made? The Kenyan play therapist often faces a lack of clients because of cultural beliefs and attitudes, the stigmatisation of the work and poverty. Would it be fair then to conclude that because of lack of professional and personal development, the study participants lack the confidence to practice?

**5.3.2 Supervision for the play therapists in Kenya**

“Are accredited counsellors who have trained on recognised counselling courses and are supervised by recognised supervisors more helpful to their clients than non-accredited counsellors who have trained on non-recognised courses supervised by non-recognised supervisors”? (Dryden, 1991cp.3)
Continued practicing without supervision is unethical (Ecclestone, 2003). Maintaining quality service is the responsibility of the therapist; who is expected to observe professional ethics and aim for professional competence. This is one way of lessening burnout and protecting the clients from harm (Corey, 2005; Van der Westhuizen, 2009).

Responses across all participants pointed out to the need for a supervisory service. They expressed concerns over their survival in the practice. While supervision may be a professional requirement (BACP, 2010), and identified as a critical service in Kenya for the Kenyan play therapy, this is a gap to practice that will take some time for an experienced play therapy supervisor to emerge (Hunt, 2009:56-57). Yet supervision is the cornerstone of continuing professional development. It is also the foundation of clinical development for counsellors which is beneficial for personal and professional growth (Resnick and Estrup, 2000; Wheeler and Richards, 2007). This places a demand on any practicing therapist to fulfil their commitments to their clients by providing quality of care, which needs practitioners who are appropriately supported. They are accountable and able to give careful consideration to the limitations of their training and experience, because it is in supervision that knowledge of development, theories of change, self-awareness and continuous assessment become integrated into clinical practice (Landreth, 2002).

In considering the Kenyan situation with regards to supervision, the play therapists may be indeed committed to giving quality services to their clients but without the support needed to facilitate this, the quality of these services may be questionable. It has been clearly stated that it is in supervision that continuous assessment takes place, without which it would be difficult to assess their work and establish if they are growing or not. This assessment would be more beneficial if it fits the therapeutic process and the supervisor is trained in and knowledgeable of the specific play therapeutic orientation of the play therapist (Ray, 2004). It has been suggested that for greater depth in understanding, given the nonverbal nature of play therapy, supervisees may benefit from exploring supervision issues through nonverbal means like the use of symbolism, metaphoric play, and art (Howmeyer and Morrison, 2008).

If supervision is lacking, the therapists may feel stuck and be rigid in their ways of giving services without being aware of it (Scaife, 2004; Hawkins and Shohet 2007). This may result in feelings of
helplessness, sometimes embedded in anger to a point that even seeking for help may be seen as a threat to the therapist's own confidence (Hawkins and Shohet, 2007). In other words if you are rigid in your ways of working, you may reach a point that you convince yourself that it is the right way to work (my opinion). This can be a blind spot for the therapist (Kirk, 2010; Carroll, 1996). Seeking assistance may be seen as inability to perform or defeat, this in itself may threaten your own confidence and you may start to look at yourself as a failure if this feeling is not addressed in a forum where self-awareness, unhelpful beliefs, or gaps in skills and knowledge can be facilitated or challenged (Vallance, 2004; Stoltenberg, 2005).

Supervision having been described as the foundation of professional growth (Shohet, 2007; Estrup, 2000), gives the therapists a chance to reflect on their work (Aveline, 2007; Neukrug, 2007).

In a group supervision, the therapist can learn from other therapist new ways of working, the therapist's work can be evaluated, and monitored which has been summarized to function as educative, supportive, and administrative (Carroll, 2004). In my experience, if the therapist is given a chance to learn from others, this therapist will be able to gain new skills and if their work is evaluated and monitored there is a high chance of the therapist feeling cared for and supported.

Could lack of supervision mentioned above be the contributor to lack of confidence to practice?

In Kenya, play therapy supervision is non-existent. Having put across the place for on-going supervision in a therapist's career, with no regulating body or properly structured professional foundation in form of supervision, it is no wonder that there is lack of confidence to practice for the study participants. These participants were denied a chance to grow professionally in their journey. The therapist is supposed to move from novice to master craftsman (Schwenk, 2006). They may very well be still stuck at the novice stage, considering that they are neither supported nor accountable, with no place to affirm and evaluate their work or even to check on their self-awareness. From personal experience, what is available in Kenya in the form of supervision for play therapists is peer supervision. However, peer supervision does not instil confidence to the supervisee.
5.3.3. Social learning

The question remains: In the absence of the regulating body what could come to the rescue of play therapists? Is social learning in a community of practice the solution in the Kenyan scenario?

Play therapy is a new phenomenon in Kenya with no proper supportive structures in place. It would be worthwhile for play therapists to turn their attention to social learning. This theory argues that learning does not come from being taught; what is required is an active social participation of members in a community of practice. This would enable a process of identity construction (Wagner, 1979) and provide the opportunity to learn more effectively by observing others (Wenger, 1998). Within these relationships, as the therapists interact they are able to imitate the behaviours of others (Bandura, 1977). As therapists work within their communities with others, they can bond and are able to acquire more knowledge and gain insight about their practice. They also learn how to solve the problems they face more effectively than if they were to sit in a classroom or a workshop (Lave & Wenger, 1991; Wenger, 1998, 2001; Wenger et al., 2002).

In a community of practice, the new therapists have a chance to learn from the more experienced therapists through the social process of sharing stories and examples. While they gain insight on various aspects of the practice, they themselves would be contributing to the development of their community (Barab & Duffy, 2000). The therapists would be able to discuss and establish their place within the broader picture of the community, and look at the circumstances that surround their work within the community, as well as developing greater awareness of their practice (Wenger, 1999, 1998). It is important to note that in the absence of supervision this could be the most ideal forum where the therapist could access support, discuss and evaluate the situation of play therapy nationally and come up with solutions that can benefit both therapists and clients. However, because the body of play therapists is fragmented, coming and working together in a community of practice would be a challenge that would need commitment. I hope that after this study, participants will have the chance to read and be nformed by its findings and conclusions. I summarise these findings as:

a) A lack of support via supervision, which may lead to feelings of isolation, frustration or even guilt.
b) A level of uncertainty that can lead to confusion and an inability to practice

c) A lack of self-awareness, not knowing one’s ability or strength, leading to a lack of confidence

d) A lack of sufficient practice leading to an inability to accumulate experience.

e) Negative public perceptions and attitudes, with their work not respected, under-valued or taken for granted.

It is my opinion that if the play therapists felt valued they would not lack the confidence to practice.

5.4. Summary of chapter five

The keys findings of this study are that the therapists felt unsupported and unprepared and that there was a general feeling that there was a need for further training in order to develop better understanding of the intervention. They thought this would enhance their practical skills, professional development, and serve as a forum to learn more. The therapists experienced challenges in their lack of understanding of play therapy, both from themselves and their significant others.

The study participants also felt that there was lack of awareness in the communities where the practitioners serve and this affects therapeutic practice. It also affects the development of play therapy as a practice and as a profession. There is a lack of appreciation for the work done and attitudes resulting from cultural perception and practices hinder them from working ethically.

The participants had experience of the effectiveness of the intervention, although they indicated not knowing what works. This as a result gave them both a feeling of fulfilment and reward alongside confusion and the felt sense of incompetence. In addition, they tend to work in isolation and there is a lack of professional support. As the KCPA Act (2014) gains momentum, a possible solution would be to establish a community of practice.
5.5. Reflexivity statement

Finlay (2002:209) describes the process of engaging in reflexivity as “...full of ambiguity and multiple trails as researchers negotiate the swamp of interminable deconstructions, self-analysis and self-disclosure.” According to Rennie (2004: 183), “Reflexivity is self-awareness” and continues to state that this self-reflection is carried out in a number of ways. One of the most valuable way is for the researcher to keep a self-reflective journal from the inception to the completion of the investigation for the purposes of keeping records of experiences and that any emerging self-understandings. These can then be examined and set aside or consciously incorporated into the analysis.

Being aware of my potential influence on the study resulting from my position as an insider required my reflexivity as a researcher, always being consciously aware of the biases and experiences I bring to this study (Cresswell, 2007). It has been stated that the qualitative researcher acknowledges the complexity of the interaction between the researcher and the researched (Bradbury-Jones, 2007). I had the challenge of identifying my subjective voice, my thoughts, and feeling through reflexivity in this study. To this Patton (2002:65) adds that our “…cultural, political, social, linguistic and ideological origins” need to be brought into consciousness and openly discussed in relation to the research findings. This resonates with how Etherington (2004:46) has defined reflexivity within research as:

“...being aware of what influences our relationship to our topic and our participants. Those influences inform personal, cultural or theoretical constructs that we can use to guide our interactions as we engage in the research and represent our data.”

My task as a reflexive researcher was to be aware of and record these influences as an exploratory journey into the experiences of practicing play therapy. Having kept a journal from the beginning of my Doctorate programme helped me to look back and explore some of the impact of my subjectivity to this study.
Here is a quote from my journal:

*I am passionate about play therapy, I now really enjoy working with children and seeing them blossom, and happy after our sessions, but do I really understand what makes these children change? (March 2010).*

Being fully aware of my doubts in my ability to practice play therapy, I therefore set out to confirm whether my fears were mine alone. This I had hoped to establish by exploring my fellow play therapists’ experiences. Lincoln (2008:278) has described this as a “conscious experiencing of the self as both inquirer and respondent as teacher and learner, as the one coming to know self within the process of research itself”.

After many years of practicing counselling both as a general counsellor and as a play therapist, my lack of confidence in practicing play therapy became obvious, despite my apparent successes according to the feedback I received. After my first client (John) whose story I shared in my introduction chapter, I experienced play therapy as a mystery (Schaefer, 1999). The feedback I received was humbling. Severally I was being subjected to questions like ‘what magic did you perform on this boy, the boy has changed, he is a very good boy now’. This created a conflict in me. My not having children stigmatised me as it put me in the category of “infertile woman”, which lowered my value in the hierarchy of my community, coupled with the gender inequality in my society. Gilbert and Scher (2009) are of the opinion that an individual’s attitudes are informed by the values placed on their gender. I had identified with this societal perception and values for so long that despite my efforts to suppress it, its effects could be traced in my behaviours and decision-making. This confirms Hays et al.’s (2007) assertion that behaviours that are associated with gender are learnt through a process of socialisation and become automatic. I had been led to conclude that I could never understand about children. Because of the fear that nobody could trust me with their children, my initial pursuit of play therapy was purely an academic venture and an area of professional advancement to add to my resume but not to practice.

However, I did decide to practice and, as time went by, it became more and more clear to me as to why I decided to work with children. I came to the realisation that this was to fill a personal need of being childless. This was a way to prove both to myself and to society that within me I had nurturing
abilities (motherly instincts). As the years went by and I continued practicing play therapy, the fear of not being good enough with children became less challenging because my play therapy sessions continued to be successful and I began to build a reputation as a “very good child counsellor and play therapist.” At first, what I was hearing or what I made myself to hear was that I was a “good mother”. However, the more I kept hearing these positive feedbacks, the more I started to have doubts about my ability to practice. I could no longer trust what I was hearing. The fear of being exposed came into play: soon people would come to discover that I do not really know what I am doing and that the success was only by chance since I did not understand play therapy. I became a victim of ‘Imposter Syndrome’. According to Clance and Imes (1978), the syndrome involves women not experiencing an internal sense of success and continue to feel as imposters. This pushed me to want to know the experiences of my fellow play therapist.

Quote from my journal:

*Are the feedbacks I get from my practice of play therapy genuine? How can I be successful when I do not know what I am doing? Is this a fluke? (June 2009).*

As I reflect back, I realise that this should have been a heuristic research “personal journey of discovery” (McLeod, 2011:68). Heuristic research involves using personal subjective experiences as data (Douglass and Moustakas, 1985). However, maybe unconsciously, the fear of self-discovery may have been so great that it clouded my decisions around my choice of research methodology. My choice of descriptive phenomenological approach was consciously guided by the desire to be able to capture the experiences of the participant. However, in addition, it makes them visible, not myself or so I believed! I wanted their voices to be heard, not my voice, even though I was aware of my embodied subjective experience of play therapy. As Finlay (2011) says, reflexivity helps the researcher to critically focus on their personal experiences and how this impacts the study.

After my desires (or shall I say my fears) led me to get to know the experiences of my fellow therapist, during the interviews I became aware of how my pre assumptions influenced my choice and the wording of my questions. As I asked the questions, I could hear echoes of my own experiences described. Finlay (2011) has stated that the bases for our experiences are our
personal history, and that when we access others’ experiences our perception and experiences come into play.

Journal quote;

*I do not really understand play therapy. Do the other play therapists do? (January 2012).*

Doing this research has been therapeutic and both personal and professional development for me as a researcher. It has made me look into myself and face some of the fears that have been crippling my practice. This could be described as personal transformation (Sela-Smith, 2002). Padilla (2003) is of the opinion that when we understand something, it changes us. I can understand my experience in terms of Merleau-Ponty’s (1968) argument that to understand something means to have related it to ourselves in such a way that we might discover there an answer to our question. This understanding has introduced a feeling of guilt that I have overly focused on myself rather than on the research. Finlay (2011) has warned us about being caught up in self-indulgence: however, I am at the same time encouraged by Giorgi (1994: 205) who says, “nothing can be accomplished without subjectivity.”

Although I remain a practitioner who has undertaken research, over the past seven years of my Doctorate journey, as a researcher there has been a shift in confidence. Initially, I found a lack of confidence in doing research, which paralleled my lack of confidence in practicing play therapy. Lennie and West (2010:86) have stated “the production of undue fear in the researcher is to be avoided.” However, at the beginning, my main concern was about being good enough, about being able to do justice to my research participants, considering my position of being an insider researcher. Just as at the beginning of play therapy practice, I struggled with the feeling of not being good enough.

Since doing Doctorate research is about learning rather than being taught, I must confess that it has been a struggle to not be a student researcher. This may be rooted in our education system and our traditional way of life, which is authoritative and involves being taught what to do. In doing this research, I discovered that while my lack of confidence to practice was rooted in my traditional
beliefs, my lack of confidence in doing the research had its roots in the Kenyan education system, with its focus on teaching as opposed to self-exploration. In the process of doing this research I have learnt to be critical and question not only myself, but even other works that have been done and reported in the literature. I have also been aware of my experiences of the topic being researched as a "passionate concern" (Sela-Smith 2002:63). I have learnt not to take things on face value and to be trustful of my inner voice. I have also learnt that for self as a researcher to be congruent and transparent while remaining objective and committed is important when conceptualizing and contextualizing the participants’ data in an effort to communicate “the context in which the data is located” (Etherington, 2004:47).

**Contribution to knowledge:**

This study has contributed to knowledge in several ways. To begin with, this research is the first of its kind to be done in Kenya by a Kenyan. In the findings, it became evident that culture impacts on the way play therapy is practiced in Kenya and that the training curriculum is not inclusive of this element. In her research on the brief play therapy training offered to counsellors in Kenya, Hunt (2006) identified the need of future direction; based on this study, an important future direction is for the inclusion of the cultural component in the training curriculum as a significant curriculum development. Alongside this, it has highlighted the gap in the area of supervision, the lack of a community of play therapists, the need for professional membership and the need for awareness creating in enhancing play therapy practice.

It became evident in the findings that therapists struggled with lack of supervisory support. Participants of this study have been practicing without confidence in their work. The study highlights the fragmented nature of practice and the practitioner body as a major factor in this. There is a lack of structured professional support, which contributes to the sense of stagnation, and fatigue that is experienced by the play therapists in this study. While developing a community of practice is one way of building support for professionals, it is clear that this is not obvious to the participants. The study portrays the self of the practitioner as one who is highly challenged by the aforementioned factors. Finally, this research has identified the need for awareness creating amongst the significant others in the child’s life, which has been termed as parental involvement.
CHAPTER SIX: CONCLUSION

6.0. Introduction

The aim of this chapter is to discuss to what extent the study has achieved the objectives set out to answer the research question: “How do non-directive play therapists experience their work with children in the Kenyan context?”

Results from this study show that neither the practitioners nor the members of the communities that they serve seem to understand the practice of play therapy. Through experience, the participants know that play therapy is effective even though they do not understand how it works - a pointer to their struggles in understanding the therapeutic process.

In order to achieve therapeutic movement, Robinson (2011) has stipulated as a requirement that:

1) The frame of mind of the therapist should be that the child is capable of healing him/herself.

2) The therapists should possess personal qualities as competencies.

“…a play therapist working within a humanistic/non-directive approach works from the premise that the child has the inner resources and power to heal himself. She creates a therapeutic relationship between herself and the child in order to facilitate the child’s psychological growth. In order to do this, the core competencies of congruence, acceptance and empathy need to be present in the personal qualities of the play therapist.” (Robinson, 2011, p.217)

This notwithstanding, the participants still voice confusion. They lack the confidence to practice, a factor that they attribute to their training, citing it as brief and doubting its adequacy in equipping them for competent practice. Turner (2007) reports that the length of training does not necessarily equate with the growth of the professional; an opinion reflecting that held by Jones and Larner.
(2004) that competence is not necessarily a result of training but is gained from practice. This seems to indicate the value of gaining more experience of play therapy practice for play therapists in Kenya. It may indeed be more valuable than the further training which they perceive as their greatest need.

Similarly, this confusion experienced by the participants seems to have been contributed to by the lack of awareness in Kenyan society concerning the value of therapy and the subsequent nature of parental involvement, factors which therapists in the literature acknowledge as challenging. The need for awareness-creating is timely and parental involvement is necessary. Brumfield and Christensen (2011:209) have said, “Therapist’s ability to explain play therapy and to engage the parents is certainly of utmost importance”. Landreth and Bratton (2006) claim that this could be achieved through filial therapy training. Filial therapy trains parents in basic child-centred play therapy skills and procedures, where parents learn to follow the child’s lead, reflect the child’s feelings (Homeyer and Morrison, 2008). This is an element which largely seems to have been absent in the participating therapists’ training.

The revelation of parental involvement was a learning point for me as both a researcher and a practitioner and could be a learning point for the play therapists in future since they appear to be largely unaware of this knowledge. This is my assumption since most participants did not highlight the lack of parental involvement, except for one individual who indicated that therapy would have been enhanced by the involvement of significant others. However, this does not identify her as one who understands the therapeutic significance of involving the parents. Her idea of involvement was restricted to ensuring the child attended therapy as opposed to filial therapy proposed by Landreth and Bratton (2006) in which the parent is involved in a therapeutic sense.

While highlighting the significance of parental involvement may fill the gap of knowledge in the practice of play therapy locally, it also creates a hypothesis for future study in the area. Research could usefully be undertaken into the practicability of the inclusion of parents in therapy, considering the cultural norms that shape our attitude towards children and their activities. This may well highlight how therapists themselves as practitioners are influenced by cultural attitudes and might
help start a professional discussion of how this might impact on the potential to work with children in a fully person-centred manner.

This study has demonstrated that there is tension between training and cultural practices, which at times hinder the play therapists from practicing ethically. A majority of the participants expressed the impact of culture on practice. However, most held a strong unquestioning allegiance to their cultural backgrounds despite their training background. According to Drewers (2006) and Russ (2007), these biases and prejudices resulting from ethnic and cultural differences are unconsciously carried to therapy. These points to the seeming lack of a multicultural element in the training of play therapists within Kenya, which if included would have potentially allowed the exploration of cultural issues. In my opinion, such exploration would have enhanced practice and potentially improved therapeutic outcomes.

From my own experiences as practitioner and as researcher, having reviewed the literature on communities of practice, I would conclude that although training may be the foundation, play therapists would benefit from setting up their own communities of practice in which they can support one another. Within this support structure, they could network and increase their awareness and professional knowledge by learning from more experienced colleagues (Wenger, 1998). Participants lack a supervisory service which Wheeler and Richards (2007) view as the cornerstone of professional development. However, in the absence of this, play therapists need to be proactive in personal and professional development. Dotati and Watts (2005:476) view this as “initiated by greater self-awareness… being self-aware would facilitate genuine developmental movement”. This self-awareness is a way of gaining confidence for the play therapists.

6.1. Limitations of this study

This is a small-scale piece of qualitative research, which does not claim to represent the experience of play therapists in Kenya as a whole. Prestwood and Waller (2004:206) refer to such a study as providing a ‘brick’ rather than ‘building the whole house’.
All study participants were trained by KAPC, in Nairobi, Mombasa and Kisumu. The sample size was small and lacked the inclusion of participants trained by other institutions. Generally, I acknowledge that samples of this nature are limited and the findings cannot be generalised (Lincoln and Guba, 1985) to represent all the non-directive play therapists practicing in Kenya.

Giorgi (2006) suggests that whatever is illuminated by findings in a descriptive phenomenological research gives information of the area under investigation irrespective of the sample size. However, such ‘information’, while having potential utility, cannot be understood as representing “universal truth” (McLeod, 1999:208). Okech & Kimemia (2012) suggest that in the wake of modernisation many people moved to urban areas in search of work and livelihood. This urban growth means that these findings may have some potential for wider transferability to other urban areas within Kenya, although this is uncertain.

A further limitation I see of this research is that I was an insider without a co-researcher; thus, I became the sole analyst of the data. As an insider researcher, I was very much a part of the research and this is bound to have affected my approach to and analysis of the research. Chew-Graham et al. (2002:288) describe the potential for the research relationship to become a “….case of shared conceptual blindness allowing the interviewer’s own feelings and opinions about the field to govern the dialogue and interpretation.”. Throughout the study, I sought to acknowledge and work with my preconceptions as much as possible during the analysis. I have also expressed my tensions reflexively throughout. However, to claim that I have not influenced the research would be unreasonable. I have considered that being a practitioner-researcher in the field being researched could bring limitations as well as strengths in that participants by virtue of being known to me may have given information that they perceived as helpful to. Had I recruited a person who is external to the field as a co-researcher, it may have brought out different perspectives, both convergent and divergent, and the shared analysis might have added another level of trustworthiness to the findings (West and Talib, 2002). I thus acknowledge this as a potential limitation of the research.

A further limitation is that, as few research studies have focused on play therapy in the Kenyan context, and research generally has not focused on the experiences of the play therapist, there is a resultant lack of literature to support the findings of this study even in the western world. Moreover,
the research literature on the effectiveness of play therapy tends to be based on meta-analysis reviews of quantitative research studies.

6.2. Recommendations

Coming from a background of a collectivist way of life, having established that the community of practice is a source of professional support the play therapists should embrace the concept, which would essentially pull them together from the present fragmentation in which they exist as practitioners. This could afford them a forum for expression and professional growth as an interim measure.

Reviewing the literature for this study it became apparent that there was need for documented evidence on the experience of play therapists in the Kenyan context; a gap that this research acknowledges as existing and has tried to bridge. In addition, the impact of culture on practice cannot be ignored. Addressing this gap through further research may contribute to the knowledge base and improve practice.

The findings highlight the seeming inadequacy of the training provision for play therapists within Kenya. The brevity of the training, the lack of a multicultural perspective or focus on parental involvement featured as critical elements that were absent and would be necessary to include in the training curricula of institutions of learning. The continuity and growth of the profession depends on counselling modalities that are dynamic, culturally congruent, and socially relevant, which can only be achieved if the counselling training institutions and professional organisations collaborate in the process of shaping curricula, training, and supervision programmes (Okech & Kimemia, 2012).

This study established that play therapy is not well known as a therapeutic intervention by both significant others in the lives of children and the public within Kenya. Holding regular workshops to advance play therapy would be beneficial to the practice and the clients.
REFERENCES


Alter, A. (2013). Drunk Tank Pink: And Other Unexpected Forces That Shape How We Think, Feel, and Behave. New York, NY: Penguin


British Association of Play Therapy (2011) *Ethical Basis for Good Practice in Play Therapy*. Available online at: http://www.bapt.info/ethicalbasis.htm [Accessed 01.03.2011].

British Association for Counselling and Psychotherapy (2002). *Ethical Framework for Good Practice in Counselling and Psychotherapy*. Rugby: BACP.


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Qualitative Research, 4 (3), 383- 402.


APPENDICES

Appendix 1: Sample letter of invitation to research participants

Study Title: How do play therapists experience and understand their work with children in the Kenyan context.

Dear Sir/Madam,

My name is Lillian Aoko Awimbo. I am a doctoral candidate in the counselling studies at the University of Manchester.

I am conducting a research study as part of the requirements of my doctoral in counselling studies, and I would like to invite you to participate.

I am studying the experiences and understanding of play therapist of play therapy. If you decide to participate, you will be asked to describe in detail your experience of working with children and using play therapy as an intervention in a one to one in-depth interview.

The venue of the interview will at a place and time convenient to you, and should last 45mins. To 1hr. 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 (+254 722 733273, e-mail l_awimbo@yahoo.com) or my research supervisor .................. and or Research Ethics office at the University of Manchester at.....................

With kind regards,

Lillian Aiwmbo
Lillian Aoko Awimbo
P.O Box 10092-80101
Mombasa
+254 722 733273, E-mail: l_awimbo@yahoo.com
Appendix 2: Research Participant Consent Form

<table>
<thead>
<tr>
<th>Project</th>
<th>Doctorate Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>How do play therapists experience and understand their work with children in the Kenyan context</td>
</tr>
</tbody>
</table>

I agree to take part in the research project specified above. I have had the project explained to me, and understand that agreeing to take part means that I am willing to be interviewed and that the interview will be recorded and the information gotten from, me shall be made public.

I also understand that my participation is voluntary, and that I can withdraw at any stage of the project without being penalized or disadvantaged in anyway.

I understand that any data that the researcher gets from the interview for use in the project will not contain names or identifying characteristics.

I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party.

I understand that reports based on the interview(s) will be accessed by the examiners and later made public in a library.

I agree to be interviewed by the researcher Yes No

Thank you for accepting to take part in this research.

<table>
<thead>
<tr>
<th>Participant’s name:</th>
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<tbody>
<tr>
<td>Signature:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
<tr>
<td>Interviewer’s name:</td>
</tr>
</tbody>
</table>
Appendix 3: Research interview questions

Questions for first interview

Could you describe in detail your experience of working with children as a play therapist?

What would you say is your understanding of play therapy?

Could you share with me what you would consider as a success case in your practice?

What would you consider as some of the challenges you encountered while working with children?

Based on your experience of play therapy would you say that your training equipped you sufficiently?

Is there anything else you wish to add?
Appendix 4: Sample of Interview Transcript

The participant is of African origin female, of Christian background, is over 35 years of age, a trained counsellor and counsellor trainer, has been practicing play therapy for years alongside her professional counselling she holds MA in counselling studies and certificate in play therapy.

Interview: 1:1. (This was the first participant, interview done on a Monday) pseudonym Okinyo:

Interviewer- –welcome, thank you for agreeing to take part in this study. You are aware of my research title and what my research is about. I would like to remind of you of the informed consent form which you signed earlier and that you are free to pull out of the research at any point if you feel uncomfortable. I would also like to a sure you of confidentiality and that your Identity and that of your client and the data that you give me are safe with me and that both your identities will not appear anywhere in the research. If you agree with this, we can continue whenever you are ready.

Participant- Yes I am willing to continue and I am ready to start

Interviewer-I have some questions that I am going to ask you to help me answer my research question, which is 'How do play therapists experience their work with children in the Kenyan context? In addition, my first question to you is:

Interviewer-could you describe in detail your experience of using play therapy as means of intervention with children?

Participant – Thank you, my experience has been not without goodness and also not without some level of challenges, I have worked with children some who are as young as 3 years and some as old 12-14 years and I found that even as I worked with older children I found that play therapy was a good intervention even though with some of them I would say I used play and other ways of intervention especially with the older ones but play therapy was very effective and could have been made better with the support of the adults in the children’s ‘lives.

Interviewer--: mmm
Participant: I have worked with children in the orphanage homes mostly and worked with children referred to me by significant adults.

Interviewer- mmm

Participant- With the youngest one I think that is where I would like to start I must appreciate that it was difficult for me to say what was helpful but I strongly feel that the establishment of safety, based on this case study the trusting relationship was quite effective.

Interviewer- mmm

Participant- this was demonstrated by my client she used to look forward to the sessions this was reported by her mother. My client’s mother was very supportive and collaborative for the benefit of the child and this made play therapy effective and rewarding, so when the significant others in the child’s life was supportive like in this case this was useful but where the caregiver posed challenges and were not collaborative and supportive for whatever reason then it became very challenging.

Interviewer- mmm

Participant- my difficulty was that I did not know how to negotiate and this became very difficult. Like in most of homes I worked, it was not easy I suspected the home administrators had the fear for not knowing what to expect and felt that there was something they needed to protect.

Interviewer- hmm

Participant- most of the cases I have been dealing with are mainly traumatised children who have experienced different cases of child abuse.

Interviewer-when you talk of child abuse are you at liberty to be more specific please?

Participant –mainly I have dealt with children who are sexual abused and children engaged in child labour. The cases of sexual abuse took place in home settings, sometimes in school, with the orphanage homes leading in my opinion. I would refer to these cases as assaults but some went beyond.

Interviewer-mmm
Participant- from my professional perspective the proprietors are usually people known to this children and this in many occasions came with further challenges. For example the case study of my youngest client that I shared earlier, having been sexually abused in school by one of the staff, one of the parents, the mother was very cooperative and had wanted to go all the way with case even to pursue the legal aspect while the father having been approached by the school administrators this being one of the big time schools to drop the charges and settle it outside court in an effort to protect the school’s image seemed to work against it and was ready to push everything under the carpet and continue as though nothing had happened.

Interviewer- hmmm

Participant- while this was going on the offender was still in school and no action had been taken and this caused me a lot of anxiety. I found myself at a conflict in that knowing full well that this was a criminal offence yet I found myself helpless and confused, taking any action without the consent of the parents or that one parent considering that he is the head of the family, knowing the right thing to do, yet I could not do it made me feel confused and frustrated.

Interviewer- hmmm

Participant- this to some extend touches on our culture as Africans where the head of the home’s decisions supersedes any other decision.

Interviewer- hmm

Participant - also I felt that I was getting entangled in the family wrangles yet my concerns were my little client I did not know what to do at this point, what was also even more frustrating was the helplessness that I felt and also the seeing my client in a position of helplessness that I was she had to continue going back to the same school yet the offender was there no action had been taken. This frustrated all my efforts of trying to help my client
Interviewer-so would you say that your culture affects your practice?

Participant-long silence, yes it takes a lot to reflect how my culture would interfere with how I work with children, there is a lot of taboo and stigma connected to sexuality, especially when a child is sexually abused the parent(s) would like to protect the image of the family by keeping quiet.

Interviewer- mmm

Participant-also as a trained counselor/play therapist I am suppose to keep away my values this goes for my cultural values as well out of my work. Culturally children are supposed to be directed this does not go well with my nondirective play therapy training.

Interviewer- mmm

Participant- this takes me back to my childhood where as a child I worked so hard and that was acceptable by then so I see that a little work is ok, now this is considered child labour therefore considered child abuse. Therefore, my struggle has been as to whether or how I can integrate some of my cultural values or do away with them altogether for the benefit of child client without destroying the goodness of play therapy.

Interviewer-hmm

It was very disheartening for me seeing my client coming back to therapy looking low and the mother reporting that she seems to have regressed and behaving in maladaptive manner like still having nightmares, which she had seemed to overcome.

Interviewer-mmm

Participant-this frustrated me a lot, but a sense of joy came when the mother decided to withdraw her from school and have her stay at home but at the same time, I felt bad that she had to miss school. She later moved the child to another school and this was a big relief for me.

Interviewer hmm what would you say worked for you?

Participant- the joy has been working with children and seeing them in an environment where they were less fearful seeing children rejuvenated, I think for me that is joy. They are not the same
children that were brought to me, their studies have improved and to see the children at the homes relating better with their peers and even the relationship amongst the staff improved. I guess that it is this joy that keeps me going.

Interviewer- mmm

Participant- I also feel that the therapeutic relationship between the therapist and the child a trusting relationship where the child feels accepted has been great for me as well as empathy, when a child feels understood also was key to my success I guess this allowed the child to become powerful and creative.

Interviewer: hmmm, would you say that your training prepared you well?

Participant: I would say my training prepared me well to some level and I also consider it sufficient in that I am now aware of my boundaries and to know that I am bound by ethics, my earlier training as counselor has also added to my advantage.

Interviewer: is there anything else that you feel could make play therapy more beneficial?

Participant: since I am the agent for the child change, it would be more important to get more training eeeh at some point it was difficult for me to know what was working for me eeeh like when my youngest client remember I said she is just a little more than 3years. There were times when I would get lost when it came to metaphors mmm as if she would ask me what name to call a certain thing or toy and I would be stuck. I hope the future models would integrate and appreciate the dynamics of the cultural aspect of playing materials like toys.

Interviewer- hmm you feel further training would enhance your practice?

Participant-yes in further training I would learn more skills and even be more confident that I understand play therapy better. I believe training would not only benefit me as a therapist but also the care givers of the children this training would do us good

Silence
Participant-also creating awareness would benefit towards receptiveness of play therapy. For me the baseline is lack of awareness especially with organisations as this may create easy access to the children

Interviewer- hmm

Participant-counselling itself is still going through the phases of acceptance in this country so in creating awareness this would create opportunities and finding ways of integrating play therapy in hospitals, schools and other organization that do not have child friendly centres even other organisations like Federation of Women Lawyers (FIDA) who deal with children who are traumatised would benefit from a basic course and understanding of play therapy.

Interviewer- hmm

Participant-, sometimes I am drawn to have group play therapy because of lack of understanding of play therapy of the people involved hence the need of creating awareness.

Silence

Participant-the bigger challenge has been when working with bigger children. The significant others in these children’s lives believe that they know what is good for the children,

Interviewer- what does that mean for you?

Participant-It is frustrating. This gets deeper when you can’t access the children I can’t help thinking of what these children might become in the future I believe that we need to break the circle of my parents did the same I did the same so my children will do the same.

Interviewer-hmm

Participant- another hindrance is the assumptions that children things are childish therefore taken for granted and not worth paying for. In this light, the therapists should volunteer their services. People need to understand that play therapists need to have economical gain from their practice. My fear is that this assumption may have caused some play therapist not to practice this has come
up in interaction with other play therapists. In addition, my fear is that if this trend continues play therapy as a profession may die totally.

Silence

Participant-another challenge has been eeh I do not know whether it is because of poverty or lack of knowledge but I have experienced frustrations when you start working with a child suddenly this child is withdrawn from you.

Interviewer- hmm

Participant- I find this so frustrating in that you are left hanging. Mostly this happens when the child has been sexually abused or sometimes the agent feels that they do not want to pay for your services sometimes I feel that they may not be aware of the damage that this action does to the child

Interviewer-hmm

Participant-the child is withdrawn and you are not given any explanation or a child is brought one session and does not show up for further appointments, now you do not know what have happened to the child.

Interviewer- when such a thing happens what does that mean to you?

Participant- confusion, and a feeling of inadequacy I guess eh...you are left feeling helpless and sometime very angry not knowing what to do next.

Interviewer-hmm would you have any recommendation?

Participant- yes I would recommend supervision eh I feel the aspect of supervision would help the therapist deal with such issues and may give the therapists a working guideline. In addition, I would recommend that in creating awareness, some basic courses for the significant adults in the children’s lives may create a better understanding of play therapy and with understanding; play therapy could be more effective and make the play therapists work a lot easier and more fulfilling.
Interviewer - mmm, I don’t know if you have any more recommendations to make or anything that you would like to add?

Participant - no I think I have said all that came to mind

Interviewer - well I see that our time is almost over, and if you don’t have anything, more I would like to take this opportunity to thank you for your time.

Participant - thank you for giving me this opportunity.

The five steps of data analysis used in this study are as follows:

Step 1: Bracketing and the phenomenological reduction as demonstrated below:

Participant – Thank you,1my experience has been not without goodness, and also not without some level of challenges/.2 I have worked with children some who are as young as 3years and some as old 12-14years/ and3 I found that even as I worked with older children I found that play therapy was a good intervention even though with some of them I would say I used play and other ways of intervention especially with the older ones/ but 4play therapy was very effective and6 could have been made better with the support of the adults in the children’s ‘lives./

Interviewer:-: mmm

Participant: 7I have worked with children in the orphanage homes mostly and worked with children referred to me by significant adults. /

Interviewer- mmm

Participant- 8With the youngest one I think that is where I would like to start I must appreciate that it was difficult for me to say what was helpful but9 I strongly feel that the establishment of safety, based on this case study the trusting relationship was quite effective/.

Interviewer- mmm
Participant-10 this was demonstrated by my client, she used to look forward to the sessions this was reported by her mother./11 My client’s mother was very supportive and collaborative for the benefit of the child and this made play therapy effective and rewarding, so when the significant others in the child’s life was supportive like in this case this was useful/ but12 where the caregiver posed challenges and were not collaborative and supportive for whatever reason then it became very challenging/.

Interviewer- mmm

Participant-13 my difficulty was that I did not know how to negotiate and this became very difficult./14Like in most of homes I worked, it was not easy I suspected the home administrators had the fear for not knowing what to expect and felt that there was something they needed to protect/.

Interviewer- hmm

Participant- 15most of the cases I have been dealing with are mainly traumatised children who have experienced different cases of child abuse/

Interviewer-when you talk of child abuse are you at liberty to be more specific please?

Participant –16mainly I have dealt with children who are sexual abused and children engaged in child labour/.17The cases of sexual abuse took place in home settings, sometimes in school, with the orphanage homes leading in my opinion. I would refer to these cases as assaults but some went beyond. /

Interviewer-mmm

Participant-18 from my professional perspective the proprietors are usually people known to this children and this in many occasions came with further challenges. For example the case study of my youngest client that I shared earlier, having been sexually abused in school by one of the staff,/19 one of the parents, the mother was very cooperative and had wanted to go all the way with the case even to pursue the legal aspect while the father having been approached by the school administrators this being one of the big time schools to drop the charges and settle it outside court
in an effort to protect the school’s image seemed to work against it and was ready to push everything under the carpet and continue as though nothing had happened.

Interviewer- hmmmm

Participant 21 while this was going on the offender was still in school and no action had been taken and this caused me a lot of anxiety. I found myself at a conflict in that knowing full well that this was a criminal offence yet I found myself helpless and confused, taking any action without the consent of the parents or that one parent considering that he is the head of the family knowing the right thing to do, yet I could not do it made me feel confused and frustrated.

Interviewer- hmmmm

Participant-25 this to some extend touches on our culture as Africans where the head of the home’s decisions supersedes any other decision.

Interviewer- hmm

Participant -26 also I felt that I was getting entangled in the family wrangles yet my concerns were my little client I did not know what to do at this point what was also even more frustrating was the helplessness that I felt and also the seeing my client in the same position of helplessness that I was, she had to continue going back to same school yet the offender was there, no action had been taken. This frustrated all my efforts of trying to help my client.

Interviewer- would you say that your culture affects your practice?

Participant-long silence, yes it takes a lot to reflect how my culture would interfere with how I work with children there is a lot of taboo and stigma connected to sexuality, especially when a child is sexually abused the parent(s) would like to protect the image of the family by keeping quiet.

Interviewer- mmm

Participant-also as a trained counsellor/play therapist I am expected to keep away my values this goes for my cultural values as well out of my work. Culturally children are supposed to be directed this does not go well with my nondirective play therapy training.
Participant-32: this takes me back to my childhood where as a child I worked so hard and that was acceptable by then, so I see that a little work is ok, now this is considered child labour therefore considered child abuse/.33 So my struggle has been as to whether or how I can integrate some of my cultural values or do away with them altogether for the benefit of child client without destroying the goodness of play therapy. /

Participant-34: It was very disheartening for me seeing my client coming back to therapy looking low and the mother reporting that she seems to have regressed and behaving in maladaptive manner like still having nightmares, which she had seemed to overcome.

Participant-35: this frustrated me a lot, but a sense of joy came when the mother decided to withdraw her from school and have her stay at home/ but36 at the same time I felt bad that she had to miss school/. 37She later moved the child to another school and this was a big relief for me.

Interviewer- hmm what would you say worked for you?

Participant-38: the joy has been working with children and seeing them in an environment where they were less fearful seeing children rejuvenated I think for me that is joy/.39 They are not the same children that were brought to me, their studies have improved and to see the children at the homes relating better with their peers and even the relationship amongst the staff improved./40I guess that it is this joy that keeps me going/.

Participant-41: I also feel that the therapeutic relationship between the therapist and the child a trusting relationship where the child feels accepted has been great for me as well as empathy/42when a child feels understood also was key to my success I guess this allowed the child to become powerful and creative.
Interviewer: hmmm, would you say that your training prepared you well?

Participant: I would say my training prepared me well and I also consider it sufficient in that I am now aware of my boundaries and to know that I am bound by ethics, my earlier training as counsellor has also added to my advantage.

Interviewer: is there anything else that you feel could make play therapy more beneficial?

Participant: since I am the agent for the child change, it would be more important to get more training at some point it was difficult for me to know what was working for me like when my youngest client remember I said she is just a little more than 3 years. There are times when I would get lost when it came to metaphors as if she would ask me what name to call a certain thing or toy. I believe training would not only benefit me as a therapist but also the caregivers of the children this training would do us good.

Interviewer: hmm you feel further training would enhance your practice?

Participant: yes in further training I would learn more skills and even be more confident that I understand play therapy better.

Silence

Participant: also creating awareness would benefit towards receptiveness of play therapy. For me the baseline is lack of awareness especially with organisations as this may create easy access to the children.

Interviewer: hmm

Participant: counselling itself is still going through the phases of acceptance in this country so in creating awareness this would create opportunities and finding ways of integrating play therapy in hospitals, schools and other organization that do not have child friendly centers even other
organisations like FIDA (Federation of Women Lawyers) who deal with children who are traumatised would benefit from a basic course and understanding of play therapy.

Interviewer- hmm

Participant- 54I hope the future models would integrate and appreciate the dynamics of the cultural aspect of playing like toys/,55 sometimes I am drawn to have group play therapy because of lack of understanding of play therapy of the people involved hence the need of creating awareness./

Silence

Participant-56the bigger challenge has been when working with bigger children./57The significant others in these children’s’ lives believe that they know what is good for the children/, Interviewer- what does that mean for you?

Participant-58It is frustrating/. 59This gets deeper when you can’t access the children I can’t help thinking of what these children might become in the future I believe that we need to break the circle of my parents did the same ,I did the same so my children will do the same/. Interviewer-hmm

Participant-60 another hindrance is the assumptions that children things are childish therefore taken for granted and not worth paying for/.61 In this light the therapists should volunteer their services/62people need to understand that play therapists need to have economical gain from their practice/.63 My fear is that this assumption may have caused some play therapist not to practice this has come up in interaction with other play therapists/.64 And my fear is that if this trend continues play therapy as a profession may die totally./

Silence

Participant-65another challenge has been eh I don’t know whether it is as a result of poverty or lack of knowledge/ but66 I have experienced frustrations when you start working with a child suddenly this child is withdrawn from you./

Interviewer- hmm
Participant-67 I find this so frustrating in that you are left hanging/.68Mostly this happens when the child has been sexually abused or sometimes the agent feels that they don’t want to pay for your services/69 sometimes I feel that they may not be aware of the damage that this action does to the child/

Interviewer-hmm

Participant-70 the child is withdrawn and you are not given any explanation or a child is brought one session and does not show up for further appointments, now you don’t know what have happened to the child./

Interviewer- when such a thing happens what does that mean to you?

Participant-71 confusion, and a feeling of inadequacy I guess/eh…72you are left feeling helpless and sometime very angry not knowing what to do next/.

Interviewer-hmm would you have any recommendation?

Participant-73 yes I would recommend supervision eh I feel the aspect of supervision would help the therapist deal with such issues and my give the therapists a working guide line/74. And I would recommend that in creating awareness some basic courses for the significant adults in the children’s lives may create a better understanding of play therapy/ and75 with understanding play therapy could be more effective and make the play therapists work a lot easier and more fulfilling./

Interviewer-mmm, I don’t know if you have any more recommendations to make or anything that you would like to add?

Participant- no I think I have said all that came to mind

Interviewer- well I see that our time is almost over, and if you don’t have anything more I would like to take this opportunity to thank you for your time.

Participant-thank you for giving me this opportunity.
Step 2. Delineating units of meaning

Participant – Thank you, her experience has been with mixed feelings of fulfillment, and of challenges. She has worked with children some who are as young as 3 years and some as old 12-14 years and discovered that even though play therapy was effective she needed some other ways of intervention with older children. She confirms that play therapy was very effective and could have been made better with the support of the adults in the children’s ‘lives.

Interviewer: mmm

Participant: I have worked with children in the orphanage homes mostly and also worked with children referred to me by significant adults.

Interviewer: mmm

Participant: She found it challenging establishing what it was that was helpful starting from the youngest ones of her clients. She strongly felt that the establishment of safety and trusting relationship was quite effective.

Interviewer: mmm

Participant: This was demonstrated by my client, she used to look forward to the sessions this was reported by her mother. She found play therapy effective, rewarding, useful, and beneficial to her client when the significant other in her client’s life was supportive and collaborative and became challenging when there was no co-operation.

Interviewer: mmm

Participant: Her lack of negotiating skills made it difficult for her. Like in most of homes I worked, it was not easy I suspected the home administrators had the fear for not knowing what to expect and felt that there was something they needed to protect.
Participant - 15most of the cases I have been dealing with are mainly traumatised children who have experienced different cases of child abuse

Interviewer - when you talk of child abuse are you at liberty to be more specific please?

Participant - 16mainly I have dealt with children who are sexual abused and children engaged in child labour. 17. she felt that the children were abused by people known to them and referred to this cases as assaults but some went beyond.

Interviewer - mmm

Participant - 18her professional perspective was that the proprietors are usually people known to this children and this in many occasions came with further challenges. For example the case study of my youngest client that I shared earlier, having been sexually abused in school by one of the staff, one of the parents, 19the mother was very cooperative and had wanted to go all the way with case even to pursue the legal aspect 20while the father having been approached by the school administrators this being one of the big time schools to drop the charges and settle it outside court in an effort to protect the school’s image seemed to work against it and was ready to push everything under the carpet and continue as though nothing had happened.

Interviewer - hmmm

Participant - 21while this was going on the offender was still in school and no action had been taken and caused me a lot of anxiety. 22she experienced conflict, confusion and helplessness at knowing full well that this was a criminal offence yet un able to take any action without the consent of the parents or that one parent considering that he is the head of the family 23knowing the right thing to do, 24yet I could not do it made me feel confused and frustrated.

Interviewer - hmmm

Participant - 25this to some extend touches on our culture as Africans where the head of the home’s decisions supersedes any other decision.
Participant - 26 also I felt that I was getting entangled in the family wrangles yet my concerns were my little client 27 I did not know what to do at this point what was also even more frustrating was the helplessness that I felt and 28 also the seeing my client in the same position of helplessness that I was, she had to continue going back to same school yet the offender was there no action had been taken. 29 This frustrated all my efforts of trying to help my client

Participant - long silence, yes it takes a lot to reflect how my culture would interfere with how I work with children, 30 there is a lot of taboo and stigma connected to sexuality, especially when a child is sexually abused the parent(s) would like to protect the image of the family by keeping quiet.

Interviewer - mmm

Participant - also as a trained counselor/play therapist I am expected to keep away my values this goes for my cultural values as well out of my work. 31 Culturally children are supposed to be directed this does not go well with my nondirective play therapy training.

Interviewer - mmm

Participant - 32 this takes me back to my childhood where as a child I worked so hard and that was acceptable by then so I see that a little work is ok, now this is considered child labour therefore considered child abuse. 33 So my struggle has been as to whether or how I can integrate some of my cultural values or do away with them altogether for the benefit of child client without destroying the goodness of play therapy.

Interviewer - hmm

Participant - 34 It was very disheartening for me seeing my client coming back to therapy looking low and the mother reporting that she seems to have regressed and behaving in maladaptive manner like still having nightmares which she had seemed to have overcome.
Participant- 35this frustrated me a lot, 36 but a sense of joy came when the mother decided to withdraw her from school and have her stay at home but at the same time I felt bad that she had to miss school. 37She later moved the child to another school and this was a big relief for me.

Interviewer- hmm what would you say worked for you?

Participant- 38the joy has been working with children and seeing them in an environment where they were less fearful seeing children rejuvenated I think for me that is joy. 39They are not the same children that were brought to me, their studies have improved and to see the children at the homes relating better with their peers and even the relationship amongst the staff improved.

40I guess that it is this joy that keeps me going.

Interviewer -mmm

Participant- 41I also feel that the therapeutic relationship between the therapist and the child a trusting relationship where the child feels accepted has been great for me as well as empathy 42when a child feels understood also was key to my success I guess this allowed the child to become powerful and creative

Interviewer: hmmm, would you say that your training prepared you well?

Participant :43 I would say my training prepared me well and I also consider it sufficient in that I am now aware of my boundaries and to know that I am bound by ethics44, my earlier training as counselor has also added to my advantage.

Interviewer: is there anything else that you feel could make play therapy more beneficial?

Participant: 45since I am the agent for the child change, it would be more important to get more trainingeeeh 46at some point it was difficult for me to know what was working for meeeeh like when my youngest client remember I said she is just a little more than 3years. 47There are times when I would get lost when it came to metaphors mmm like she would ask me what name to call a certain
thing or toy. I believe training would not only benefit me as a therapist but also the care givers of the children this training would do us good.

Interviewer-hmm you feel further training would enhance your practice?

Participant-yes in further training I would learn more skills and even be more confident that I understand play therapy better.

Silence

Participant-also creating awareness would benefit towards receptiveness of play therapy. For me the baseline is lack of awareness especially with organisations as may create easy access to the children.

Interviewer- hmm

Participant- counselling itself is still going through the phases of acceptance in this country so in creating awareness this would create opportunities and finding ways of integrating playtherapy in hospitals, schools and other organization that do not have child friendly centers even other organisations like FIDA (Federation …) who deal with children who are traumatised would benefit from a basic course and understanding of play therapy.

Interviewer- hmm

Participant- I hope the future models would integrate and appreciate the dynamics of the cultural aspect of playing like toys. Sometimes I am drawn to have group play therapy because of lack of understanding of play therapy of the people involved hence the need of creating awareness.

Silence

Participant-the bigger challenge has been when working with bigger children. The significant others in these children’s lives believe that they know what is good for the children,
Participant-58 It is frustrating. 59 This gets deeper when you can’t access the children I can’t help thinking of what these children might become in the future I believe that we need to break the circle of my parents did the same, I did the same so my children will do the same.

Interviewer- hmm

Participant-60 another hindrance is the assumptions that children things are childish therefore taken for granted and not worth paying for. 61 In this light the therapists should volunteer their services. 62 People need to understand that play therapists need to have economical gain from their practice. 63 My fear is that this assumption may have caused some play therapists not to practice this has come up in interaction with other play therapists. 64 And my fear is that if this trend continues play therapy as a profession may die totally.

Silence

Participant-65 another challenge has been eh I don’t know whether it is as a result of poverty or lack of knowledge but I have experienced frustrations when you start working with a child suddenly this child is withdrawn from you.

Interviewer- hmm

Participant-67 I find this so frustrating in that you are left hanging. 68 Mostly this happens when the child has been sexually abused or sometimes the agent feels that they don’t want to pay for your services. 69 Sometimes I feel that they may not be aware of the damage that this action does to the child.

Interviewer- hmm

Participant-70 the child is withdrawn from you and you are not given any explanation or a child is brought one session and does not show up for further appointments, now you don’t know what have happened to the child.

Interviewer- when such a thing happens what does that mean to you?
Participant: confusion, and a feeling of inadequacy I guess eh... you are left feeling helpless and sometime very angry not knowing what to do next.

Interviewer: hmm, would you have any recommendation?

Participant: yes I would recommend supervision eh I feel the aspect of supervision would help the therapist deal with such issues and my give the therapists a working guideline.

Step 3. Clustering units of relevant meaning to form themes:

Clusters of relevant meaning

Emotions experienced while working with children in play therapy

a. Caused me a lot of anxiety (#21)
b. She found herself in a conflict, knowing that this was wrong but could do nothing about it (#22, 23) the frustration and the helplessness could be felt in her tone of voice.
c. She felt confused and helpless and a feeling of inadequacy (#25, 27, 28, 29, 71, 72,)
d. She found it very disheartening to see her client regress (#34)
e. She is frustrated when this happens (#35, 58, 66, 67)
f. It was a big relief for her when the child was moved to another school (#37)
g. Her joy has been to see children change and relate better (#38, 40)
h. She feared that play therapy might die if nothing changed (64)

There would be a feeling of fulfilment when the intervention is effective and well understood.

Challenges experienced during play sessions

a. It was not without some level of challenges (#2)
b. It was difficult for me to say what was helpful (#8)

c. Where the caregiver posed challengers and she did not know how to negotiate (#12,13)

d. This became very difficult, it was not easy (#14)

e. This in many occasions came with further challenges (# 18)

f. Seemed to work against it ( # 20)

g. She did not know what to do at this point (# 27)

h. All her efforts of helping her client was frustrated ( # 29)

i. Her training and her culture does not go well together (# 31)

j. She is struggling cannot make a decision ( # 33)

k. She found it very disheartening to see her client regress (# 34)

l. At times she found it difficult to know what was working, at times she found herself lost (#46,47)

m. Lack of awareness and lack of understanding (# 51, 55)

n. She found working with bigger children a bigger challenge (# 56)

o. Another hindrance is the assumption that children’s things are childish (# 60)

p. People need to understand better about play therapy (#62)

q. She found being left hanging challenging ( # 67)

**Relationship between the child and therapist/significant others in the child’s life**

a. Could have been better with the support of the adult in the children’s lives (#7)

b. She feels that the establishment of a safe, trusting relationship was effective (# 9,41)

c. The client’s mother was supportive and collaborative and this benefited both the child and the therapist (#10,11,19)

**Therapeutic movement**

a. They are not the same children (# 39)

b. This allows the child to be powerful and creative (# 42)
Therapist fulfilment

a. She felt a sense of joy when the child was withdrawn from school (#36)
b. Her sense of joy came when the children were less fearful and rejuvenated (#38)
c. It is this joy that, keeps her going (#40)
d. Make the therapist work easier and fulfilling (#75)

Therapist’s Perception on training

- She considers her training sufficient, though further training would be welcomed (#43, 45, 48, 49)

Role of culture

a. This to some extent touches on our cultures as Africans (#26)
b. There is a lot of taboo connected to sexuality (#30)
c. Culturally children are supposed to be directed (#31)

Discovery

a. She discovered that play therapy was effective even with older children (#4)
b. She discovered how useful it was when the significant other in a child’s live was supportive (#11, 12)
c. She found herself confused and helpless not able to do what she felt was the right thing (#22, 23)
d. She discovered that there was a lot of stigma connected to sexuality (#30)
e. That creating awareness would benefit towards receptiveness of play therapy
f. Lack of knowledge about play therapy (#65) may create a better understanding of play therapy (#74)

Effectiveness of Play Therapy

a. Play therapy was a good intervention (#4)

b. Play therapy was very effective (#6)

c. The trusting relationship was very effective (#9)

d. Play therapy effective and rewarding (#10)

e. With understanding of play therapy could be more effective, easier and fulfilling (#75)

Integration

How could she integrate some of her cultural values to benefit the child client (#33)

Category of children

a. She has worked with children who are traumatised, both young and old (#3, 6, 15, and 16)

b. In some cases, there was an overlap to the clusters, like #10,12,22,23,34,67,75.

c. It is bound to happen depending on opinion, experience and skill (Hycner, 1999).

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<thead>
<tr>
<th>Clusters of meaning</th>
<th>Central theme</th>
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<tbody>
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<td>The experience of using play therapy</td>
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<td>II. Challenges experienced during play sessions</td>
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<td>III. Relationship between the child and therapist / significant others in the child’s life</td>
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VIII. Discovery

IX. Lack of knowledge about play therapy

X. Effectiveness of play therapy

XI. Kind of children worked with in play therapy sessions

Step 4: Summarizing each interview, validating it and where necessary modifying it

This process was carried out on all the six interviews.

Step 5: Extracting general and unique themes from all the interviews and making a composite summary: See chapter four