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How Therapy Affects the Counselor: Development through Play Therapy Practice and Supervision

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I am submitting herewith a dissertation written by Tiffany Paige Brooks entitled "How Therapy Affects the Counselor: Development through Play Therapy Practice and Supervision." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Counselor Education.

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Dedication

I dedicate this dissertation to my family. Each one of you offered support and encouragement through this process. Thank you Mom, Gina Miller, for always reminding me of everything I am capable of beyond what I believe for myself. DeWayne, I appreciate the many sacrifices you make for Mom and us. I also want to thank my siblings and their spouses: Nicole, Justin, Tyler, and Brittaney, for all the ways you challenge me to grow every day. And most of all, Tyner, my husband, there are not enough words to thank you for everything you have done for our family, especially during this process. Millie Tyner thank you for all the joy you brought us every day of your life. Tyner and Millie Tyner, you both deserve honorary degrees for this past year. I love you all!

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As a counselor educator, I value the many educators that have believed in me along the way. I could list so many teachers along the way from first grade to graduate school that took the time to support and challenge me in my educational journey. Thank you!

As I stated in my dedication, this work could not have been completed without the ongoing support and encouragement of my family and also my friends. Adam and Brittany, thanks for the many laughs. I do not know what the last three years would have been like without the two of you. I cannot wait for our top ten list. To all of my other close friends from near and far, thank you for the encouraging, texts, calls, and even getaway trips that helped me through this process. A huge acknowledgement is needed to recognize the close friends, especially the Payne family, that spent quality time with Millie Tyner while I was trying to finish up the last few months. Thank you for all your love and support!

Abstract

Therapeutic relationships and counselor qualities as contributions to therapeutic relationships are widely recognized as critical to counseling outcomes (Norcross, 2011). Counselors in training (CITs) tend to possess certain traits at certain stages, such as high anxiety, lack of confidence, and a high focus on self in an early stage of development. Child-centered play therapy (CCPT) represents a specialization within counseling, and the current research highlights how the CITs learn CCPT within the classroom (Fall, Drew, Chute, & More, 2007; Homeyer & Rae, 1998; Kao & Landreth, 1997; Lindo et al., 2012; Ray, 2004; Ritter & Chang, 2002; Tanner & Mathis, 1995) but not within training experiences. Thus, the purpose of this study is to explore how counselors develop during an early training experience in CCPT utilizing a case study (Stake, 1995; Yin, 1994, 2003) of an existing supervision group. I utilized the Integrative Developmental Model (IDM) as a theoretical lens to better understand the participants. I used the constant comparative method (Lincoln & Guba, 1985; Merriam, 1998) to analyze the online blogs, semi-structured interviews, and focus group. Several themes emerged including counselor transformation, empathy-shared experience, performance anxiety, confidence development, CCPT buy-in, skill development, greater understanding of theory and of self, as well as valuing supervision and the supervisory relationship. I discuss the findings in relationship to current research on counselor development and within the context of IDM. I also provide implications for counselor educators and supervisors, as well as outline ideas for future research.

Table of Contents

List of Tables

List of Figures

Chapter One: Introduction

Relational elements of counseling, such as empathy, unconditional positive regard (UPR), and genuineness, represent well-evidenced therapeutic factors both as a set and as separate qualities (as a set: Cooper, Watson, & Holldampf, 2010; Elliott, 2002; Lambert & Okiishi, 1997; Orlinsky & Howard, 1978; Patterson, 1984; empathy: Bohart, Elliott, Greenberg, & Watson, 2002; Elliott, Bohart, Watson & Greenberg, 2011; UPR: Farber & Doolin, 2011; Farber & Lane, 2002; genuineness: Grafanaki, 2001; Kolden, Klein, Wang & Austin, 2011). Norcross (2011) highlighted the importance of therapeutic relationships and counselor qualities as contributions to the therapeutic relationship as critical to counseling outcomes. It seems that the development of the person of the counselor is important to outcomes for clients (J. L. Cochran & Cochran, 2015).

Further, it seems that often beginning counselors struggle with confidence (Gibson, Dollarhide, & Moss, 2010; Skovholt & Rønnestad, 1992; Worthington & Roehlke, 1979) and a form of performance anxiety that embodies their focus on self (Skovholt & Rønnestad, 1992) in early stages of training. The beginning counselors require a form of external validation (Gibson et al., 2010; Rønnestad & Skovholt, 1993; Skovholt & Rønnestad, 1992) before they can self-validate and view themselves as a counselor in the professional community (Gibson et al., 2010).

This exploratory study investigates the developmental process of counselors through initial experiences providing child-centered play therapy (CCPT), a specialty area in counseling. This study utilizes an existing CCPT supervision group, exploring their experiences holistically and in their own words with interactive blog journals, interviews, and a focus group addressing counselor development, skill development, and confidence development. Within this chapter, I introduce the population and the theoretical framework for this study. I outline the purpose of

the study including research questions and definitions of terms. In addition, I describe the delimitations, limitations, and the organization of the study.

Counselors in Training

Over the past 40 years, the profession continues to expand the literature surrounding counselor development, particularly of counselors in training (Choate, Smith, & Spruill, 2005; Gibson et al., 2010; Leach & Stoltenberg, 1997; Rønnestad & Skovholt, 2003; Skovholt & Rønnestad, 1992). Several components of the counselor development literature contributed to an understanding of counselors in training (CITs).

First, the research indicates a few common factors of CITs experience. Gibson et al. (2010) suggested that CITs began to develop professional identity as they entered graduate counseling programs, not upon graduation. Gibson et al. had the CITs define counseling and professional identity in their own words. CITs described intense anxiety early in their training experiences, particularly in regards to performance. An example of this type of performance anxiety included being hyper-focused on what to say next to a client and possibly missing what the client actually said (Rønnestad & Skovholt, 2003; Skovholt & Rønnestad, 1992). Another theme centered upon a "change from idealism to realism for the practitioner" (Skovholt & Rønnestad, 1992, p. 513). The move from idealism to realism demonstrated a counselor's move from a belief in "practitioner power to client power" (Skovholt & Rønnestad, 1992, p. 514). This represents the practitioner's ability to loosen control and allow the therapeutic relationship to be more effective as a result (Rønnestad & Skovholt, 2003; Skovholt & Rønnestad, 1992). CITs, later in their graduate studies, defined counseling as an empowering relationship between counselor and client (Gibson et al., 2010), or the counselor's role may be identified as a

facilitator of change (Mellin, Hunt, & Nichols, 2011), as opposed to being responsible for the change (Skovholt & Rønnestad, 1992).

Second, the CITs rely upon clinical experience to aid in growth of confidence, which aids in a positive development of professional development. Skovholt and Rønnestad (1992) discussed the importance of reflection in relation to CITs. Reflection represented an important component of professional development. This included the participants' ability to process alone and with others, as well as being open to feedback. Rønnestad and Skovholt (1993) advocated for continuous reflection to prevent from negative professional development such as burnout. Negative aspects of professional development included "incompetence, impairment, burnout, and disillusionment" (Rønnestad & Skovholt, 2003, p. 7). Rønnestad and Skovholt (2003) advocated for a greater understanding of counselor development, as a preventative measure of the negative aspects listed above. CITs identified key people ranging from supervisors, peers, to clients, as integral pieces of their development (Rønnestad & Skovholt, 2003; Skovholt & Rønnestad, 1992). Gibson et al. (2010) described how CITs later in their graduate work began to rely upon supervision, as opposed to classroom experiences, for more educational moments.

Third, CITs can develop particular attitudes, skills, and knowledge, as related to CCPT. Several studies suggested that play therapy courses increase students' attitudes, skills, and knowledge of CCPT (Homeyer & Rae, 1998; Kao & Landreth, 1997; Lindo et al., 2012). Literature suggests that CCPT supervised practice may be particularly important in counselor development. Tanner and Mathis (1995) advocated for novice play therapists' need for training on how to implement the play therapy skills in sessions with children. Lindo et al. (2012) found and described beginning play therapy students feeling anxiety surrounding skills and confidence in the approach while valuing supervised practical experiences. Similarly, Kao and Landreth

(1997) found beginning play therapy students in their study identified application opportunities as explanations for increasing knowledge and confidence in skill application. Thus, practical experiences and training in CCPT aided in beginning play therapy students' increase in confidence in skill development (Homeyer & Rae, 1998).

Another common experience of CITs learning CCPT surrounds the idea of CITs using CCPT skills outside of session or class (Kao & Landreth, 1997; Lindo et al., 2012) such as while babysitting (Lindo et al., 2012). Kao and Landreth (1997) described how play therapy affords the counselor both professional and personal growth, because they develop skills, such as acceptance, that can be used outside of session both with children and themselves. Many participants described their need for dominance, such as letting go of control, decreasing outside of class with family or at work.

Integrative Developmental Model

The Integrative Developmental Model (IDM) represents a developmental approach in training and understanding clinicians. The original model developed in 1987 appeared more general and simplistic in nature describing a supervisee's development through four stages (McNeill, Stoltenberg, & Romans, 1992; Stoltenberg, 2005; Stoltenberg & McNeill, 2010). The current IDM, accounts for supervisees changing as they gain competency in specific domains related to clinical practice (Stoltenberg, 2005; Stoltenberg & McNeill, 2010). Supervisees shift in "self and other awareness, motivation, and autonomy" (Stoltenberg, 2005, p. 859). The structure of self- and other-awareness includes both cognitive and affective development (Stoltenberg & McNeill, 2010). This model includes four levels of development (Level 1, Level 2, Level 3, and Level 3 [Integrated]). Supervisees change from a focus on self during Level 1, to a focus on clients in Level 2, finally to a combination of focus on clients with a self-awareness in

Level 3 (McNeill et al., 1992; Stoltenberg, 2005; Stoltenberg & McNeill, 2010). Level 3i counselors find the balance between all aspects of professional identity including the clinical domains of practice, as well as the needed personal characteristics that could affect the clinical roles (Stoltenberg & McNeill, 2010).

During Level 1, motivation levels are high because of the excitement of the new position. In Level 2, sometimes counselors begin to question skills, thus motivation wanes some. Then during Level 3, as the counselors regain confidence, motivation increases again (Lovell, 2002; McNeill et al., 1992; Stoltenberg, 2005; Stoltenberg & McNeill, 2010). Worthen and McNeill (1996) found within their study that most of the practicum-level supervisees identified disillusionment in the counseling process. To aid in determining developmental level, supervisors utilize the following domains: "intervention skills competence," "assessment techniques," "interpersonal assessment," "client conceptualization," "individual differences," "theoretical orientation," "treatment plans and goals," and "professional ethics" (Stoltenberg & McNeill, 2010, p. 25-27). From the IDM perspective, new supervisees can be expected to experience high anxiety early in their work, thus supervisors need to provide high structure. Further along in their development, the supervisees can take more ownership in the process. Leach and Stoltenberg (1997) identified Level 2 students as demonstrating more efficacy in working with difficult client behaviors. Yet supervisees can fall at multiple levels of development at the same time, thus the supervisor may need to provide different methods even within the same session (McNeill et al., 1992; Stoltenberg, 2005; Stoltenberg & McNeill, 2010). For this study, I use the framework of IDM, as a lens to understand the constructs of counselor development, skill development, and confidence development. This study seeks to add to the

literature on CITs in the context of supervision, thus the IDM perspective may aid in a better understanding of the participants.

Statement of the Problem

Rønnestad and Skovholt (2003) recommended that in order to actively prevent negative professional development such as impairment or burnout, the field needs to continue to explore the arena of counselor development. The emphasis on counselor development seems particularly important in CCPT. J. L. Cochran and Cochran (2015) offered the quote, "you're the best toy in the playroom" (p. xxv) or in other words, the person, the counselor, being with each client matters to the effectiveness of the work. A piece of this study focuses on the supervision relationship, and I believe that the person, the supervisor, being with the supervisee affects supervisee development, in a similar fashion as the counselor and child in CCPT.

Venart, Vassos, and Pitcher-Heft (2007) asserted that counselor wellness played a major role in the counselor's ability to relate to the client, and Eriksen and Kress (2006) indicated maintaining a positive wellness outlook on the treatment of clients. Yager and Tovar-Blank (2007) suggested that even though many counselors possess a natural drive to promote wellness with their work with clients, CITs need an extensive process of wellness promotion integrated into their counselor education and supervision. Wellness promotion, especially during the skill training and supervision phase of a counselor's development, increased counselor self-efficacy upon entering the field (Roach & Young, 2007) and assisted in the prevention of counselor burnout and impairment (Lawson, Venart, Hazler, & Kottler, 2007).

Purpose of the Study

The purpose of this study focuses on how CITs develop as professionals within the constructs of skill and confidence development while conducting CCPT. There is very little

research on how CITs learning a specialization, such as CCPT, develop while conducting therapy, and this serves as a follow-up to a pilot study already conducted. Existing literature on CITs and CCPT focuses within play therapy coursework (Homeyer & Rae, 1998; Kao & Landreth, 1997; Landreth & Wright, 1997; Lindo et al., 2012), as opposed to during supervision of the CITs conducting CCPT. This research could aid in counselor educators and supervisors' understanding of their CITs during practicum and internship experiences, particularly while learning CCPT. This study provides another outlook on the traits of CITs, according to the IDM, occurring during training experiences (Stoltenberg & McNeill, 2010). In addition, this study aims to better understand how learning CCPT affects the counselor, in particular.

Research Questions

1. How do the CITs describe their development while utilizing CCPT?
2. What was the CITs experience with the skills of empathy and unconditional positive regard (UPR)?
3. If the CITs recognize change, how do they describe the process? What factors assisted them in their change process?
4. How does supervision affect the CITs during the process of learning CCPT?

Definitions of Terms

In this section, I provide definitions for the concepts and terms relevant to this study.

- Counselors in training (CITs): Graduate counseling students at different stages of training from pre-coursework, prepracticum, preinternship, to pregraduation (Gibson et al., 2010). For the purpose of this study, the participants include students in practicum, internship, and a doctoral level internship or an advanced graduate student.
- Play Therapy Terminology:

The play therapy terminology will be described in further detail in chapter two, so this chapter provides a brief overview of relevant concepts.

- Child-centered play therapy: CCPT represents a counselor-facilitative approach that employs the child's use of play as a main form of expression, as opposed to traditional talk therapy (Axline, 1969; N. H. Cochran, Nordling, & Cochran, 2010).
- Empathy: Empathy requires the counselor to share in the experience of the child beyond just reflecting feeling and action, for example the counselor becomes a part of the feeling and the action and strives for shared experience throughout their work (N. H. Cochran et al., 2010).
- Unconditional Positive Regard (UPR): The counselor offers the child acceptance that allows the child to feel safe in the room. This acceptance can even be described as the counselor prizing the child, or the counselor demonstrates an attitude of finding it a privilege to work with the child (N. H. Cochran et al., 2010).
- Limit Setting: In order to provide a safe environment, the therapist establishes certain limits or boundaries for the child (Axline, 1969). Examples of appropriate limits include safety of counselor and child, physical property protection, and time (Axline, 1969; N. H. Cochran et al., 2010). N. H. Cochran et al. (2010) suggests using an empathy sandwich when establishing a limit, meaning the counselor addresses the child with empathy, sets the limit, and then reflects the child's feeling or reaction to the limit. Thus, the counselor addresses the child before and after with empathy. For example if a child is about to break a toy, then

the therapist will address the child with empathy, tell the child the breaking the toy is something the child may not do, and then follow-up with empathy.

Delimitations

The population represents the boundaries of this study. This study focuses on an existing group of CITs that were conducting CCPT for the first time, so this group does not represent the graduate students' program as a whole. This supervision group met during one semester, so the population is limited to the supervision group meeting during that particular semester. I chose to utilize a case study method in order to describe the nuances of the participants' experiences, so I did not utilize quantitative measures to account for the amount of change.

Limitations

The case selection represents a possible limitation, because they were an existing group the participants were not individually selected for this study, specifically. The participants represent a heterogeneous group, in terms of their previous clinical experiences, although they all lacked CCPT experience which aids in their homogeneity. Since IDM assesses across the developmental level, the previous clinical experiences could pose as a limitation, since they are not beginning this process with the same baseline experiences.

The description of the participants presents another possible limitation, because in order to protect their anonymity I can only provide limited description information. Because of this limited information, the reader may not have a full understanding of the participants' context and experience.

Another limitation of this study includes the technological difficulties involved in utilizing an online blog as a form of a journal. Because of these difficulties, the blog did not

begin as early in the semester, so some of their initial processing may not have been captured in this data set.

Stake (1995) identified how all types of research include interpretation, and continued by referencing that qualitative researchers are more involved in the interpretation including field observations, analyzing and synthesizing data utilizing subjective interpretations at times. This subjectivity can represent a possible limitation, but I utilized several methods to ensure reflexivity (Glesne, 2011) and triangulation of data (Merriam, 1998; Stake, 1995) that I outline in Chapter 3.

Organization of the Study

Chapter one presents a brief introduction of the CITs population and how the IDM theoretical framework fits into this study. It also includes a statement of the problem, the purpose, research questions, relevant definitions, delimitations and limitations of this study. Chapter two provides a more in-depth examination of the literature relevant to CITs and IDM that affect counselor development, skill development, and confidence development, particularly in regards to CITs learning CCPT. Chapter three presents an overview of the method and data analysis that will be utilized for this research study. Chapter four presents the findings. Finally, chapter five includes a discussion of the findings, including conclusions and implications for counselor educators and supervisors.

Chapter Two: Review of the Literature

In this chapter, I address the historical context of the counselor education field in particular the literature about counselor development. In addition, I include an overview of CCPT to aid in the reader's understanding of the participants' experiences. The chapter continues by addressing the existing literature that addresses CITs and CCPT. Finally, I provide an overview of IDM and how this theory intersects with the CITs' literature.

Historical Perspective

In the field of counselor education, CITs have become a focus of research in the last 50 years. Hogan (1964) wrote an expository piece about the development of counselors during their career. Hogan hypothesized four stages of development and suggested the need for supervisors to adjust supervision according to the level of development. Kaplan (1964) discussed the lack of research in regards to first year counselors. Kaplan outlined the need for research to help modify training programs to decrease problems for new counselors, as well as employers. In the next section, I provide an overview of the literature about the population of CITs.

Counselors in Training

Anxiety

The literature on CITs provides several common factors of CITs (Gibson et al., 2010; Rønnestad & Skovholt, 1993; Skovholt & Rønnestad, 1992; Stoltenberg, 2005; Stoltenberg & McNeill, 2010). Skovholt and Rønnestad (1992) researched development of counselors or therapists through various professional stages. Their study included 100 participants with 20 representing each stage ranging from first year graduate students, advanced doctoral students, to doctoral-level practitioners with 5, 15, and 25 years of postdoctoral experience. Skovholt and Rønnestad utilized a questionnaire and initial interviews with the participants, and then follow-

up interviews allowed participants to discuss the accuracy of the researchers' developed stage descriptions. The beginners in the field described anxiety and intense pressure during their graduate school experiences. Several authors identified this level of anxiety in beginning CITs (Gibson et al., 2010; Rønnestad & Skovholt, 1993; Skovholt & Rønnestad, 1992; Stoltenberg, 2005; Stoltenberg & McNeill, 2010).

Confidence Development

As CITs develop professionally, their confidence also changes throughout the process (Gibson et al., 2010; Skovholt & Rønnestad, 1992; Worthington & Roehlke, 1979). Gibson et al. (2010) conducted focus groups with CITs in various stages of their programs ranging from pre-coursework, pre-practicum, pre-internship, or pre-graduation. Newer CITs, pre-coursework and pre-practicum, relied upon external sources (i.e., coursework and professors), whereas the other CITs relied upon intrinsic factors (i.e., goal-setting for professional conference attendance) to progress their development of professional identity. CITs in pre-coursework and pre-practicum tended to rely upon expert definitions of counseling, whereas the pre-internship and pre-graduation groups provided more personal definitions of counseling. Pre-internship and pre-graduation participants focused more on the need for supervision as opposed to classroom experiences to provide learning.

Skovholt and Rønnestad (1992) suggested the participants' anxiety and lack of confidence did occur in loops that recycled through a professional's career but not in a predictable time period. The participants described utilizing peer support and professionals such as supervisors or faculty members as important in affecting professional development but also crucial for external support in early development during practicum and internship. Participants earlier in their work tended to define self through others' lenses of their work, whereas later in

development professionals found themselves able to be more true to themselves and discard pieces of the professional role that were incongruent.

Worthington and Roehlke (1979) conducted interviews with beginning practicum students and supervisors. The authors sought to identify supervisees' perceptions of supervisors' behaviors that the supervisees viewed as effective. The supervisees expressed anxiety about feedback, and they desired to gain confidence in becoming an effective counselor.

Counseling Skills

The research about CITs includes a focus on their counseling skills both during and after training (Carkhuff, 1969; Heppner & Roehlke, 1984; Leach & Stoltenberg, 1997; Rønnestad & Skovholt, 1993; Skovholt & Rønnestad, 1992; Worthington & Roehlke, 1979). In a seminal article, Carkhuff (1969) evaluated 16 types of training programs ranging from doctoral programs to clinical facilities. Carkhuff suggested the trainers' skill level as being crucial for the trainee to develop, because the review highlighted how the trainees' skills appeared to move in the same direction as the trainer.

In a study of 142 masters and doctoral students at Level 1 and Level 2, which represent the beginner and intermediate levels of counselor development, Leach and Stoltenberg (1997) evaluated students' self-efficacy as related to two domains of IDM including Intervention Skills Competence and Individual Differences. Utilizing the Counseling Self-Estimate Inventory (COSE) and the Supervisee Levels Questionnaire-Revised (SLSQ-R), Leach and Stoltenberg elicited information regarding the participants' beliefs of their skill as related to their level according to the IDM. The results highlighted the assumption of IDM that Level 2 students exhibited more efficacy in their microskills, working with difficult client behaviors, and counseling culturally diverse clients than the Level 1 students. The Level 2 participants

demonstrated more awareness of their own personal values and the relationship with the qualities of the client than the Level 1 students.

In their study about supervisee perceptions of supervisor behaviors, Worthington and Roehlke (1979) suggested an important aspect of their study's results including the supervisees valued being taught the needed clinical skills. The participants valued a supervisor that offered support, modeled the needed skills, and offered resources to do further research. Worthington and Roehlke outlined how the supervisors and supervisees differed in their perceptions. Supervisors discussed the value of giving accurate feedback as the most important aspect of supervision.

Heppner and Roehlke (1984) conducted three separate studies examining different factors of supervision and the effects on the supervisees. Within study two, the participants consisted of beginning counseling practicum students, advanced practicum students, and clinical interns. Similar to Worthington and Roehlke (1979), study two focused on the students' perceptions of supervision, and what behaviors they identified as affecting supervision. Heppner and Roehlke suggested that all supervisees identified gaining skills as important to viewing supervision as effective. The types of counseling skills differed among developmental level such as intake skills, case conceptualizations, to personal characteristics in the counseling relationship.

Influential people, as well as changes occur over time, affect CITs' counseling skills. Skovholt and Rønnestad (1992) described how clients influenced the participants' development by providing feedback to the therapist as a person, interventions, or professional crises such as not showing improvement. Gibson et al. (2010) explained how the CITs, newer to the profession in prepractium, identified professional identity by the skills needed for licensure, whereas CITs

later in the programs began to view it systemically. This section consisted of an overview of literature specific to CITs, and the following section provides an overview of CCPT.

Child-Centered Play Therapy

Theoretical Framework

CCPT derives from the person-centered approach of Carl Rogers (1961) and Virginia Axline (1969). Utilizing CCPT, the therapist believes that the child has the power within him or herself to change, if facilitated through the therapeutic relationship, and through his/her work in CCPT, the child finds the ability to begin to embrace all pieces of self, the positive and the negative and change in positive ways, if development is less than optimal currently (Axline, 1969; N. H. Cochran et al., 2010). While CCPT can be described as a nondirective approach, the counselor is an active participant utilizing specific skills throughout the process (N. H. Cochran et al., 2010).

Rogers and Axline hypothesized several factors that influence therapeutic change. Rogers (1951) asserts the client-centered therapist's attitude includes a respect for others and their ability to self-direct, as opposed to the therapist guiding the session. Rogers indicated how client-centered therapy is more than just a set of techniques. Rogers (1951) argued that a "counselor who is effective in client-centered therapy holds a coherent and developing set of attitudes deeply imbedded in his personal organization, a system of attitudes which is implemented by techniques and methods consistent with it" (p. 19).

Rogers (1992) indicated six conditions needed for personality and/or behavior change to occur. First, the client and therapist have to be in "psychological contact" (p. 827) with one another. Second, the client is experiencing distress caused by his/her incongruence. Rogers (1961, 1992) described how the therapist creates a safe environment for the client by being

congruent and demonstrating empathy and UPR for the client. Third, Rogers (1961) defined "congruence" (p. 61) as the therapist demonstrating genuineness and being truly present in the session communicating his/her thoughts and feelings of the client when necessary. Fourth, UPR describes the counselor's ability to care for the client without any agenda or ultimatum. Fifth, empathy represents the therapist's ability to understand and communicate the client's feelings and experiences (Rogers, 1961, 1992). Sixth, Rogers indicated the importance of the client feeling understood at least minimally because of empathy and UPR. Rogers (1961) indicated how research shows that the presence of these conditions, as opposed to "technical knowledge and skill," assist in "therapeutic change" (p. 63).

Axline adapted Rogers' philosophical principles to apply while working with children, thus developing CCPT. Axline (1969) described play as the "natural medium for self-expression, the child is given the opportunity to play out his accumulated feelings of tension, frustration, insecurity, aggression, fear, bewilderment, confusion" (p. 16). Axline explained how after the emotional expression, the child finds the power to show his/her real self. Upon the therapist's acceptance, the child can begin to embrace all parts of self. The therapist helps the child to feel more secure by offering acceptance and understanding.

Axline (1969) developed the following eight principles for the therapist:

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.

4. The therapist is alert to recognize the *feelings* the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behavior.
5. The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship. (p. 73-74)

N. H. Cochran et al. (2010) indicated the importance of the therapist striving for all eight principles, because these guidelines can create "a sense of emotional safety, acceptance, nondefensiveness, and willingness to explore and work on therapeutic issues" (p. 86).

Stages. Nordling and Guerney (1999) provided a conceptual framework of the stages within CCPT that children can experience. These stages provide the therapist with a view of a typical child's progression through CCPT. The stages consist of certain behaviors and/or themes that can be consistent across child. Nordling and Guerney indicated the importance of understanding that these stages are not always necessarily demonstrated in the same order, nor for the same duration with each child. Even further, these stages may not occur for every child, but these stages could occur with most children if the conditions of CCPT are provided. Nordling and Guerney (1999) defined the stages as "warm-up," "aggressive," "regressive," and

"mastery" (p. 17). The therapist also can conceptualize the client's work as being in a "transitional" stage, when the child was exhibiting actions or themes that blended two stages (Nordling & Guerney, 1999, p. 22).

The "warm-up" (Nordling & Guerney, 1999, p. 17) stage is characterized by the child exploring the playroom. As the child continues to orient himself/ herself to the playroom and the CCPT process, they may question or be more guarded of the therapist. The child may begin to test limits, partly to find out what the therapist will allow him/her to do while in special playtime. During this stage, trust and rapport between the client and therapist begins to form.

The "aggressive" stage is characterized by "emotional self-expression" (Nordling & Guerney, 1999, p. 19). This stage can look different depending on the child's presenting problem. For children referred for anger, their play in this stage can include more rage/anger, dominant or controlling behavior. For children referred for anxiety, their session themes focus on "emotional flexibility and self-assertion" (Nordling & Guerney, 1999, p. 19). Typically, during this stage the child demonstrates high-energy play and "assertive" verbalizations (Nordling & Guerney, 1999, p. 20).

During the "regressive" (Nordling & Guerney, 1999, p. 20) stage, the child's play centers on themes of attachment, nurturing, and relationships with others. Some examples of play in this stage include feeding a baby, cooking a meal, and protecting/rescuing dolls. Some children also exhibit age-regressed behaviors such as baby talk, curling up in the fetal position on the floor, and crawling around the room.

The "mastery" stage represents "a time of strengthening and consolidating therapeutic gains" (Nordling & Guerney, 1999, p. 21). During this stage, the child's play typically is solitary and/or interactive play. The child tends to exhibit competency, self-control, and surpass difficult

situations. Within this stage, the child can exhibit small moments of aggressive and/or regressive behaviors, and Nordling and Guerney (1999) explained these moments as continuing to resolve his/her therapeutic issues.

Limit setting. Axline's (1969) eighth principle in CCPT outlined the use of limits within the therapeutic relationship. A limit needs to be set for a variety of behaviors, for example, the physical safety of the client and/or counselor (Axline, 1969; N. H. Cochran et al., 2010). Axline recommended setting limits sparingly, but did indicate how limits give the child a sense of security. These limits assist in grounding the child to reality, and they assist in the child learning how to self-regulate (N. H. Cochran et al., 2010). N. H. Cochran et al. (2010) suggested that beginning therapists can struggle in stating limits as "specific, understandable, enforceable behaviors" (p. 159). N. H. Cochran et al. (2010) provided instruction for the therapist on how to state limits utilizing "the empathy sandwich" (p. 141). Essentially, the therapist addresses the child with empathy, sets the limit, and utilizes empathy again to address the child's response to the limit.

Benefits

Schaefer (1993) outlined fourteen therapeutic factors that lead to possible benefits for the clients.

1. Play assists in "overcoming resistance" (Schaefer, 1993, p. 5) by helping the client and therapist to build rapport and establish a working alliance.
2. Play provides children with "communication" (Schaefer, 1993, p. 6) of both conscious and unconscious thoughts and feelings. This provides the child and therapist with a better understanding of the child.

3. Play provides the child with a sense of "power, control, and mastery of the environment" (Schaefer, 1993, p. 7). The sense of mastery produces self-esteem, as the child continues to find mastery in his/her behaviors.
4. Play allows the child to demonstrate "creative thinking" (Schaefer, 1993, p. 7) for solutions to problems without the fear of negative consequences.
5. "Catharsis" (Schaefer, 1993, p. 8) refers to the release of strong emotions for therapeutic value.
6. "Abreaction" (Schaefer, 1993, p. 8-9) refers to the child experiencing traumatic events, and he/she plays out these events in a safe environment. This type of plays assists the child by allowing them to achieve mastery over traumatic events.
7. "Role-play" (Schaefer, 1993, p. 9) allows the child to pretend and practice new behaviors and skills. This type of play also helps the child experience empathy.
8. "Fantasy" (Schaefer, 1993, p. 10) assists children in learning about themselves. Within fantasy, they experience power, control, and feelings of mastery.
9. "Metaphoric Teaching" (Schaefer, 1993, p. 10) provides children with insight by allowing them to connect with characters and feeling a decrease in isolation.
10. Play assists the child in "attachment formation" (Schaefer, 1993, p. 11) with the therapist.
11. "Relationship enhancement" (Schaefer, 1993, p. 11) refers to the focus on the relationship between counselor and child. Play helps the counselor and child to form a positive relationship, where the child is accepted and feels safe. Rogers' suggested that this acceptance helps the client self-actualize (as cited in Schaefer, 1993).

12. Play provides the child with "enjoyment" (Schaefer, 1993, p. 12). This can contribute to a child's happiness. In addition, play can serve as a remedy to stress.
13. Play helps children to master "developmental fears" by exposing them to fearful situations during play, so they can begin to have positive feelings associated with fear inducing stimuli (Schaefer, 1993, p. 12).
14. "Game play contributes to a child's cognitive, emotional, and social development" (Schaefer, 1993, p. 13).

Clinical Implications

Schaefer (1993) suggested that play can "facilitate normal development" and also "alleviate abnormal behavior" (p. 3). A therapist can utilize CCPT as an intervention for an array of presenting problems. N. H. Cochran et al. (2010) recommended "applications for common childhood problems," "as well as anxiety, depression, oppositional defiance, sexual and physical trauma, grief, and adjustments to life events" (p. 6). CCPT can also be utilized as an adjunctive treatment, or it can also be used before diagnosis of organic or biological disorders. The rationale for using CCPT before diagnosis is because it can help rule out symptoms that are temporary or signs of adjustment problems or developmental delays (J. L. Cochran & Cochran, 2015). J. L. Cochran and Cochran (2015) indicated how clients with emotional problems also benefit from CCPT, because CCPT can help develop a stronger "internal locus of control and self-regulation and promotes a sense of self-worth, self-responsibility, and self-efficacy" (p. 6).

Bratton, Ray, Rhine, and Jones (2005) constructed a meta-analysis of 93 articles ranging from unpublished to published data about play therapy. This analysis included research that utilized play therapy as a treatment, including controlled research design and effect size. Bratton et al. recommended more rigorous research standards for outcome play therapy research, because

of the large number of studies that had to be excluded for lack of well-defined research procedures. Within this analysis, Bratton et al. suggested play therapy demonstrated efficacy for children demonstrating affective and behavior difficulties. Both humanistic-nondirective and directive treatments showed impact with humanistic-nondirective possessing a greater impact. The results indicated, "play therapy has a large effect on children's behavior, social adjustment, and personality" (Bratton et al., 2005, p. 385).

Increasing the focus on humanistic work, Lin and Bratton (2015) conducted a meta-analysis of 53 CCPT research studies from 1995-2010. This review confirmed the effectiveness of CCPT with a moderate effect size of .47. Two results highlighted the impact of CCPT with non-Caucasian clients and children under the age of seven. Lin and Bratton hypothesized this treatment choice as a great option for multicultural counseling. In addition, these results highlighted the impact of CCPT for younger clients, and the authors recommended more research for CCPT with older clients. Lin and Bratton (2015) suggested CCPT as an effective treatment for a variety of treatment problems with "greatest benefit for broad-spectrum behavioral problems, children's self-esteem, and caregiver-child relationship stress" (p. 54). This section included an overview of CCPT, and the following section includes a focus on CITs utilizing CCPT.

CITs Utilizing CCPT

Intersection between Attitudes, Skills, and Knowledge

The literature focuses on CITs learning CCPT possesses a focus on the CITs attitudes, skills, and knowledge surrounding CCPT (Fall et al., 2007; Homeyer & Rae, 1998; Kao & Landreth, 1997; Lindo et al., 2012; Ray, 2004; Ritter & Chang, 2002; Tanner & Mathis, 1995). Homeyer and Rae (1998) examined if the length of play therapy courses affected the students

within their attitudes, skills, and knowledge. In this study, Homeyer and Rae compared students in a three week summer course, to students in a five week summer course, to students in a semester long 15 week course. The students filled out the Play Therapy Attitude-Knowledge-Skills Survey (PTKASS) as a pre and post assessment of their course. Their findings suggested an increase in knowledge, attitude, and skills in all lengths of a course, except for attitudes in the five-week course. Homeyer and Rae explained how this group began the course with attitudes more in-line with play therapy beliefs and still experienced growth, even if not to a statistically significant level. All three groups indicated a growth in confidence after practicing their play therapy skills through training. However, the authors suggested longer training times, such as a 15-week experience, better prepared the students for a practicum experience.

Kao and Landreth (1997) utilized the PTKASS and the California Psychological Inventory (CPI) with an experimental group of 37 graduate students in an initial play therapy course training versus a control group of 29 graduate counseling students with no play therapy course or training. Their findings suggested that knowledge, attitudes, and skills of the students in the play therapy course increased, while their dominance and intellectual efficiency decreased. The researchers hypothesized the decrease in dominance and intellectual efficiency to be related to the concepts of letting the child take the lead. The intellectual efficiency refers to decrease in verbalizations and task initiation and completion, so allowing the child to take the lead could be a rationale for their decrease in intellectual efficiency. The decrease in dominance scores included items such as beliefs in others to guide themselves or letting go of control. Kao and Landreth proposed several reasons why the students demonstrated more positive beliefs about children such as: the major tenets of the CCPT, the practical experiences with children, and even possibly the professor's influence. For the increase in knowledge and confidence in skills, Kao

and Landreth presented several possible explanations such as role-playing and practicum experiences.

Lindo et al. (2012) utilized a mixed-methods approach to explore how play therapy students change in relation to their attitudes, beliefs, and skills, as a result of an introductory play therapy course. This study included 13 participants with limited training in play therapy. The researchers administered the PTKASS as a pre and post assessment of the play therapy course. At the end of the course, the researchers interviewed the participants to explore further the students' perceptions of the course. The participants demonstrated statistical increases in the attitudes, beliefs, and skills subscales of the assessment after the course.

Attitudes

The literature focuses on CITs attitudes as they relate to CCPT (Lindo et al., 2012). Lindo et al. (2012) found a theme surrounding the students' "behavior, attitudes, feelings, or perceptions" (p. 160) because of the play therapy course. The authors discussed how the play therapy course served as an opportunity to validate the participants' thoughts about self and children, for example, a participant felt that it validated her career choice with children, whereas several described how the philosophical tenets of this approach fit their beliefs about children such as that a child can lead the way to change. Lindo et al. suggested that as students began to utilize empathy on themselves (i.e., striving to feel and accept one's own emotions) that it creates the possibility of them extending that same attitude to clients and significant others in their lives. Lindo et al. (2012) continued, "Although not explored in this study, it seems reasonable to believe that when one is more accepting, empathic, and understanding of themselves and others, their relationship satisfaction with others in their lives will increase as well (p. 163).

Skills

The literature focuses on CITs skills as they relate to CCPT (Fall et al., 2007; Landreth & Wright, 1997; Lindo et al., 2012; Ray, 2004; Tanner & Mathis, 1995). Fall et al. (2007) surveyed 305 current registered play therapists supervisors (RPT-S) to examine their supervision and training experiences. A few of the most common issues of the supervisees that the supervisors identified included limit setting, ethics and legal issues, as well as skills and techniques related to the modality of play therapy. Another common issue included working with the parents of clients. When asked about issues they face within supervision, one of the most common themes included "ensuring competence and good practice of the supervisee" (Fall et al., 2007, p. 137). One particular skill in CCPT that poses a challenge for CITs is limit setting (Fall et al., 2007; Landreth & Wright, 1997; Ray, 2004).

Landreth and Wright (1997) described limit setting as a vital piece of the therapeutic process, but it also serves as a challenge to many beginning play therapists. The authors expressed the therapist needing balance in offering an accepting stance while still maintaining a safe environment that includes occasional limit setting. This study included 132 students in an introductory play therapy course with no other prior training in this modality. Landreth and Wright examined the students' beliefs about using limits before and after the course. The results indicated a trend of increased use of limits. The researchers highlighted how the therapists of the course showed more consistency in the use of limits. Landreth and Wright also compared the results to another study utilizing experienced play therapists as the participants, and the same consistency in limits remained. The participants tended to indicate use of limits in regards to physical aggression against the therapist, toys/environment, and safety of child.

Lindo et al. (2012) described how all of their participants had an overall positive experience in the course, however, they all also found the practical components of the course a challenge. The practical components consisted of "required home play sessions and the in-class supervised play therapy sessions" (Lindo et al., 2012, p. 160). The participants described the challenges including anxiety surrounding their skills and confidence in the approach within the practice play sessions. Yet also, half of the participants described the practice sessions as helpful. Nine of the twelve participants in this study expressed using the play therapy skills outside of the classroom.

Ray (2004) discussed the differences in basic and advanced skills in play therapy, and the author also provided suggestions for supervisors on how to address these skills in a developmental context of supervision. Ray outlined several common responses of beginning play therapists such as animating too much when speaking to children or providing too many verbal responses. The author identified limit setting as a frequent topic within supervision in regards to timing of limit setting, types of behaviors, and protocol when a child does not respond to limits. Another recommendation for supervisors included maintaining awareness of the supervisee's personal and professional limitations; because a supervisee's personal life could affect the case conceptualizations (Ray, 2004).

Tanner and Mathis (1995) advocated for novice play therapists' need for training on how to implement the play therapy skills in sessions with children. They indicated how the modality of CCPT encourages counselors to utilize the relationship building skills such as reflecting feeling and limit setting.

Knowledge

The literature focuses on CITs knowledge as they relate to CCPT (Ritter & Change, 2002). Ritter and Chang (2002) examined 134 play therapists' self-perception of multicultural competence and training experiences. The findings suggested that the play therapists reported multicultural competence, particularly in the domains of awareness and terminology. The participants felt the least knowledgeable about racial identity development. The play therapists indicated the same domains in regards to their training, meaning they felt most adequately trained in awareness and terminology, but least trained in racial identity development. This finding suggested "a relationship between multicultural competence and adequacy of training" (Ritter & Chang, 2002, p. 108). The authors' study also demonstrated the more classes or training in multicultural awareness indicated a higher self-perception of competence.

Integrative Developmental Model

Theoretical Framework

IDM represents a model of supervision that I use as a lens to have a better understanding of the participants and this study. CCPT is a counseling approach, where the counselor demonstrates qualities and skills, such as empathy and UPR. Yet the nature of the therapy is that it becomes individualized for each client, through the client's choices or actions and in the unique use of the therapeutic relationship. The therapeutic relationship of CCPT is deeply personal and therefore somewhat unique to each counselor (N. H. Cochran et al., 2010). Thus, the IDM is a particularly fitting model through which to understand participants in this study. This model is appropriate for this study, because IDM values the nuances of a supervisee's experience in training. Because of the nuances within CCPT as a specialization, this model can account for the uniqueness of each participant's experience. As referenced earlier, supervisors

utilize IDM to assess their supervisees' level of development, as well as their skill level among various domains (McNeill et al., 1992; Stoltenberg, 2005; Stoltenberg & McNeill, 2010). Supervisees' developmental levels may differ between domains (McNeill et al., 1992; Stoltenberg, 2005; Stoltenberg & McNeill, 2010), and this provides the supervisor with a more complex, accurate description of the supervisees (Stoltenberg & McNeill, 2010).

Three overriding structures. Stoltenberg and McNeill (2010) outlined "three overriding structures" (p. 23) that explain trainee's development in clinical practice. The three overriding structures include "self- and other- awareness: cognitive and affective," "motivation," and "autonomy" (Stoltenberg & McNeill, 2010, p. 23-24). The structure of self- and other-awareness indicates the trainee's focus on self and/or client. This component includes an emphasis on the trainee's thought process including working memory of sessions, reflection, and knowledge base. The affective component includes components such as the trainee's anxiety and/or the ability to utilize empathy. The structure of motivation includes "the supervisee's interest, investment, and effort expended in clinical training and practice" (Stoltenberg & McNeill, 2010, p. 24). Within this structure, a few examples of important factors would be the role of supervisor in increasing/decreasing motivation and/or the influence of regulatory mechanisms. The third structure of autonomy references the trainee's need for autonomy or independence over time. Autonomy includes changes in dependence on "supervisors or other authority figures" (Stoltenberg & McNeill, 2010, p. 24).

Specific domains. The specific domains that also serve as assessment factors of clinical practice are "intervention skills competence," "assessment techniques," "interpersonal assessment," "client conceptualization," "individual differences," "theoretical orientation" "treatment plans and goals," and "professional ethics" (Stoltenberg & McNeill, 2010, p. 25- 27).

These domains are broad and trying to be inclusive of all areas of clinical practice. Stoltenberg and McNeill (2010) aimed to increase specificity by including the clinical domains, rather than just labeling a supervisee with a level of development.

Levels of counselor development. Stoltenberg and McNeill (2010) outlined common traits or factors of trainees in each level of development. Level 1 therapists may encompass any of these traits among the overriding structures. They may exhibit high motivation, anxiety, and focus on self as opposed to clients (McNeill et al., 1992; Stoltenberg, 2005; Stoltenberg & McNeill, 2010). Within supervision, they may display high dependence on the supervisor and need structure in the process (McNeill et al., 1992; Stoltenberg & McNeill, 2010).

Level 2 therapists may vacillate between high and low motivation depending on case complexity (Stoltenberg & McNeill, 2010) and feelings of inadequacy within the work (McNeill et al., 1992; Stoltenberg & McNeill, 2010). They can begin to turn their focus away from self into client, which means they can demonstrate understanding of the client, in turn possibly engaging empathy (Stoltenberg, 2005; Stoltenberg & McNeill, 2010). The cognitive and affective development can cause the trainee to over identify with the client. The supervision relationship can become more strained in this level as the trainee vacillates between autonomy and dependence (McNeill et al., 1992; Stoltenberg & McNeill, 2010).

Level 3 therapists can demonstrate more stable motivation (McNeill et al., 1992; Stoltenberg & McNeill, 2010), with slightly higher levels as they become more comfortable in their counselor identity (Stoltenberg & McNeill, 2010). Their affective and cognitive development includes the ability to process both the client and personal reactions within the therapeutic relationship (McNeill et al., 1992; Stoltenberg, 2005; Stoltenberg & McNeill, 2010). Within supervision, they have learned how to reflect upon their own strengths and weaknesses,

as well as take in feedback and compare it to their own personal beliefs of self and client (Stoltenberg & McNeill, 2010). McNeill et al. (1992) indicated that supervision is not only less structured, but supervisors need to balance support and challenge supervisees to make decisions on their own.

Level 3i therapists are "fully functioning across domains" (Stoltenberg & McNeill, 2010, p. 44). Stoltenberg and McNeill (2010) described how rare it is for clinicians to reach this level of development. When a therapist does reach this level, they are considered an expert in the field. Stoltenberg and McNeill (2010) utilized the following metaphor of a rock climber to explain the theory of IDM further:

> Imagine the client to be a novice climber who has slipped into a crevasse (a hole) and is calling to the supervisee for help. The Level 1 climber (the supervisee) may stand at the edge of the crevasse, mountain-climbing manual in hand, and yell down advice or focus primarily on emotionally supporting the stranded climber. Alternatively, the supervisee may go off and seek guidance from the experienced team leader (the supervisor) concerning how to assist the stranded person (client). In either case, the supervisee is attempting to assist the client despite having had little or no experience with or personal understanding of the process. He or she is standing on the edge, sending interventions down to the client ("you feel stuck," "reach for the rock," "stretch for that handhold," "that's how I've done it," "you can do it"), hoping the client will find his on her way out. Communicating a developing understanding of the climbing process to the stranded climber or calming fears, and seeing that this can have an impact (the climber might make some progress climbing out), is sometimes sufficient. The supervisee's perception of his or her understanding of rock climbing is enhanced, and he or she feels the power of

therapy and begins to develop confidence. On the other hand, a lack of progress by the climber in escaping the crevasse may be discounted by the supervisee as the climber "not yet being read to climb out" (p. 32-33).

Intersection of theoretical principles. Stoltenberg and McNeill (2010) provided many examples of how the overriding structures intersect with the domains across developmental levels. One of the examples Stoltenberg and McNeill provided included a Level 1 supervisee. This supervisee was worried about performance, so the supervisee utilized the supervisor's theoretical orientation to model his/her own work after the supervisor. This brief example displays the self- and other- awareness and autonomy structures intersecting with the domain of theoretical orientation in clinical practice. This could provide a supervisor with a better understanding of the supervisee, who is falling within Level 1 of his/her development.

Relevant Research

As a result of Stoltenberg and colleagues ongoing development of the IDM over the last 25 years (Stoltenberg, 2005), researchers began examining the IDM related to various factors (Leach & Stoltenberg, 1997; Lovell, 2002; Worthen & McNeill, 1996). For example, Worthen and McNeill (1996) explored "good" supervision events from the supervsisees' perspectives, and they indicated supervisor qualities of "empathy, a nonjudgmental stance toward them, a sense of validation or affirmation, and encouragement to explore and experiment" (p. 29). In addition, the supervisor normalized the supervisees' experiences, sometimes by using self-disclosure of similar moment in their training. Typically, through these experiences the supervisees found themselves able to put aside their self-protectiveness and learn from the experience and the supervisors' input. Lastly, Worthen and McNeill (1996) suggested that "outcomes of good supervision" (p. 28) included the supervisees' confidence increasing, as well as an increase in

their abilities to conceptualize clients more broadly. The supervisees also found themselves more ready to face the challenging situations, and excitement for approaching the situation, increasing in trust within the supervisory relationship, and professional identity. In addition, supervisees further along in their development described being more grounded in their confidence (Worthen & McNeill, 1996).

As a second example, Leach and Stoltenberg (1997) researched individual and skill differences across the eight domains of IDM in Level 1 and 2 students, as related to their self-efficacy of working with reactive depressed and sexually abused clients. Level 2 students reported higher self-efficacy in relation to sexually abused clients, when they had seen more of these types of clients prior to this current experience. On the other hand, supervisees reported no difference among depressed clients, and the authors suggested this might be because of perception of difficulty of presenting problem. In regards to working with clients with more cultural differences, Level 2 students indicated greater efficacy.

Lovell (2002) explored the relationship between adult cognitive development and level of development, according to the IDM, in CITs. The results indicated the multiple complexities and variance for CITs consistent with the theory. The author found the cognitive developmental level to be the strongest predictor of the loss of scores in structures such as motivation. Lovell suggested an explanation that new counselors experience lapses in motivation. Lovell recommended having students take the Supervisee Levels Questionnaire Revised (SLQ-R) on a consistent basis throughout their program. Also, Lovell suggested that supervisors be aware of the disequilibrium that can occur even in supervisees that rapidly ascend through the levels.

In sum, the IDM represents a large body of literature in relation to supervision and CITs. Stoltenberg and colleagues have continued to research and adapt this model accordingly

(McNeill et al., 1992; Stoltenberg, 2005; Stoltenberg & McNeill, 2010). Other scholars have aided in this process by adding to the literature while examining a variety of factors related to the IDM (Leach & Stoltenberg, 1997; Lovell, 2002; Worthen & McNeill, 1996) and some of these factors (e.g., confidence development) are related to this study.

Chapter Three: Methodology

Method

In this chapter, I discuss the research questions, participants, procedure, instrumentation, and the data analysis procedures for this study. Little research has focused on counselor development within a specific modality. This study aims to expand the literature on how child-centered play therapists develop while administering CCPT. This study uses a qualitative design, specifically a case study design (Stake, 1995), to explore both the similarities and the nuances of the CCPT CITs experiences. While Stake (1995) describes case studies as qualitative in nature, and Yin (1994, 2003) suggests that case studies can be either quantitative or qualitative, the important feature of this method for this study is that this research occurs in the real world, as opposed to a laboratory (Yin, 1994). A case study allows for multiple descriptions and interpretations (Stake, 1995), thus this method allows for each of the participants' experiences to be described.

Specifically, Yin (1994) defined a case study as an "an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between the phenomenon and context are not clearly evident" (p. 13). This study is bound by time and the participants involved, which will be discussed further in this chapter. Merriam (1998) explained that most studies exploring educational practice can be considered case studies. Yin (1994) suggested that an "extreme or unique case" (p. 39) can be a reason for selecting a single case design. This study represents an unique case, because the CITs involved utilize CCPT, a specialty in counseling. While this study seeks to understand the CITs individual experiences, it also tries to develop an understanding about counselor development during supervision of CCPT. Merriam (1998) described case studies as focusing on the "process rather than outcomes, in

context rather than a specific variable, in discovery rather than confirmation" (p. 19). Yin (2003) discussed how within an exploratory case study the researcher observes "a social phenomenon in its raw form" (p. 6). This study seeks to understand each of those components (i.e., process, context, and discovery) of the CITs experience during CCPT. In this study, I utilized the participants' interactive blogs during supervision, responses during individual interviews mid-way through the semester, and interactions in a focus group processing the experience at the end of the semester to understand their process of development in the context of engaging in CCPT.

Case studies seek to answer how or why questions (Yin, 1994). The author outlined how what questions can be exploratory in nature and relevant to case study research. Yin (1994) continued that these types of questions aid in developing "hypotheses and propositions for further inquiry" (p. 5). Thus, this study's research questions include a combination of exploratory what and how questions and they follow below.

Research Questions

1. How do the CITs describe their development while utilizing CCPT?
2. What was the CITs experience with the skills of empathy and unconditional positive regard (UPR)?
3. If the CITs recognize change, how do they describe the process? What factors assisted them in their change process?
4. How does supervision affect the CITs during the process of learning CCPT?

In Table 1, I demonstrate how the research questions might align with the IDM. Naturally, the participants may address different structures and domains within their responses.

Table 1: Research Questions Related to IDM

Research Question	IDM Overriding Structure and or Domain
1. How do the CITs describe their development while utilizing CCPT?	"Self- and Other- Awareness" (Stoltenberg & McNeill, 2010, p. 23)
2. What was the CITs experience with the skills of empathy and unconditional positive regard (UPR)?	"Intervention skills competence" (Stoltenberg & McNeill, 2010, p. 25)
3. If the CITs recognize change, how do they describe the process? What factors assisted them in their change process?	Dependent on the participants' response about their change
4. How does supervision affect the CITs during the process of learning CCPT?	"Autonomy" (Stoltenberg & McNeill, 2010, p. 24)

Context

Stake (1995) indicated the need for providing the context of case studies to provide the reader "with a sense of *being there"* (p. 63). The CITs in this study practiced CCPT, as a part of community program, providing counseling services to high-risk children in need in preschool and elementary settings. The children's ages range from 3-8 years old. Teachers and principals work together to provide referrals of children in need of these services. Thus, the CITs do not conduct intake sessions. Upon referral, the principals coordinate the needed paperwork from parents and teachers for the clients to receive the counseling services. Two supervisors worked with the CITs, either at the preschool or elementary school. The supervisors possess extensive training and advanced certifications in CCPT. Together they conduct a comprehensive course in CCPT, and the participants in this study completed this course.

As a piece of this community program, the CITs participated in individual weekly supervision with their respective supervisor depending on whether the CIT was seeing clients at the preschool or elementary school. Then all the participants and both supervisors engaged in

group supervision twice a month for 17 weeks. Typically, individual and group supervision included tape reviews of sections of the participants' work. The participants generally selected the tapes, but sometimes the supervisor prompted the tape selection. Generally, the supervisees selected these tapes for either feedback or for specific questions about their work.

Participants

As indicated by Stake (1995) and Yin (1994), a case study needs boundaries. As stated previously, this study is bound by time and the participants involved. The participants included an existing supervision group of four CITs. As stated earlier, the CITs had completed a comprehensive skills course in CCPT. They later expressed interest in providing services within the professors/supervisors' service/research project. I selected this group and asked them to participate in this study, and they all agreed to be a part of the study.

The participants included three masters students, a clinical mental health student and a school counseling student completing their respective internships, and a clinical mental health student completing practicum. The fourth participant is a counselor education doctoral student completing a clinical internship. For two out of the four participants, this experience included their only clinical experience during this semester. The school counseling participant was concurrently completing a school counseling internship. The clinical mental health internship student utilized two different internship sites, one administering CCPT and the other at a local agency with a different specialization focus. The practicum masters student clinical experience prior to this semester included no prior clinical experience, except concurrently the student served in a different capacity, which gave her minimal opportunities to practice her clinical skills with adults. The internship masters' students had previously completed practicum, approximately a day a week of closely supervised counseling services, before this experience,

and they were in their final semester of internship. The doctoral student had previous counseling experiences both in his/ her masters and post masters work, equating to approximately 3 years of clinical experiences. Even though they possess a range of previous clinical experiences, they are similar in their lack of CCPT experience and supervision. For all the participants, this experience represented the first time they were administering CCPT.

In order to protect the anonymity of this group, I purposely chose not to outline more specifics (e.g., gender and racial/ethnic backgrounds) about the participants. For the ease of the reader, I utilize all female pronouns throughout the report of this study.

Procedures

In accordance with the Institutional Review Board procedures, the participants signed an informed consent (Appendix A) for participation in the blog journals, focus group, and interviews. These forms outlined the information about the study including the benefits and possible risks. The consent also informed the participants that involvement was voluntary, and they could withdraw at any time. The participants understood that their participation would not affect their grades in their practicum or internship experiences.

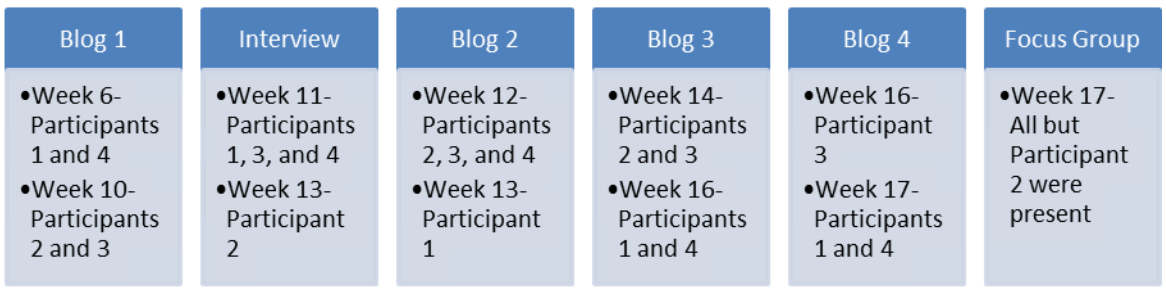

Figure 1: Data Collection with Timeline

Figure 1 outlines the data collection procedures including the timeline of occurrence throughout the 17 weeks. The data collection process utilized an online blog four times through the semester as a form of journal. However, one participant did not complete the fourth journal entry. As recommended by Paulus, Lester, and Dempster (2014), the blogs included several measures to protect the participants' anonymity. The blogs were password-protected, not searchable via Google, and the participants used pseudonyms. Because of technological difficulties, these began halfway through the semester by week 10 and continued until the end of the semester, week 17, as opposed to starting at the beginning of the semester. The timing of the writings were spaced around the group supervision meetings, and I recommended that they occur by the 10th, 12th, 14th, and 16th week of the semester. I encouraged the participants to write about their experiences in conducting CCPT. I explained to the participants that I wanted this to be a space where they could respond to what was happening within them while engaging in CCPT. To ensure client confidentiality, I asked that they not include any client information in their writings. The participants had access to the other participants' blogs to read and comment on their writings. No participant chose to comment on the blogs. This offered another way for the CITs to interact with one another outside the supervision group if they chose to during the course of the semester.

Halfway through the semester, weeks 11-13, I conducted 30-45 minute semi-structured interviews with each of the participants. I asked the following questions (Appendix B):

- Tell me about your experience with CCPT.
- How have you (either as a counselor or person) changed, if at all, while utilizing CCPT? What has helped this change to occur?

- Tell me about your experience utilizing unconditional positive regard and empathy through CCPT and supervision.
- Tell me about your experience with supervision.
- Anything else that can help me understand "what" your experience is with CCPT and "how" you have experienced it?

I did not ask the question about supervision to two participants, so those two participants utilized a blog entry to respond to that particular question. At the end of the semester, week 17, I conducted a semi-structured focus group during their final group supervision meeting of the semester. I addressed the same questions as the individual interviews (Appendix B), and in both situations, I asked follow-up questions as needed to ensure a better understanding of the participants' responses. One participant was not present for the focus group, so three participants, the two supervisors, and myself were involved in this focus group. The blogs and interviews allowed the participants to describe their individual experiences, while the focus group gave the opportunity for the collective experience of the group. In addition, the focus group fit into the educational format of the existing supervision group and allowed for closure at the end of the training experience.

The pilot study explored the CITs in a previous supervision group of the same supervisors. The CITs served as participant researchers and piloted similar versions of the interview questions for this study in journal format. I also interviewed previous interns about their experiences with CCPT, and based on that study we added the blog element for an open-ended opportunity for the participants to explore their development.

Data Analysis

Stake (1995) suggests the analysis of data does not necessarily start at a particular point; however, it can begin with initial impressions. In order to begin the data analysis process, first, I compiled the blogs into Word documents separated by each participant's pseudonym. Second, I transcribed the participant interviews and the focus group. This all serves as the data from each participant's experience as a child-centered play therapist.

Upon completion of the interviews, I downloaded the files onto my password-protected computer within compliance of IRB. I chose to utilize Inquirium (2012) InqScribe, as my transcription software. This software offers researchers several affordances to the research process. Paulus et al. (2014) discussed the affordance of InqScribe's ability to synchronize the transcript to the media file. The affordance of synchronization was important, because I could easily access different parts of the interview and ensure the trustworthiness of the transcript. The transcript assisted in understanding the interviews and focus group during data analysis. Konopasek (2008) echoed this suggestion by saying that through the documents, a researcher can "travel in time and space" (Assigning primary documents section, para. 4). The transcripts allowed me and the participants to travel in that way back to the interview or the focus group.

For this study, I utilized a thematic coding process to provide both direct interpretation and categorical aggregation (Stake, 1995) of the data. I employed a research team to assist in the coding process. Utilizing colleagues serves as a strategy to ensure the validation of data (Creswell, 1998; Stake, 1995). In addition, the research team aids in investigator and theory triangulation by using multiple sources to evaluate the same data (Stake, 1995). The research team included two master's students with education and training in CCPT similar to the

participants' previous coursework. I met with the team beforehand to train them on the following process.

For this study, I utilized the constant comparative method by Glaser and Strauss (Lincoln & Guba, 1985; Merriam, 1998). This method originated as a process for grounded theory, but this method can be relevant for other qualitative methodologies because of the concept-building nature of qualitative research (Merriam, 1998). Glaser and Strauss (1967) outlined four steps to their method being, "1. comparing incidents applicable to each category, 2. integrating categories and their properties, 3. delimiting the theory, and 4. writing the theory" (p. 105). Steps one through three focus on the researcher creating, merging, and consolidating the data into categories.

Lincoln and Guba (1985) provided separate explicit procedures for the unitizing and categorizing processes, and for the purpose of this study, I combined these into one list. In addition, I adapted this process for an electronic system, as opposed to the notecard system.

1. The members of the research team individually determined units of meaning. These units possess the characteristics of being "heuristic" (Lincoln & Guba, 1985, p. 345) or eliciting action from the researcher, and the units can stand alone.
2. Upon identifying the unit, the researcher enters the unit into the computer.
3. After identifying all units, the researcher selects the first unit, reads it, and notes the contents. During this step, the researcher makes notes and highlight important factors that arise in the data. Merriam (1998) discussed this as an opportunity for the researchers to have a "conversation with the data, asking questions of it, making comments to it" (p. 181).

4. The researcher chooses the second unit, reads it, and notes the content. The researcher begins to determine if the second unit is a "look-alike" or "feel-alike" (Lincoln & Guba, 1985, p. 347) with unit one. If so, then they are placed together, and if not the researcher creates a new unnamed category in the list.
5. If a new unit either does not fit the previous or a new lists, then the researcher creates a new miscellaneous list
6. As the lists became longer, the researcher writes a rule "that seem to characterize the residue of cards" (Lincoln & Guba, 1985, p. 348) and then provides a title of the category for the rule. Then the researcher reviews the list to make sure the units all fit under the provisional rule. This category review causes the researcher to either move some units to new categories, to the miscellaneous pile, or create a new rule.
7. Once the researcher categorizes all the units, he/ she reviews the miscellaneous list and category set to either edit or discard the relevant units. During this stage, the researcher reviews the categories for overlapping qualities, as well as possible relationships or possible sub-categories.
8. The research team now meets together to discuss his/ her respective category list. I served as the leader for these meetings.
9. The team leader begins by selecting a category, reading the title and rule aloud, and questioning the other researchers for similar categories and definitions.
10. Then the team discusses the possible similarities and differences in the teams' categories until they agree upon category names and rules.
11. This process continues until they discuss all the categories (Lincoln & Guba, 1985).

12. The research team for this study repeated the above process one more time until we reached consensus on all units and categories.

Following these 12 steps, I conducted a member check by contacting the participants via email and providing them with a brief overview of the findings within their individual data points. This allows the participants to clarify or edit their experiences accordingly. Stake (1995) warns against the misrepresentation of data, so I believe that including the participants in the analysis process is crucial in accuracy of their experiences. Member checking and triangulation of data represent important parts of ensuring accuracy of data (Creswell, 1998; Glesne, 2011; Merriam, 1998; Stake, 1995).

Triangulation Procedures

I conducted several triangulation techniques to ensure the trustworthiness of the data collected (Creswell, 1998; Glesne, 2011; Merriam, 1998; Stake, 1995). I acknowledge that my own training within CCPT represents an integral aspect of my own personal counselor development. I have engaged in CCPT during two internship experiences under different supervisors, also I have participated in multiple trainings offered through relevant professional organizations. During the pilot study, I responded to similar questions as the participants in a journal and focus group format. This served as an initial bracketing experience for me in the recognition of some of the following thoughts.

Several of my core ideas that connect with this study: (a) all children deserve a chance to be heard and understood (b) a child has the power within him/herself to lead the way within the therapeutic setting (c) CCPT offers the child the ability to learn how to self-regulate his/her own emotions and actions (d) With proper supervision, CCPT aids in a counselor's training and development of the core conditions of providing deep empathy and UPR (e) With increased

confidence in CCPT, the counselor begins to believe in the power of CCPT more. I expect to find similar beliefs of the other participants to my own, because of the similar training we all received. I also assume to find that the participants also shared in their belief in CCPT efficacy.

To aid in separating out personal bias, I utilized a reflexive journal as recommended by (Glesne, 2011), as well as processing with my chair. Glesne (2011) recommends researchers utilizing reflexive thought to understand their personal thoughts in relation to the research. I engaged in this practice by recognizing the possibility of personal bias which Merriam (1998) addresses how the researcher needs to be aware of this possibility. Watt (2007) indicated that, "By engaging in ongoing dialogue with themselves through journal writing, researchers may be able to better determine what they know and how they think they came to know it" (p. 84). Also, I utilized member checking (Glesne, 2011; Merriam, 1998) procedures while collecting data to allow the participants an opportunity to discuss the results in reference to their experience. During data analysis, the research team utilized the comparative coding process referenced earlier. This represents another technique to ensure that the different researchers attempted to bracket out their personal beliefs about CCPT from the data as a whole. This allowed the researchers to challenge one another on whether or not the themes were representing his/her subjectivity or the participant's individual experience.

Chapter Four: Results

In this chapter, I provide a brief overview of the data analysis procedures, present the results and review the themes and subthemes that derived from the constant comparative method as described by Lincoln and Guba (1985). In addition, I utilize direct quotes from the participants to provide "the reader the vicarious experience of having been there" (Merriam, 1998, p. 238).

Data Analysis

As described in detail in chapter three, I utilized the constant comparative method (Lincoln & Guba, 1985) with the assistance of a research team. As we developed a list of categories that became the primary themes of this study, I followed member checking procedures (Glesne, 2011; Merriam, 1998) by sending a copy of data (i.e., the individual participant's blogs, interview and focus group transcript), and then later I sent preliminary themes via email to the participants. Two of the four participants responded upon receipt of the copies of their blogs, interview and focus group transcripts. One participant explained that she is currently looking for a counseling position, and expressed just re-reading the particular data points made her happy and gave her "a new vote of confidence." I followed up with each of the participants via email with the preliminary themes that the research team established. One participant replied to the email agreeing that these themes encompassed her experience. Other participants did not respond.

In the following sections, I provide the research questions and the relevant themes that connect with the question. I include a figure of each set of themes for a visual image of the hierarchical nature of some of the themes. I also provide a table with the theme and one quote to exemplify each theme. I describe the data sources utilized for each research question. I found

that the data sources appeared to produce proportional amounts of data, and that the participants discussed a variety of themes in all sources.

Research Question #1: How do the CITs describe their development while utilizing CCPT?

All of the sources of data (i.e., the blogs, interviews, and focus group) served as sources for this research question. Each participant commented extensively on her development.

Counselor Transformation

The theme of *counselor transformation* refers to the growth or change process that occurred in the participants. Three of the four participants described their development as an opportunity to grow, or they recognized changes within themselves alongside of the changes with the children they worked with in CCPT. Words they used to describe their development included "transform," "transition and progress," "lifelong process," and "rewarding." One participant described how the changes within herself helped her to see that she wanted to continue the work, because she wanted to continue to challenge herself to grow in this capacity.

One participant wrote about her development saying, "As a new child-centered play therapist, my learning curve has been quite large..." In her interview, a participant discussed a few personal hardships that she went through as a child, and she said CCPT has helped to, "open myself back up to the future…it has allowed me to almost heal in a way." In the focus group the same participant said, "I found myself in a very great place, a place I could have never imagined being without it."

Empathy-Shared Experience

The theme of *empathy-shared experience* actually highlights a skill that the participants report developing during CCPT. I include this theme within this research question, because the

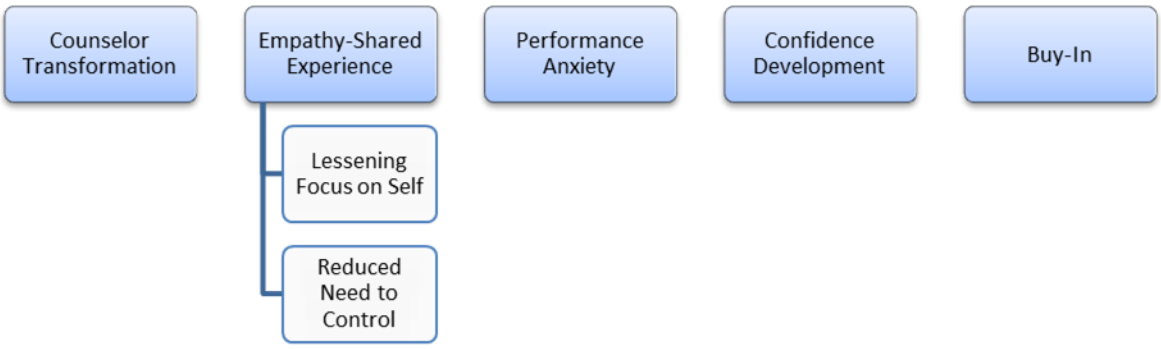

Figure 2: Research Question #1 Themes

Table 2: Research Question #1 Themes and Examples

Theme	Example
Counselor Transformation	"But it [CCPT experience] has been a really big growth process for me, and I think it pushed me so much…"
Empathy-Shared Experience	"I know that as long as I am staying with the child, I won't get lost in the session…"
Lessening Focus on Self	"you're usually thinking about your clients and the people that you're working with. So, it's a very selfless mindset and attitude."
Reduced Need to Control	"I do have a lot of control issues and play therapy kind of forces you to confront them, because you are essentially completely out of control in that session"
Performance Anxiety	"I also started very concerned about skills and just thinking a lot about what I wasn't doing, when I wasn't seeing what I thought I should be seeing, and I think that took away from focusing on the child."
Confidence Development	"I am confident in my skills and barely have to put much thought into utilizing them."
Buy-In	"helps you trust the process, that leap of faith that you [CIT] will do that, if you set the environment right…that they [clients] will get there [embracing the process]."

subthemes that follow connect to the participants' ability to be present with their clients. They suggested that when they were able to be present with the clients they changed in relation to the subthemes of *lessening focus on self* and *reduced need to control*. This represented the participants' experience pertaining to utilizing the concept of remaining in the 'here and now' with the clients or just 'being with'. The *shared experience* highlighted the participants' ability to remain present in the session. One participant explained the shared experience poignantly comparing it to how other people may perceive the work saying,

> Because most of the time you're not really doing anything than just being there, to someone walking into the room you might just seem like someone just sitting there, but really it's way more going on than that. It's internal. So I think in that way it's been a huge opportunity to sit with those emotions and be ok if they rise to the surface and don't do anything with them. But just be there and be ok with what pops up.

All the participants described the importance of being present in the session, and one clarified, "I know that as long as I am staying with the child, I won't get lost in the session." The participants described this shared experience as aiding in them "not having an agenda for things that need to be accomplished" or even personally not focusing on their "to-do list" in session. They explained a process of turning off an internal dialogue either about themselves personally or a list of things that they should be saying or doing in session. One participant explained how the process of the shared experience has produced a sense of calm or peace within her.

Lessening focus on self. This subtheme represents how when the participants were present with their clients, they became *less focused on self*. One way they became less focused on themselves is they stopped focusing on their personal "to-do list." They stopped being preoccupied with what they should say, do, or even where to sit in session. One participant

described how beginning to not focus on herself was a rewarding by-product of conducting CCPT. She explained, "you're usually thinking about your clients and the people that you're working with. So, it's a very selfless mindset and attitude. It is funny how being so selfless can fill up your own cup in ways, and that's been a rewarding experience**."**

Reduced need to control. This subtheme describes how the participants let go of *control* while engaging in CCPT. All of the participants described the process of letting go of control as integral in their development. The different aspects of their work they had to let go of included the following: thoughts, things they should have said, traits (e.g., loosening up) or what the CIT did not know or could not control. Three participants described the importance in giving control to the client and allowing the child to lead the way. One explained further that even the child chooses to be in relationship with you. Another described how she struggled with giving the client control in role-plays, and her tendency was to become over-involved. She explained how her supervisor helped her address this skill saying, "you're almost like a puppet. You need to allow them to kind of pull the strings."

One participant described how she had to let go of her preconceived notions of how CCPT would go based on her course in CCPT, particularly in relation to the stages of CCPT. She began to trust what was supposed to happen would happen. Two participants indicated that during termination they had to let go of worry for the clients' growth or wellbeing. One wrote about how she had two clients that left school, so it was a premature termination, meaning it was an unpredicted reason for ending CCPT. Both participants recognized they had done as much as they could, and they had to trust in the small impact they had made. They also described needing to trust in the child to continue in their growth process. Similarly, a participant wrote about how

she used to take on "unwarranted responsibility," and how letting go of control allows the client to take on more of the responsibility in their counseling experience.

Two participants recognized how giving the client control affected them, particularly with anxiety. One participant wrote, "Earlier on, I worried about the unpredictability of following the child's lead and not having a particular plan for the session. However, I have found an interesting certainty about the process that has become very assuring to me." The other participant expressed, "Giving up that control made it an anxious thing for me. It was very anxiety ridden." In another part of the interview she admitted to having control issues and said, "play therapy kind of forces you to confront them, because you are essentially completely out of control in that session."

Three other themes occurred for the participants in relation to the research question about counselor development including: decrease in *performance anxiety*, increase in *confidence development,* and an increase in CCPT *buy-in*.

Performance Anxiety

All the participants described moments of experiencing *anxiety* or self-doubt related to their work with CCPT. All described instances, especially in the beginning in their work, where they doubted whether or not they could provide CCPT based on the skill set needed. Three participants also expressed doubt in their counseling skills in general in the beginning. This form of performance anxiety could be identified as being less secure about their counselor identity. These responses included the following: "less secure about who I am as a counselor," "self conscious…in counseling," and questions including "If I am cut out for this?," "if I am enough to do this?," and "can I do this?" The participants' anxiety stemmed from various places ranging from: fearing the client taking the lead, peer comparisons (i.e., feeling like she was the least

experienced), and anxiety in front of prominent adult figures (i.e., teachers and supervisors). Two participants described their anxiety as being a form of them being hard on themselves, and one of them expounded saying that she had evaluation apprehension and perfectionistic tendencies that brought about this anxiety.

Three of the four participants described ways the anxiety decreased for them including: seeing the clients' progress, the recognition that the fear could keep her from being useful to clients, and even filming sessions helped one to feel more comfortable. All three described how they began to feel more comfortable with CCPT, and this helped them with their anxiety. One wrote, "it [CCPT] now comes so naturally. I barely have to think about the specific skills and focus on how I am applying them, it just sort of happens."

Confidence Development

All participants described an increase in *confidence* through the course of the semester. Two participants explained how they became more confident in their CCPT skills, and two described how CCPT required less thinking for them. One clarified, "it's [CCPT] felt a lot more natural for me. It just flows, and I know more where to go when I am present, where it's not about thinking. It just felt more natural." Two participants explained how the more they conducted CCPT, the greater their confidence became. Another participant explained that her faith in herself and in the process made the journey easier.

One participant explained how she gained more confidence as a counselor in general, and another described how her increase in confidence in CCPT allowed her to feel more confident in other specializations of counseling. A participant explained how putting the child first helped her confidence in the process to grow, because she realized it was not dependent upon her ability or what she did or did not do in session. For this participant the more she recognized the need

for the *shared experience*, the more the *therapeutic relationship* increased, and finally her *confidence* increased. One participant described an increase in confidence when communicating with teachers about both CCPT and clients.

Buy-in

The participants described moments when they began to *buy-in* to CCPT. The definition for this theme included the participants' reactions to CCPT, such as contentment with the specialization, or they described their ability to "trust the process." The participants' reactions to CCPT that assisted in them buying in to the approach including, "contentment," "happiness," "rewarding," "proud," "beneficial," "very enjoyable," and "privileged…to learn and to practice." Three of the four participants explained how the clients helped them believe in the process. These nodal moments included times where a client not only smiled but also laughed for the first time, or when the client initiated play with the CIT. One participant described these times as seeing the client's progress helped her to believe in the progress. A participant described how the client knows the way, and when she sees the client doing the work she continues to trust in the process.

For one participant, her supervisor encouraged her to trust the process, and this helped her to embrace the philosophy of needing to "get out of your own way and trust the process." One participant wrote about how her trust in the person-centered process increases her comfort level as a CIT. This level of buy-in helped the participant to not focus on the performance, and this helped her to be more comfortable in CCPT than her other clinical work. Whereas, another participant described how she was able to buy-in more to CCPT, when she was able to conceptualize her clients utilizing psychodynamic theory to understand her clients better.

Research Question #2: What was the CITs experience with the skills of empathy and unconditional positive regard (UPR)?

I utilized all data sources to answer this question. Question #3 in the interview and focus group protocol (Appendix B) specifically addressed this question with the participants. All of the participants' blogs addressed the utilization of the skills either in session with various successes and challenges, outside of session with prominent adult figures (e.g., teachers), and challenges with limit setting.

Skill Development

The broad theme that emerged within this research question included *skill development*, where the participants described their development of skills in general. One participant described her skills as greatly improved since she first began, while another one said, "I barely have to think about the specific skills and focus on how I am applying them, it just sort of happens." Specifically, this theme included several subthemes of the specific skills.

Empathy-shared experience. Empathy represented the largest category in this theme. The research team described four subthemes of empathy to capture the participants' experiences fully. I explained the first subtheme, *empathy-shared experience*, in detail in research question #1.

Empathy-shared experience challenges. As the participants' described the *shared experience*, they also explained the *challenges* presented with this specific skill, particularly the difficulty in staying in the moment with the client. Similar to the *shared experience* theme, they described an internal dialogue that would cause them to struggle with being present with the client. Earlier in their work, they were more concerned with where they should sit, what they should say or do, or even what they should have said or done. One participant explained how

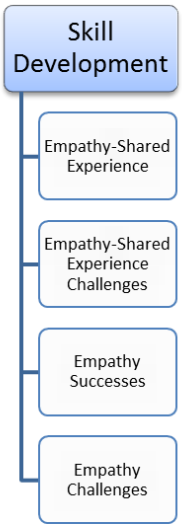

Figure 3: Research Question #2 Themes

Table 3: Research Question #2 Themes and Examples

Theme	Example
Skill Development	"I feel like my skills have already greatly improved"
Empathy-Shared Experience	"I know that as long as I am staying with the child, I won't get lost in the session…"
Empathy-Shared Experience Challenges	"I need to work hard at staying in the moment with her."
Empathy Successes	"I feel like that's been really huge for me is using empathy with the limit and just practice and getting better and making that just kind of natural."
Empathy Challenges	"And for me, especially in the beginning of my work, empathy was the one skill I think I struggled with the most because of my lack of experience with children."

she had certain thoughts about her client in session, "…and I kind of have to remind myself to carry on…just a little bit longer just until I get out of session, so I have time to process it and think it through." Limit setting posed a challenge for two of them. One participant described how she should have set a limit sooner, and became preoccupied in her mind about what she should have done. The other participant said, "you're worried about limiting, and you're not really thinking about UPR and you kind of lose that aspect." This is an example of how becoming preoccupied with a skill in limit setting distracted from remaining in the *shared experience* with the client.

Empathy successes. The third subtheme within the category of the skill development of empathy includes the participants' descriptions of *empathy successes* during their semester with CCPT. Three of the four participants explained moments in session where the child felt comfortable enough to clarify the CITs' reflection of feeling, for example a CIT said to the client, "'it makes you mad when that happens', and he looked at me [CIT] and said, 'NO, it makes me angry.'" Another participant explained how beginning to trust that the client will clarify her feelings "turned down the pressure" that the CIT was putting on herself.

Two participants shared stories about how the client was beginning to engage in his/her play in a certain way, but the client was showing hesitancy. In both instances, the CIT reflected the hesitancy and the client was able to engage fully in the play. For example, a participant wrote in her blog:

> She [client] looked around the room and peeked into the different boxes of toys. She then saw the massive punching bag and walks towards that. She touched it a few times and walked around it, looking at it from every angle. She then looked up at me and told me that she can punch it really hard but won't do it today. I [CIT] reflected her eagerness to

> punch the bag and her hesitancy about doing it today. She then took a massive, full body swing at it. She looked at me and said that she did that just to see if she could make the punching bag fall, which it didn't at the time. She then told me that she knows she can make it fall, but won't try it this time. I again reflected her eagerness and hesitation. She then punched it again, even harder than the first time, picked it up, and punched it again. She continued to do that while also laughing for the remainder of session, experimenting with her own strength and the power behind her punches. By the end of the session, she was sweaty and exhausted.

Empathy challenges. The participants described *challenges* with reflecting feelings or expressed uncertainty about if they were giving accurate empathic responses. One participant explained that her struggle with empathy at times was as a result of her fear of inferring too much about her client rather than just "going with their gut" and allowing for clarification later. Whereas, another participant expressed her struggle with empathy was because of a lack of experience of working with children prior to this experience.

Research Question #3: If the CITs recognize change, how do they describe the process? What factors assisted them in their change process?

Through the course of the participants' time learning and engaging in CCPT, they recognized changes in how they understood the process of CCPT and how they understood pieces of themselves, and all of the data sources were useful in answering this research question.

Greater Understanding of Theory

Two participants explained how other people (e.g., teachers) do not always understand CCPT, or how simple it may sound to others that do not really understand the process. Another participant explained, "…I found purpose…CCPT has a lot of purpose. I just

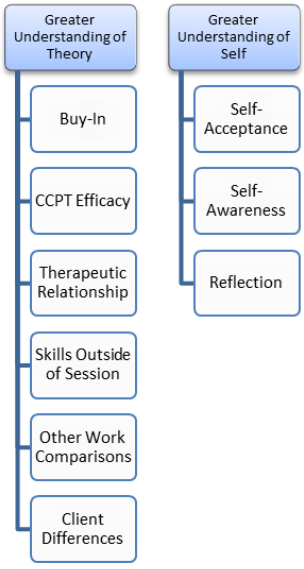

Figure 4: Research Question #3 Themes

Table 4: Greater Understanding of Theory Themes and Examples

Theme	Example
Greater Understanding of Theory	"…I found purpose…CCPT has a lot of purpose. I just didn't understand it."
Buy-in	"helps you trust the process, that leap of faith that you [CIT] will do that, if you set the environment right…that they [clients] will get there [embracing the process]."
CCPT Efficacy	"Hearing positive feedback like this [client's reduction in bullying] increases my motivation to really utilize the therapeutic impact I truly believe CCPT has.."
Therapeutic Relationship	"Seeing the children's progress…helps me focus on the more relevant change agents, the relationship and the child's experience."
Skills Outside of Session	"it [CCPT] has helped me with empathy across situations"
Other Work Comparisons	"…I can be the same person [utilizing empathy and UPR] in an individual setting with an adolescent in a very different situation, where we are verbalizing our emotion, we're verbalizing everything…"
Client Differences	"I feel like I have gained a completely different understanding of how sessions might go with each unique child."

didn't understand it." The following subthemes of *buy-in, CCPT efficacy*, the *therapeutic relationship, skills outside of session, other work comparisons,* and *client differences* are all examples of how their understanding of the theory increased.

Buy-in. I discussed this subtheme earlier in how the CIT developed. This subtheme fits in both categories, because it encapsulates how the CIT developed but also shows the CIT began to believe in the process of CCPT. Their level of *buy-in* in turn affects them by allowing the other subthemes to emerge in their work.

CCPT efficacy. The research team defined *CCPT efficacy* as the belief in CCPT producing the desired result, evidenced by the CIT's observation of change or received reinforcement from others (e.g., teachers). All participants described changes within their clients including excerpts such as: "significant changes," "so much progress," "complete difference ," or "large change." Three specifically stated how this change was not immediate, and how it affected them. One participant wrote, "It's funny how magnified the little signs of progress become and how much more I've learned to appreciate them," while another participant described how seeing one client's change made her hopeful for her other two clients. This kind of hope from positive feedback gave another participant "motivation to utilize the therapeutic impact." Three participants explained how their clients changed in the following ways: seeking relationships with the CIT and/or others outside of session, expressing aggression within session effectively, reduction in bullying, or an increase in confidence.

Two participants described how feedback from prominent adult figures such as parents, teachers, and adults helped to reinforce CCPT efficacy. In the focus group, a participant described how her supervisor and she had examined the statistical improvements of her clients, but she also "intuitively" sensed the "difference" in her kids.

Therapeutic relationship. The *therapeutic relationship* as defined by the research team refers to how the participant placed value on the relationship particularly as a change agent or described the client's relationship resistance. Participants explained the importance of the relationship within CCPT including: "change agents, the relationship and the child's experience," "CCPT has the therapeutic power to promote positive relationship," " bigger picture-the relationship and the child's experience," and "CCPT truly is all about the relationship." One participant expounded how her trust in the process [*buy-in*] and her focus on the relationship [*therapeutic relationship*] allowed her to be less concerned with *performance* and creating a self-defeating attitude. Similarly, another participant described how her lack limit setting in a moment with a client did not rupture the relationship.

Three participants described how their clients experienced moments of resisting relationship with them. A participant indicated how one of her client's level of relationship resistance decreased over time. Describing the difference between her clients, one participant wrote that another child-centered play therapist transferred this client, and this client was already in the aggressive stage. The participant wrote, "it felt like I just had to hop on and ride along and that didn't allow ME time to establish that relationship with her in order to form that connection." Another participant wrote that she sensed how difficult it was for her client to be in relationship with her, and the participant had to resist becoming more active in rapport building. In her interview, she described a comfort with relationship resistant clients saying

> If you [the client] want to hide and you don't want to be seen or you want to play by yourself, then that's okay. And then when it's okay for me to move forward, then I'll move forward… And they're [clients] working themselves up to that [being in

relationship], and I think even more they need time and patience and somebody who will accompany them through that [the times when they are avoiding relationship].

Specifically, two participants indicated ways the therapeutic relationship affected them as CITs. In the focus group, one explained that the uniqueness of the relationship is "shaping her as a counselor." She clarified that the uniqueness lies in that "they [clients] don't experience [the *therapeutic relationship*] in any other setting, at least with the kids we work with...I guess that relationship can change. But being in the counselor-child relationship is that it is constant for them, and it's unique experience to them." Another participant explained, "We [CITs] are also learning we're enough to be there with them and just me being there is enough to be therapeutic…"

Skills outside of session. This subtheme encompasses how the participants described using the *skills related to CCPT outside of session*. Two participants gave several examples in their blogs, interviews, and within the focus group. One participant described how she used "empathy across situations." She expressed that she utilizes the skills with parents, teachers, friends, partner, and limit-setting with her niece, while another participant listed adolescents, high school students, and co-workers in the education system. Both expressed how empathy translated to many different situations. One of the participants described how she realized that she uses empathy more than before CCPT and is also not as reactive to what people say, and she continued that she has become more calm and patient. The other participant described how she realized that she "can have relationships with children," and how she thinks that CCPT has given her more confidence as a parent, thus making her a "better parent." As a school counselor, the participant included the importance of providing UPR to high school students with academic and behavior issues.

Other work comparisons. The research team defined this subtheme simply when the participants compared CCPT to other counseling experiences. One participant compared her previous counseling experiences to CCPT saying that she had not experienced moments in her previous work like she did in CCPT. As referenced earlier, for this participant bringing in her understanding of psychodynamic interpretations assisted her in conceptualizing clients. This participant struggled with CCPT in the beginning because of the difference in approach and population. She expressed her confusion in the beginning of her work of how to work with a four year old, because she was accustomed to adults, who can communicate, or adolescents, where the counselor can be directive and address problem behaviors directly. On the other hand, another participant expressed her comfort with CCPT versus her interactions with adults. She expressed that with her work with adults she questions her skills and tends to place the responsibility on herself as opposed to the client, so she plans to apply her CCPT approach to all work, futuristically.

In working with different populations, a participant found that she could be ok with adult clients correcting her, because she had found she was ok with client clarifications in CCPT, because they are not a personal attack but are generally helping the CIT understand the client's perspective. Another participant referenced her work with adolescents saying, "…I can be the same person in an individual setting with an adolescent in a very different situation, where we are verbalizing our emotion, we're verbalizing everything…You're still a person in a relationship, bringing UPR to the table, using empathy…"

Client differences. This subtheme refers to the participants describing the complexities of working with clients that possess various complexities. One participant said, "I feel like I have gained a completely different understanding of how sessions might go with each unique

child." The participants listed the following differences: stages look different (e.g., aggression can look different from child to child), "different ways of being in the playroom," "different behaviors, personalities, and stages," transition client versus brand new client, and response to termination.

Greater Understanding of Self

Through the course of the participants' experience with CCPT, they identified different ways that they gained a *greater understanding of self*. Two of the ways they changed included an increase in *self-acceptance* and *self-awareness*. The participants described how utilizing *reflection* assisted in this process.

Table 5: Greater Understanding of Self Themes and Examples

Theme	Example
Self- Acceptance	"It seems like I will have to be more unconditionally acceptant of myself in order to be more useful to my clients."
Self- Awareness	"The aspect of my development that I believe has helped me the most is my emotional awareness and reflection of what goes on for me during sessions."
Reflection	"you [CIT] have to be very reflective, and you have to kind of process everything."

Self-acceptance. The participants described their ability to *self-accept*, which we defined as acknowledging the need to extend empathy and UPR to themselves or being enough, as they were, in the session or relationship for the client and the process. All the participants described that they learned that self-acceptance is vital to CCPT. They used very similar words saying the following: "I am enough" despite the participant's lack of skills, "confidence of being

enough," being enough was not just a lesson for the child but for the CIT as well, "unconditionally acceptant of myself," "I still matter to the relationship," "more helpful to clients if I am more compassionate towards myself and kinder in my thoughts." One participant questioned how she could offer acceptance "for anything and everything" that the child does, yet not do it for herself.

Several described how supervision aided in the process of self-acceptance. One participant discussed the importance of offering UPR to self during supervision to help her not be defensive, because she had a tendency to want to be perfect. The participants valued the group supervision process, which I will discuss in detail in a later section. One participant described how she found that through "others' eyes I am capable," and another found that the more advanced CITs helped her to be more compassionate to herself. During individual supervision, one participant struggled with a difficult client, and she described how the supervisor normalized her feelings toward the client. She expressed,

> And I think that was a pivotal moment for me. I think empathy and UPR comes first when you allow yourself to empathize and have positive regard for yourself, and once you get to that point and allow yourself to feel all of those negative emotions, then it can really translate to UPR and empathy for the client.

Two participants described ways they struggled with self-acceptance. In her interview, one discussed how she does not know how to play, and initially she called herself pathetic. She quickly took it back, and she explained that she is "so hard" on herself." Another participant wrote in her blog:

> It can also sometimes mean that I am not willing to look at the things that I am ashamed of. And that in not looking at those, I do not accept the role of an agent; I lose the

opportunity to grow in that area. Like Rogers' says, I cannot change or move from what I am, until I thoroughly accept what I am.

Self-awareness. The research team defined *self-awareness* by the participants' descriptions of their awareness and reflection of self either during or after session. All participants described ways they became more self-aware through the process of CCPT. For one participant, she described becoming calmer and finding an inner peace, that she was slower to react with friends and her young niece. Similar to becoming more calm, another participant discussed how CCPT helped her to "turn down the thinking," and she attributed her "emotional awareness and reflection" to be helping her development the most. Another participant described how she believes that the CIT needs to experience personal growth first to be effective with clients, but she found that she had to immerse herself into CCPT or "just do it" to overcome her personal barriers.

For one participant her self-awareness focused on her connecting with the "child inside" of herself. She had experienced personal tragedy at a young age that forced her to grow up quickly, so she commented, "seeing them [clients] reminds me of who I was and I almost felt like I had lost that person for a while." This participant also attributed the inner child connection to increasing her empathy with children, because she could remember what it was like to be where the child was in the moment of their play.

Reflection. The subtheme of *reflection* refers to the participants' process of reflecting in and outside of session, which typically aided in their *self-acceptance* and *self-awareness*. One participant wrote in her blog how she anticipated writing the particular blog, because she had been reflecting on her CCPT experience and progress as a CIT. Another participant indicated

that within CCPT the CIT needs "to be reflective and….process everything." During session, a participant described how important it was for her to stop thoughts intentionally about her clients (e.g., hopes for the client's future) and come back later to process them.

Two participants described how watching videos of their sessions was crucial for their reflection process and for their skill development, like "holding up a mirror." When discussing the taped sessions, one said, "…it's just like a slap in the face, it's just like this is who you are and you bring this into session, and this is all the baggage that you're bringing. Now what are you going to do with it [the personal baggage]?" They also discussed the importance of reflecting about the client outside of session to begin to see the client "as an entire complete human being" or to "imagine what it would be like to be that child and feel that in the moment." Both of these participants felt that this form of reflection helped them have a wider, more holistic view of their clients.

Research Question #4: How does supervision affect the CITs during the process of learning CCPT?

For the primary sources for this research question, I utilized the interviews and the focus group since question #4 (Appendix B) directly asked about supervision. In two of the interviews, I did not ask this question, so those two participants responded about supervision in one of their blog posts.

Figure 5: Research Question #4 Themes

Table 6: Research Question #4 Themes and Examples

Theme	Example
Individual Feedback	"Supervision has provided me with invaluable feedback towards my work in CCPT."
Group Supervision	"I think group supervision has given me more of a wider view of experiences, and also seeing how some of the other therapists have had some of the same struggles that I do…"
Supervisory Relationship	"I guess I sensed a lot of UPR from supervisors towards me too…"

Individual Feedback

All the participants described different ways that individual supervision helped them in their work with CCPT. The participants described a focus within supervision connecting to the relevance of the *individual feedback* they received. This individual feedback included the supervisor pointing out the CIT's strengths/weaknesses, client conceptualizations different from the participant's own perspective, and encouraging to trust in the CCPT process. One supervisee described how within supervision, "I've seen a lot of transition and progress and growth in just the goals that we're working on." Several of the participants described different personal things that they worked on in supervision such as: participant's control issues, intellectualizing emotions, becoming more adaptable in session, and effective use of empathy within limit setting. Two of the participants described the importance of the supervisors offering validation or support of their work.

Group Supervision

The participants discussed the importance of the peer influence within *group supervision*, and the research team defined group supervision, simply whenever the participants' referenced their group supervision experience. Several explained that the group provided a form of external

validation by making the participants feel like they were "capable," "doing well," or even "help me be more compassionate towards myself." Two participants expressed how group supervision helped them see a variety of client situations that they had not experienced, as well as "seeing how some of the other therapists have had some of the same struggles" as the participant "in letting go of control, being there, and being highly" empathic and exhibiting "unconditional positive regard with a child."

Supervisory Relationship

A few of the participants expressed several important factors of the *supervisory relationship*. One participant expressed struggling with empathy and UPR for one of her clients, and she said that her supervisor, "has really kind of given me that space to just say whatever it is that I want to say." Two participants described how the supervisors modeled the skills of empathy and UPR, and how that was helpful for them. One explained, "I guess I sensed a lot of UPR from supervisors towards me too, so even when there are things that I could do differently that I'm still, and I have the core of what is needed for that relationship." Two supervisees offered different perspectives about their supervisory relationships. One valued that she worked with the same supervisor throughout her experience, whereas another participant described how she valued working with supervisors that had varying lengths of previous CCPT experience. This participant explained, "I am fortunate I guess to have had supervision with someone who was super experienced, then with [university doctoral student supervisor] who had experience, and then people who were on the same level as me, and just beginning, they just [helped in] normalizing [my CCPT experiences]."

Chapter Five: Discussion

In this chapter, I discuss the results in the scope of the constructs of counselors in training (CITs) and the Integrative Developmental Model (IDM). I provide a description of limitations and implications for counselor educators and/or supervisors. Finally, I outline and briefly describe ideas for future research based on this study.

Summary of Research

This study explored how CITs developed while engaging in an early learning experience providing child-centered play therapy (CCPT). I conducted an exploratory case study (Yin, 2003) to describe four CITs experience in an existing CCPT supervision group utilizing blogs, semi-structured interviews, and a focus group.

Because of the lack of research on development of CITs learning a specialization, the first and third research questions are exploratory in nature, allowing the participants to explain their experiences related to counselor development and counselor change. They also described the factors that affected their development. Because of the emphasis in CITs developing counseling skills (Carkhuff, 1969; Heppner & Roehlke, 1984; Leach & Stoltenberg, 1997; Rønnestad & Skovholt, 1993; Skovholt & Rønnestad, 1992; Worthington & Roehlke, 1979) particularly CCPT related skills (Fall et al., 2007; Landreth & Wright, 1997; Lindo et al., 2012; Ray, 2004; Tanner & Mathis, 1995), the second research question sought to add to the literature on CITs and skill development during a CCPT training experience. Because of the emphasis on supervision within CITs' development (Gibson et al., 2010; Heppner & Roehlke, 1984; Worthington & Roehlke, 1979), the fourth question allowed the participants to outline the ways that supervision affected their development.

Understanding the CITs

Since the literature on CITs and CCPT focuses on attitudes, skills, and knowledge (Fall et al., 2007; Homeyer & Rae, 1998; Kao & Landreth, 1997; Lindo et al., 2012; Ray, 2004; Ritter & Chang, 2002; Tanner & Mathis, 1995), this chapter focuses on the integration of the results regarding the CITs' attitudes, skills, and knowledge.

Evolutions in Attitudes

Lindo et al. (2012) included behaviors, attitudes, feelings, and perceptions to describe the students' attitudes in relation to their experiences learning CCPT. One of the primary attitudes that emerged from Lindo et al.'s work focused on the participants' increase in *self-acceptance*, which was also true for this study. In both studies the participants found that offering self-empathy increased the likelihood of the ability to offer empathy to clients and significant others. Within this study, one participant explained how she felt that the more she offered this attitude of *self-acceptance* to herself, the more effective she would be with clients.

Overcoming anxiety. All of the participants described how *anxiety* affected them in the beginning of their CCPT work. This *anxiety* related particularly to the skills of CCPT but also counseling in general. Several others authors suggested the common finding of anxiety in the beginning of CITs' work (Fall et al., 2007; Landreth & Wright, 1997; Lindo et al., 2012; Ray, 2004; Tanner & Mathis, 1995). Worthington and Roehlke (1979) suggested that practicum supervisees experienced anxiety surrounding their supervisors' feedback, and the same was true for participants of this study. Participants of this study explained how they experienced *performance anxiety* in front of the supervisors. One explained how the supervisors were experts, and how intimidating it was to highlight her lack of skills in the beginning, in front of the experts. In this study, the participants described developing a level of *buy-in* to CCPT. As

buy-in, or trust in the process developed, the participants began to feel more comfortable in the process.

Areas of Skill Development

As counselors develop, naturally, they cultivate particular skills related to counseling, specifically CCPT skills in this study. Particularly, the participants referenced how the supervisors and peers offered support in *skill development*, either in specific feedback or by modeling the skills such as empathy and UPR. Worthington and Roehlke (1979) suggested supervisees identified important factors of supervision including offering support and modeling skills, so this appeared to be true for these participants as well.

UPR, empathy and self-acceptance. The participants described the importance of the supervisors offering UPR and empathy to them as supervisees, and then the skill modeling increased the participants' ability to offer empathy and UPR to themselves and in turn the clients. This increase in *self-acceptance* for the participants served to be an important factor that increased the CITs comfort with the counseling skills needed within CCPT and seemed to feed back into further increased *UPR and empathy skills*. As seen in the next subsection, increased *UPR*, *empathy* and *acceptance* also seemed to support developed ways of being in *outside session relationships*, which may have further increased *UPR*, *empathy* and *self-acceptance* in sessions.

New ways of being outside of sessions. As referenced earlier Lindo et al. (2012) also suggested that the counselor's self- acceptance increased connection to clients and significant others in the counselor's lives. Lindo et al. hypothesized that even though their study did not evaluate relationships outside of the clinical relationship that the counselor would experience greater satisfaction in their relationships upon through self-acceptance and utilizing the same

skills with others in their lives. Within this study, two participants, in particular, explained in detail how they utilized the *skills outside of session*, and how effective they found them to be in a range of relationships from friendships, to children, partners, adolescents, teachers, and parents. Therefore, even though we did not ask them to assess their outside relationships before and after the training experience, some did describe marked changes in their interactions with others outside the counseling relationship, utilizing the skills of empathy, UPR, and even limit setting.

Client influence. Skovholt and Rønnestad (1992) highlighted how CITs recognized how clients shaped their skills, affecting them as persons, as well as provided feedback in response to interventions. Naturally, within CCPT the clients do not give the CITs direct feedback, but the participants described ways the children affected them. Primarily, the participants found that the *shared experience* with and acceptance of client feelings increased their *self-acceptance*, as stated earlier, and also increased their *self-awareness*. The CITs' *self-awareness* continued to increase by becoming calmer or connecting with their inner child, as a result of being in relationship and remaining present with the clients.

Reduced need to control. The participants' ability to let the child take the lead created *anxiety* for participants initially, but alleviated anxiety for them as their work continued. For all the participants they described a *reduced need to control*, both professionally and personally, as a result of CCPT. Kao and Landreth (1997) suggested the CCPT course correlated with the students' decrease in dominance scores on the California Psychological Inventory (CPI). The dominance scores referred to items such as letting go of control. The participants highlighted how the experience of CCPT assisted in their decrease of control. I did not question the participants on whether this process began in the CCPT course or within this particular training experience, but regardless they also experienced a decrease in dominance.

Overcoming skill challenges. Chapter four explains in detail the *challenges* the participants faced while conducting CCPT. The literature suggested a particular challenge with the skill of limit setting (Fall et al., 2007; Landreth & Wright, 1997; Ray, 2004). Participants in this study identified struggling with limit setting in relation to their skill of empathy, particularly in the *shared experience*. When trying to limit set, participants were preoccupied with thoughts of what they should have done differently. One participant felt she should have set a limit sooner, while another was preoccupied with the skill associated with the limit such as responding with empathy first. The participants explained that these preoccupations kept them from staying in the present moment with the child.

Confidence development. As participants overcame skill *challenges*, such as limit setting, their feeling of comfort with the approach grew. That feeling of comfort also seemed to both produce and result from *buy-in*. Their *buy-in* of CCPT encompassed their development of *confidence*.

Similar to previous research, CITs experienced an increase in *confidence* after practicing CCPT (Homeyer & Rae, 1998; Kao & Landreth, 1997). Gibson et al. (2010) highlighted how newer CITs relied upon external sources such as supervisors versus further along CITs utilized intrinsic factors to describe their development of professional identity. The results did not indicate a specific difference within timing of extrinsic and intrinsic factors, but the participants did recognize both factors as pieces of their development. The themes suggest a move from the focus on the extrinsic to the intrinsic. The participants began the experience *anxious*, needing more external support, and described how the more they engaged in CCPT, the more the theme of *empathy-shared experience* emerged. As the participants engaged, they experienced a growth in *confidence*, *buy-in*, and *efficacy*. In turn, the more they developed a *greater understanding of*

CCPT theory, they developed a *greater understanding of self*. This highlights how they highlighted both extrinsic and intrinsic factors pivotal to their development as a counselor.

Likewise, Skovholt and Rønnestad (1992) described the importance of peers and supervisors as a source of external support early in CITs development. All of the participants indicated a need for external support from their individual supervisors, as well as the peer CITs within the supervision group. The participants expressed a need for support from the supervisors in their work. Specifically, one participant described how the group assisted her in realizing that she was capable in others' eyes.

Increased Knowledge and Understanding

Development in participants' attitudes, skills, and knowledge related to CCPT suggested that the participants increased in all domains through the CCPT experience. The theme of a *greater understanding of theory* suggested participants in this study also experience an increase in knowledge through the semester. This increase in knowledge increased recognition of the purpose behind CCPT (e.g., understanding how the *shared experience* is more than just sitting in the playroom with a child). The participants continuing to engage in the needed skills of CCPT, such as empathy and UPR, assisted them in understanding the CCPT process better. Participants gleaned knowledge about the importance of the *therapeutic relationship* (e.g., viewing the relationship as a change agent). They also recognized the *differences in clients*, particularly in how the clients demonstrate the stages. This nuanced understanding of clients resulted in a further increase in knowledge about CCPT.

Integrative Developmental Model

For this study, I utilized the Integrative Developmental Model (IDM; Stoltenberg & McNeill, 2010) as a theoretical lens to gain a better understanding of the participants. I outlined

in chapter three how the research questions aligned with certain aspects of the IDM. In this section, I discuss this study's results in relation to the IDM.

Overriding Structures

The first research question asked about how the participants develop while utilizing CCPT, and the third research question asked about the changes that occur within the CIT. I estimated the first research question connected with the overriding structure of self- and other-awareness, and the third question would depend on responses. This structure highlights the trainee's focus on self and/or client. Self- and other- awareness includes a thought and an affective component. The thought component includes a CIT's thought process including reflection and knowledge base, and the affective component includes anxiety and/or utilizing empathy (Stoltenberg & McNeill, 2010). Both the thought and affective components of this structure were found in the participants' responses.

Within the cognitive and affective components of the self- and other- awareness structure, the participants exhibit behaviors that allude to the movement from Level 1 to Level 2 during their work in CCPT. In the beginning of their work, participants described a high level of self-focus that made it hard to engage in the *empathic-shared experience* component of CCPT. They explained high levels of *performance anxiety* that also created a sense of questioning their ability to engage in CCPT skills affectively. Stoltenberg and McNeill (2010) outlined self-focus, confusion, anxiety, and struggle with empathy as major indicators of a Level 1 supervisee in the self- and other- awareness structure.

Within Level 2, the supervisee focuses more on the client, thus their *focus on self decreased*. Within the cognitive and affective components, the supervisee tends to be more aware of the client and his/ her experience both in and outside of session, and the supervisee

experiences a rise in confidence in his/her competence (Stoltenberg & McNeill, 2010). Several of the participants discussed how they engaged more with clients and understood their client, particularly when they described the *empathy successes* and the growth of the *therapeutic relationship*. They all discussed how their *confidence developed* during their experience.

Stoltenberg and McNeill (2010) explained how Level 2 supervisees need to use more "reflection-in-action (RIA)" meaning self-reflection on "actions, in real time, using reasoned and purposeful experimentation to improve our performance in the here and now" (p. 10), which can pose a challenge for Level 2 supervisees. They recommended the supervisees to utilize "reflection-on-action (ROA)" meaning reflections on "actions at a later time, evaluating the process we used and the lessons learned" (Stoltenberg & McNeill, 2010, p. 10). The participants in this study discussed needing to stop thoughts in sessions to utilize *reflection* after session. Skovholt and Rønnestad (1992) indicated the importance of CITs utilizing reflection to aid in professional development. Rønnestad and Skovholt (2003) recommended the "reflection is a prerequisite for optimal learning and professional development at all levels of experience" (p. 38). They also took the stance that those counselors who were not engaging in reflection possessed a higher propensity toward negative development such as burnout.

The overriding structure of autonomy refers to the supervisee's dependence upon the supervisor (Stoltenberg & McNeill, 2010). The participants' discussed supervision in regards to the importance of the *individual feedback*, the *group supervision* process, and factors of the *supervisory relationship*. The participants discussed the importance of receiving support and the modeling of skills by the supervisors. Thus, these comments connect to Level 1 supervisees as described by Stoltenberg and McNeill (2010) including a focus on reliance upon the supervisor for an understanding of the clinical behavior. Stoltenberg and McNeill continued that Level 2

supervisees tend to express a need for independence from the supervisors, sometimes including supervisory conflict. Participants in this study did not indicate this to be true of their experience. None of the participants referred to moments of exerting independence from their supervisors or experiencing conflict in that relationship.

Specific Domains

The second research question refers to the specific skills of empathy and UPR, so this relates to the domain of intervention skills within the IDM (Stoltenberg & McNeill, 2010). Stoltenberg and McNeill (2010) indicate how a supervisee may be at a more advanced developmental level within the intervention skills domain of one theoretical framework, while remaining at a lesser developmental level in a different theoretical framework. Thematically, the results suggest that the participants resided in Level 1 of the intervention skills domain. Within this domain at Level 1 supervisees tend to latch on to a particular theoretical model, and they tend to rely upon the supervisor for skill modeling. Level 1 supervisees tend to be drawn to very structured interventions (Stoltenberg & McNeill, 2010).

Even though CCPT may not always be described as a highly structured intervention, such as the more commonly recognized highly structured intervention of Trauma-Focused Cognitive Behavioral Therapy (Cohen, Mannarino, & Deblinger, 2006), this experience provided the participants a structured experience. Extensive diagnosis and treatment planning was not needed, as each child had already been evaluated for treatment need and fit for individual intervention with CCPT. Further, while in decades past, some referred to CCPT as non-directive, CCPT as currently taught provides a high degree of focused skills for establishing a structure that facilitates client self-expression and therapeutic relationship (N. H. Cochran et al., 2010).

Limitations

The very selection of case study presents a first limitation. Seeing the research and learning opportunity, I selected an existing supervision group rather than selecting individuals to participate in a supervision group for the purpose of research. Thus, the study represents a convenience sample of an existing case.

The various clinical experiences possibly affecting development represent a possible second limitation. The four participants brought various previous or concurrent clinical experiences to their work in CCPT, so it can be difficult to be certain which experience was involved in the overarching development of each participant. The participants are heterogeneous in nature because of their clinical experiences, but they are homogenous because they all lacked experience in CCPT. Protecting the anonymity of the participants also represents the third limitation. I could not provide all the possible identifying information about the participants, thus I could not provide a full description of the context of their experiences.

The fourth possible limitation includes the utilization of technology. Because of technological difficulties, the blogs did not begin until the middle of the semester. Thus, the participants' early experiences within CCPT may not have been captured. In addition, the participants had access to each other's blogs for the learning experience and the continuity of the supervision group. This could pose a possible limitation since their reflections could have affected each other's learning, thus this could affect what they also chose to write about within the blog.

Implications

Counselor Educators

This study offers several implications for counselor educators. Tanner and Mathis (1995) suggested a need for play therapy training for novice play therapists and utilizing play therapy skills in sessions. This study highlighted the growth and development of four CITs that occurred during their early play therapy training, thus confirmed the need for more training during practical experiences. The participants valued their supervision experiences, and thus counselor educators need to encourage their students to capitalize on their supervision experiences.

The literature supports factors such as empathy, UPR, and genuineness as important elements in the therapeutic relationship and positive outcomes in counseling (as a set: Cooper et al., 2010; Elliott, 2002; Lambert & Okiishi, 1997; Orlinsky & Howard, 1978; Patterson, 1984; empathy: Bohart et al., 2002; Elliott et al., 2011; UPR: Farber & Doolin, 2011; Farber & Lane, 2002; genuineness: Grafanaki, 2001; Kolden et al., 2011). Based on this study, I suggest the following principles as important to the development of empathy and UPR:

- Self-awareness includes a CIT's ability to be aware of self (i.e., moment-to-moment awareness of significant thoughts, feelings, intentions, and motivations) in and outside of session, and how this level of self-awareness might affect him/her in utilizing empathy and UPR.
- Self-acceptance assists the CIT by beginning to learn how to approach self with empathy and UPR, which encourages the ability to offer these qualities to the clients.

- Successful experiences utilizing empathy and UPR provide the CIT with belief in the power behind these skills and belief in one's own effectiveness in therapeutic relationships.
- Therapeutic relationship continues to encourage the CIT's belief in the client and the utilization of the skills.
- A supervisor offering empathy and UPR to the CIT helps to build the supervisory relationship, which enhances the moments when the supervisor models these skills in relation to client examples. Both instances of modeling assist the CIT to believe further in the need to offer these skills to the CIT's self and then in turn clients.

The participants overcoming their *anxiety* and *development of confidence* supports the notion of CITs learning a specialization, a specific approach, as opposed to a range of approaches. Stoltenberg and McNeill (2010) suggested CITs can want a specific approach to form a therapeutic base and quickly can proceed to an advanced Level 1. On the other hand, Stoltenberg and McNeill (2010) indicated how CITs can benefit from a "comprehensive framework" that "focus on relationship skill development" (p. 54). From this study, I conclude that the participants found benefits in both approaches. They learned a specific approach of CCPT that provided them with a practical learning experience that utilized the foundation of relationship building skills that translated to their *other work* (e.g., group counseling or working with adult clients).

During their training, the participants highlighted the usefulness of *self-reflection* in order to assist within their development of *self-awareness* and *self-acceptance*. Other researchers have indicated the need for reflection within counselor development (Rønnestad & Skovholt, 1993;

Skovholt & Rønnestad, 1992; Stoltenberg & McNeill, 2010). Counselor educators and counseling programs need to ensure they are utilizing reflective practices within their programs to assist further in the professional development of future counselors.

Supervisors

This study explores how the CITs develop within an existing supervision group, so this study offers several implications for supervisors, particularly CCPT supervisors. Ray (2004) offered recommendations for supervisors in a developmental context distinguishing the differences between beginner and advanced play therapy skills. This study highlighted the importance of *skill development* assisting the CITs in alleviating *anxiety*. The participants discussed how they appreciated their supervisors' support, providing them with UPR and empathy, and their modeling of the needed skills. Supervisory support may be helpful in alleviating performance anxiety in Level 1 supervisees since the supervisor can take on the role of expert. Because of this assertion, supervisors may need to be proactive in addressing the power differential early in the supervisory relationship with Level 1 supervisees.

Particularly for CCPT supervisors, limit setting posed a *challenge* for the participants, which is in line with other authors' assertions (Fall et al., 2007; Landreth & Wright, 1997; Ray, 2004). CCPT supervisors need to be aware and knowledgeable on how to address issues surrounding limit setting with supervisees and aware to plan supervision as needed to address anxieties that may arise with limit setting.

This study also highlights how the practical experience of conducting CCPT allowed for greater learning about the *client differences* in regards to the stages of CCPT. Supervisors may need to allocate time in supervision to discuss clients and the differing ways that they present the CCPT stages. This conversation provides the supervisee with an ability to learn more about

client conceptualization and how effective conceptualizations can affect the *therapeutic relationship*.

Worthington and Roehlke (1979) also suggested the need for supervisors' modeling skills. Since none of these participants appeared to be in Level 2 in their overriding structure of autonomy according to Stoltenberg and McNeill (2010) depiction of IDM, the supervisors may have modeling the skills more than they would have if working with more advanced students. As the supervisees progress to Level 2 and strive for more autonomy, a supervisor may need to decrease in skill modeling as they may engage in more conflict in their relationship.

This study aids in the supervisors' understanding of their supervisees within a developmental context. IDM offers supervisors not only a way to conceptualize their supervisees, but it offers suggestions for supervision depending on the supervisee's developmental level (McNeill et al., 1992; Stoltenberg, 2005; Stoltenberg & McNeill, 2010). This study's participants included several traits that lined up with the IDM traits of Level 1 and Level 2 supervisees. IDM outlines the high levels of anxiety within Level 1 supervisees, and IDM also accounts for how supervisees long for structured skills within the intervention skills domain (Stoltenberg & McNeill, 2010). Level 1 supervisees may find that learning a specific specialization may help in alleviating anxiety.

The participants did not indicate a difference in importance between *individual* and *group supervision*, but the results suggested an importance on both experiences. Supervisors need to try to offer supervisees an opportunity to receive both individual and group supervision. This provides the supervisee an opportunity to benefit from *individual feedback*, as well as the *peer influences*. Group supervision offered the participants another opportunity to learn about the *client differences* through aspects of CCPT (e.g. CCPT stages). Thus, group supervision offers

CITs an opportunity to learn about working with a variety of clients and learn from others' experiences.

This study does possess a possible implication for fields outside of the field of counseling. Other fields such as education, psychology, social work, therapeutic recreation, etc. also include practical experiences as a part of their educational programs. These fields may find the developmental context of supervision to be helpful, as well as the use of reflection to aid in the growth of professionals.

Future Research

This study sought to provide more information about how CITs develop in an early training experience in CCPT. I recommend a more in-depth mixed-methods study that combines some of the previous approaches of studying students within a CCPT course and following the students into a practicum or internship experience in CCPT. Further research could utilize Lindo et al. (2012) approach using the Play Therapy Attitude-Knowledge-Skills Survey (PTKASS), as a pre and post assessment of a play therapy course. The PTKASS could be used again as the participants proceed to a play therapy practicum or internship experience. In the practical component, the researcher could utilize the Supervisee Levels Questionnaire Revised (SLQ-R; McNeill et al., 1992) to assess the supervisee's developmental level, as well as the attitudes, beliefs, and skills of play therapy associated with the PTKASS. Utilizing a mixed methods approach, this study could utilize blogs and interviews to allow the participants to track their own personal accounts of development to further account for the nuances present in different supervisees.

Another research possibility includes creating a survey including the factors relevant to CCPT CITs' development based on the participants' experiences. This survey could utilize

information from this study coupled with items from other assessments measuring factors such as: counselor self-efficacy, self-perceived propensity for empathy & UPR and self-perceived skill with empathy & UPR. This study could also utilize the SLQ-R to assess CITs' developmental level. The values could be used individually as the dependent variables to create a possible model for predicting areas of development.

Future research could focus on the use of reflection techniques, such as the online blog in practical experiences. I hope that counseling students would include participants that readily utilize and engage in these types of practices, but further research could investigate if there is a difference in the types of reflections made by different developmental level students or even students within different fields conducting practical experiences.

Because this study was an exploratory case study, I examined several broad issues related to counselor development of the needed counseling skills, counselor change, and supervision. All of my research questions represent possible ideas for more in-depth research studies with each of those as an individual research topic. This research study focused on the CITs within a specialization of CCPT, but future research could also explore counselor development in other specializations.

Summary

This study explored how counselors develop while participating in an early training experience of CCPT utilizing an existing supervision group. Through their blogs, interviews, and focus group, the participants revealed components of their development including an ability to utilize empathy with a *shared experience*, which *reduced their need to control*. They experienced a decrease in *performance anxiety* and increase in *confidence*, both in themselves as therapeutic agents of change and in CCPT. They described *skill development* including

successes and *challenges* of *empathy* and *UPR*. Through the course of the training experience, they articulated changes in *a greater understanding of CCPT theory and of self*. Their supervision experiences included relevant moments of *individual feedback*, *peer interactions*, and within their *supervisory relationships*.

References

Axline, V. M. (1969). *Play therapy*. New York, NY: Ballantine Books.

Bohart, A. C., Elliott, R., Greenberg, L. S., & Watson, J. C. (2002). Empathy. In J. Norcross (Ed.), *Psychotherapy relationships that work*. New York: Oxford University Press.

Bratton, S. C., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice, 36,* 376-390. doi: 10.1037/0735-7028.36.4.376

Carkhuff, R. R. (1969). Critical variables in effective counselor training. *Journal of Counseling Psychology, 16,* 238-245. doi: 10.1037/h0027223

Choate, L. H., Smith, S. L., & Spruill, D. A. (2005). Professional development of counselor education students: An exploratory study of professional performance indicators for assessment. *International Journal for the Advancement of Counselling, 27,* 383-397. doi: 10.1007/s10447-005-8201-0

Cochran, J. L., & Cochran, N. H. (2015). *The heart of counseling: Counseling skills through therapeutic relationships* (2nd ed.). Belmont, CA: Routledge.

Cochran, N. H., Nordling, W. J., & Cochran, J. L. (2010). *Child-centered play therapy: A practical guide to developing therapeutic relationships with children*. Hoboken, NJ: John Wiley & Sons.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York, NY: The Guilford Press.

Cooper, M., Watson, J. C., & Holldampf, D. (Eds.). (2010). *Person-centered and experiential therapies work: A review of the research on counseling, psychotherapy, and related practices.* . Ross-on-Wye: PCCS Books.

Creswell, J. (1998). *Qualitative inquiry and reserach design: Choosing among five traditions*. Thousand Oaks, CA: SAGE Publications.

Elliott, R. (2002). The effectiveness of humanistic therapies: A meta-analysis. In D. J. Cain & J. Seeman (Eds.), *Humanistic psychotherapies: Handbook of research and practice.* Washington, DC: American Psychological Association.

Elliott, R., Bohart, A. C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. *Psychotherapy, 48*, 43- 49. doi: 10.1037/a0022187

Eriksen, K., & Kress, V. E. (2006). The DSM and the professional counseling identity: Bridging the gap. *Journal of Mental Health Counseling, 28*, 202-217.

Fall, M. , Drew, D., Chute, A., & More, A. (2007). The voices of registered play therapists as supervisors. *International Journal of Play Therapy, 16*, 133-146. doi: 10.1037/1555-6824.16.2.133

Farber, B. A., & Doolin, E. M. (2011). Positive regard. *Psychotherapy, 48*, 58- 64. doi: 10.1037/a0022141

Farber, B. A., & Lane, J. S. (2002). Positive regard. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 175- 194). New York: Oxford University Press.

Gibson, D. M., Dollarhide, C. T., & Moss, J. M. (2010). Professional identity development: A grounded theory of transformational tasks of new counselors. *Counselor Education & Supervision, 50*, 21-38. doi: 10.1002/j.1556-6978.2010.tb00106.x

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory*. Chicago, IL: Aldine.

Glesne, C. (2011). *Becoming qualitative researchers: An introduction* (4th ed.). Boston, MA: Pearson Education.

Grafanaki, S. (2001). What research has taught us about congruence. In G. Wyatt (Ed.), *Rogers' therapeutic conditions: Evolution, theory and practice. Volume 1: Congruence* (pp. 18-35). Ross-on-Wye: PCCS Books.

Heppner, P. P., & Roehlke, H. J. (1984). Differences among supervisees at different levels of training: Implications for a developmental model of supervision. *Journal of Counseling Psychology, 31*, 76-90. doi: 10.1037/0022-0167.31.1.76

Hogan, R. A. (1964). Issues and approaches in supervision. *Psychotherapy: Theory, Research & Practice, 1*, 139-141. doi: 10.1037/h0088589

Homeyer, L. E., & Rae, A. (1998). Impact of semester length on play therapy training. *International Journal of Play Therapy, 7*, 37-49. doi: 10.1037/h0089422

Inquirium. (2012). InqScribe (Version 2.2). Retrieved from http://www.inqscribe.com/

Kao, S. C., & Landreth, G. L. (1997). Evaluating the impact of child-centered play therapy training. *International Journal of Play Therapy, 6*, 1-20. doi: 10.1037/h0089405

Kaplan, B. A. (1964). The New Counselor and His Professional Problems. *The Personnel and Guidance Journal, 42*, 473-478. doi: 10.1002/j.2164-4918.1964.tb04688.x

Kolden, G. G., Klein, M. H., Wang, C., & Austin, S. B. (2011). Congruence/Genuineness. *Psychotherapy, 48*, 65-71. doi: 10.1037/a0022064

Konopasek, Z. (2008). Making things visible with ATLAS.ti: Computer-assisted qualitative analysis as textual practices. *FORUM: Qualitative Social Research, 9*, Art. 12.

Lambert, M. J., & Okiishi, J. C. (1997). The effects of the individual psychotherapist and implications for future research. *Clinical Psychology: Science and Practice, 4*, 66-75. doi: 10.1111/j.1468-2850.1997.tb00100.x

Landreth, G. L., & Wright, C. S. (1997). Limit setting practices of play therapists in training and experienced play therapists. *International Journal of Play Therapy, 6,* 41-62. doi: 10.1037/h0089413

Lawson, G., Venart, E., Hazler, R. J., & Kottler, J. A. (2007). Toward a culture of counselor wellness. *Journal of Humanistic Counseling, Education and Development, 46*, 5-19. doi: 10.1002/j.2161-1939.2007.tb00022.x

Leach, M. M., & Stoltenberg, C. D. (1997). Self-efficacy and counselor development: Testing the Integrated Developmental Model. *Counselor Education & Supervision, 37*, 115. doi: 10.1002/j.1556-6978.1997.tb00537.x

Lin, Y. -W., & Bratton, S. C. (2015). A meta-analytic review of child-centered play therapy approaches. *Journal of Counseling & Development, 93*, 45-58. doi: 10.1002/j.1556-6676.2015.00180.x

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage Publications.

Lindo, N. A., Chung, C., Carlson, S., Sullivan, J. M., Akay, S., & Meany-Walen, K. K. (2012). The impact of child-centered play therapy training on attitude, knowledge, and skills. *International Journal of Play Therapy, 21,* 149-166. doi: 10.1037/a0028039

Lovell, C. W. (2002). Development and disequilibration: Predicting counselor trainee gain and loss scores on the supervisee levels questionnaire. *Journal of Adult Development, 9*, 235-240. doi: 10.1023/A:1016060328253

McNeill, B. W., Stoltenberg, C. D., & Romans, J. S. (1992). The Integrated Developmental Model of supervison: Scale development and validation procedures. *Professional Psychology: Research and Practice, 23*, 504-508. doi: 10.1037/0735-7028.23.6.504

Mellin, E. A., Hunt, B., & Nichols, L. M. (2011). Counselor professional identity: Findings and implications for counseling and interprofessional collaboration. *Journal of Counseling & Development, 89*, 140-147. doi: 10.1002/j.1556-6678.2011.tb00071.x

Merriam, S. B. (1998). *Qualitative research and case study applications in education* (2nd ed.). San Francisco, CA: Jossey-Bass Publishers.

Norcross, J. C. (Ed.). (2011). *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed.). New York, NY: Oxford University Press.

Nordling, W. J., & Guerney, L. F. (1999). Typical stages in the child-centered play therapy process. *The Journal for the Professional Counselor, 14*, 17-23.

Orlinsky, D. E., & Howard, K. I. (1978). The relation of process to outcome in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of Psychotherapy and Behavior Change* (2nd ed., pp. 1283- 1330). New York: Wiley.

Patterson, C. H. (1984). Empathy, warmth and genuineness in psychotherapy: A review of reviews. *Psychotherapy, 21*, 431- 438. doi: 10.1037/h0085985

Paulus, T. M., Lester, J. N., & Dempster, P. G. (2014). *Digital tools for qualitative research*. Thousand Oaks, CA: SAGE Publications.

Ray, D. (2004). Supervision of basic and advanced skills in play therapy. *Journal of Professional Counseling: Practice, Theory, and Research, 32*, 28-41. http://www.txca.org/images/tca/Documents/Journal/TCA_Fall04.pdf#page=33

Ritter, K. B., & Chang, C. Y. (2002). Play therapists' self-perceived multicultural competence and adequacy of training. *International Journal of Play Therapy, 11*, 103-113. doi: 10.1037/h0088859

Roach, L. F., & Young, M. E. (2007). Do counselor education programs promote wellness in their students? *Counselor Education & Supervision, 47*, 29-45. doi: 10.1002/j.1556-6978.2007.tb00036.x

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

Rogers, C. R. (1961). *On becoming a person: A therapist's view of psychotherapy*. Boston, MA: Houghton Mifflin Company.

Rogers, C. R. (1992). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting and Clinical Psychology, 60*, 827-832. doi: 10.1037/0022-006X.60.6.827

Rønnestad, M. H., & Skovholt, T. M. (1993). Supervision of beginning and advanced graduate students of counseling and psychotherapy. *Journal of Counseling & Development, 71*, 396-405. doi: 10.1002/j.1556-6676.1993.tb02655.x

Rønnestad, M. H., & Skovholt, T. M. (2003). The journey of the counselor and therapist: Research findings and perspectives on professional development. *Journal of Career Development, 30*, 5-44. doi: 10.1177/089484530303000102

Schaefer, C. E. (Ed.). (1993). *The therapeutic powers of play*. Scranton, PA: Jason Aronson Inc.

Skovholt, T. M., & Rønnestad, M. H. (1992). Themes in therapist and counselor development. *Journal of Counseling & Development, 70*, 505-515. doi: 10.1002/j.1556-6676.1992.tb01646.x

Stake, R. E. (1995). *The art of case study research*. Thousand Oaks, CA: SAGE Publications.

Stoltenberg, C. D. (2005). Enhancing professional competence through developmental approaches to supervision. *American Psychologist, 60*, 857-864. doi: 10.1037/0003-066X.60.8.85

Stoltenberg, C. D., & McNeill, B. W. (2010). *IDM supervision: An Integrative Developmental Model for supervising counselors and therapists* (3rd ed.). New York, NY: Routledge.

Tanner, Z., & Mathis, R. D. (1995). A child-centered typology for training novice play therapists. *International Journal of Play Therapy, 4*, 1-13. doi: 10.1037/h0089316

Venart, E., Vassos, S., & Pitcher-Heft, H. (2007). What individual counselors can do to sustain wellness. *Journal of Humanistic Counseling, Education and Development, 46*, 50-65. doi: 10.1002/j.2161-1939.2007.tb00025.x

Watt, D. (2007). On becoming a qualitative researcher: The value of reflexivity. *The Qualitative Report, 12*, 82-101.

Worthen, V., & McNeill, B. W. (1996). A phenomenological investigation of "good" supervision events. *Journal of Counseling Psychology, 43*, 25-34. doi: 10.1037/0022-0167.43.1.25

Worthington, E. L., & Roehlke, H. J. (1979). Effective supervision as perceived by beginning counselors-in-training. *Journal of Counseling Psychology, 26*, 64-73. doi: 10.1037/0022-0167.26.1.64

Yager, G. G., & Tovar-Blank, Z. G. (2007). Wellness and counselor education. *Journal of Humanistic Counseling, Education and Development, 46*, 142-153.

Yin, R. K. (1994). *Case study research: Design and methods* (2nd ed.). Thousand Oaks, CA: SAGE Publications.

Yin, R. K. (2003). *Applications of case study research* (2nd ed.). Thousand Oaks, CA: SAGE Publications.

Appendices

Appendix A

Informed Consent Statement for Journals and Focus Group

You are invited to participate in a research study. The overall objective of this research project is to observe how counselors/therapists develop within early career or initial experiences with child-centered play therapy (CCPT).

In order to accomplish this task we are asking you to consider allowing us to use your journal responses from our supervision group and your responses in our closing focus groups in research. Your responses as an individual will not be singled out in the study – rather, aggregate themes and anonymous example responses will be presented in research.

No known participant risks are associated with this project. However, your identity as one of the subjects in the research cannot be protected, as it is assumed that you will also participate and be identified as one of the authors of the study. Participants experiencing adverse reactions from their involvement in the study are referred to the UTK Counseling center (864-974-2196). Participants will benefit by reflecting on their own career journey. The results of the study will inform us about CCPT and counselor development in regards to personal development and in tandem with supervision experiences.

All data will be stored in a locked file in a locked file cabinet and office in UT Bailey Educational Complex and/or on the password protected computer of the Principal Investigator, Jeff L. Cochran, and Co-PI/Interviewer, Tiffany Brooks. After the study is completed and analyzed, digital recording of our focus group and electronic copies of your journal responses will be deleted. The informed consent statements and any transcripts will be retained in a separate locked file cabinet in UT Bailey Educational Complex for two years and then shredded.

If you have questions at any time about the study or the procedures you may contact Jeff Cochran at (865) 974-4178. If you have questions about your rights as a participant, contact the Office of Research Compliance Officer at (865) 974-3466.

Your participation in this study is voluntary. Your decision to participate or not will have no bearing on your supervisor's or instructor's evaluation of you. You may decline to participate without penalty. If you decide to participate, you may withdraw from the study at anytime without penalty. If you withdraw from the study before data collection is completed your data will be destroyed.

CONSENT

 I have read the above information. I have received a copy of this form. I agree to participate in this study.

Participant's name (PRINT) _____

Participant's signature _____ Date _____

Principal Investigator and Co-PI's Commitment to Terms is indicated by signatures below:

_____ Date: _____ _____ Date: _____

Jeff L. Cochran, Ph.D., PI Tiffany Brooks, Co-PI

Informed Consent Statement for Interview

You are invited to participate in a research study. The overall objective of this research project is to observe how counselors/therapists develop within early career or initial experiences with child-centered play therapy (CCPT).

In order to accomplish this task we are asking you to consider participating in a brief open-ended interview. You will be asked a series of questions about your work with CCPT. The interview should take approximately 45-60 minutes to complete. Your name on all data will be replaced with a pseudonym, and the list of names destroyed at the end of the semester. No reference will be made in oral or written reports which could link participants to the study.

No known participant risks are associated with this project. However, participants experiencing adverse reactions from their involvement in the study are referred to the UTK Counseling center (864-974-2196). Participants will benefit by reflecting on their own career journey. The results of the study will inform us about CCPT career development in regards to personal development and in tandem with supervision experiences.

All data will be stored in a locked file in a locked file cabinet and office in UT Bailey Educational Complex and/or on the password protected computer of the Principal Investigator, Jeff L. Cochran, and Co-PI/Interviewer, Tiffany Brooks. After the study is completed and analyzed, the digital recording of this interview will be deleted. The informed consent statements and interview transcripts will be retained in a separate locked file cabinet in UT Bailey Educational Complex for two years and then shredded.

If you have questions at any time about the study or the procedures you may contact Jeff Cochran at (865) 974-4178. If you have questions about your rights as a participant, contact the Office of Research Compliance Officer at (865) 974-3466.

Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at anytime without penalty. If you withdraw from the study before data collection is completed your data will be destroyed.

CONSENT

 I have read the above information. I have received a copy of this form. I agree to participate in this study.

Participant's name (PRINT) _____

Participant's signature _____ Date _____

Principal Investigator and Co-PI’s Commitment to Terms is indicated by signatures below:

_____ Date: _____ _____ Date: _____

Jeff L. Cochran, Ph.D. Tiffany Brooks

Appendix B

Semi-Structured Interview and Focus Group Protocol

1. Tell me about your experience with CCPT.
2. How have you (either as a counselor or person) changed, if at all, while utilizing CCPT? What has helped this change to occur?
3. Tell me about your experience utilizing unconditional positive regard and empathy through CCPT and supervision.
4. Tell me about your experience with supervision.
5. Anything else that can help me understand "what" your experience is with CCPT and "how" you have experienced it?

Vita

Tiffany Brooks was born in Gulfport, MS on June 7, 1986 to the parents of Tony Sawyer and Gina Miller. She has an older sister, Nicole, and younger brother, Tyler. She attended Cedar Lake Christian Academy in elementary, and upon moving to Madison, MS attended Madison Ridgeland Academy. She attended Rosa Scott Middle School and Madison Central High School in Madison, MS. Tiffany earned her Bachelor of Arts in Psychology with a minor in Counseling in 2008 from Lee University in Cleveland, TN. She continued at Lee University to earn her Master of Science in Mental Health Counseling in 2011, while working in Residential Life and Housing. In 2015, she finished her Ph.D. in Counselor Education at the University of Tennessee, Knoxville.