UNDERSTANDING PLAY AS A THERAPEUTIC INTERVENTION: A STRUCTURAL SOCIAL WORK PERSPECTIVE

by

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B.S.W., University of Northern British Columbia, 2003

PRACTICUM SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER
IN
SOCIAL WORK

UNIVERSITY OF NORTHERN BRITISH COLUMBIA

May 2012

Abstract

Play, as therapy and in therapy, has been established in the research literature as an effective method of intervention with children and youth. It has often been identified as the language of childhood and an appropriate medium for communicating with, and understanding, the world of the child. There is no one definition of play, but there is agreement among multiple disciplines that play is easily recognizable, complex, multi-faceted, and essential to healthy child development. Empirically based research involving both directive and non-directive play has demonstrated the healing power of play within the therapeutic relationship. The therapeutic alliance is considered by many mental health professionals to be the key element in facilitating healing, personal growth, and positive change.

My practicum learning experience reinforced and validated many of the therapeutic powers of play documented in the literature and resulted in enhanced clinical skills, and a greater understanding of the therapeutic value of play. The influences of culture, gender, and ethnicity, were not specifically identified, or addressed during clinical or group interventions, though the impact of culture arose as a distinct theme during the context of a group discussion and within the process of game play. Overall, play was experienced as a key component in creating and maintaining a therapeutic relationship while enabling client empowerment and an atmosphere conducive to positive growth and change.

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ACKNOWLEDGEMENTS

I would like to thank my advisor Heather Peters Ph. D., committee member Joanna Pierce MSW, RSW, my practicum supervisor Skye Perry MSW, RCSW, Megan Klotz RN BSc N, Glen Grunau MA, and Joanne Crandall Ph. D., R. Psych., for their guidance and support. I wish to acknowledge Ruth Manky, a very supportive and dear friend, and my husband William R. Crawford for his undying patience and staunch support during the course of my graduate studies. He is my touchstone.

Above all I wish to express heartfelt appreciation for the individuals and their families who shared their struggles and successes with me in the context of a therapeutic alliance. I am grateful for the opportunities they provided to learn about the therapeutic powers of play.

There are those dear to me who can no longer share in my learning journey yet who have influenced my avid interest in the therapeutic powers of play. I wish to acknowledge my father, Donald James Keir Beairsto, my brother, David Donald Beairsto, and my grandmothers, Matilda Popham and Lillian Beairsto. They are forever in my life.

DEDICATION

I want to dedicate this writing to my mother, June Marie Beairsto, for inspiring my love for social work; and to my aunt, Patricia Archibald (nee Beairsto), and best friend Susan Cooper, both teachers who encouraged and motivated my educational pursuits while modeling play as an effective medium for both healing and learning.

CHAPTER ONE: DESCRIPTION OF PRACTICUM, AGENCY, AND THEORETICAL ORIENTATION

The focus of this chapter is on providing a description of my practicum objectives, the practicum learning environment, target population and service provision, learning goals and activities, theoretical orientation, theory guiding clinical interventions, and a synthesis of the theories guiding my practicum experience and subsequent report.

Practicum Objective

I selected play, as a therapeutic intervention, as an area of learning based on my personal and professional interests. The choice was based on past and present experience in counselling with children and a formal education in the profession of social work, specifically, an undergraduate degree founded upon structural social work theory. The practicum placement was motivated by desire to gain experiential knowledge related to the phenomenon of play as a therapeutic intervention, while gaining experience with children, and sometimes parents, who engage in play-based activities in a clinical setting.

My practicum involved the completion of 560 hours with MCFD's Child and Youth Mental Health (CYMH) services where play is viewed as a medium for both learning and healing based on healthy child development. The practicum goals and subsequent learning experiences were guided by several queries which were informed, and influenced, by a review of the literature on play. Several questions guided my practicum and learning objectives. How is play used in clinical interventions to facilitate wellness and healing in children and parents? How is play impacted by the structural influences of gender, ethnicity and culture? What are the implications of the knowledge gained for my professional social work development in clinical work with children and families?

My practicum report incorporates personal reflections pertaining to knowledge gained and is critiqued from a structural social work perspective with a particular focus on feminist values of empowerment and the building of personal/collective strengths amidst the contexts of history, culture, gender, and ethnicity. These structural influences, as viewed from the experience of play, are presently lacking in the research. These realities in conjunction with professional interests and the recent introduction of progressive, critical, social work theory have encouraged my choice of lens for the critique of the practicum learning experience. For the purpose of this report, ethnicity is taken from the root word ethnic and will be defined as, "relating to race or culture" (Thompson, 1995, p. 463). The word relating implies self-identity and how an individual relates or identifies with a particular group of people.

Practicum Learning Environment

The setting for my field placement was a Child and Youth Mental Health centre located in Quesnel, British Columbia. The agency, as a subsidiary of the Ministry of Children and Family Development, is staffed by three full-time mental health clinicians, from the disciplines of nursing, social work, and psychology (clinical counselling). A mental health clinician with an MSW and registered as a clinical social worker (RCSW) with the British Columbia College of Social Workers, provided direct, agency-based supervision during the length of the practicum. A registered clinical social worker has met a series of requirements indicative of advanced knowledge and skills as designated by the BC College of Social Workers. It is not a mandatory process but rather an optional level of registration for social workers in clinical practice.

Target Population and Service Provision

Child and Youth Mental Health services (CYMH) receives referrals for children and youth up to 19 years of age addressing a range of mental health issues such as depression and anxiety. Clinicians respond to concerns involving suicide and conduct risk assessments. They provide comprehensive psychosocial mental health assessments and treatment plans, mental status exams, and therapeutic interventions based on evidence-based practice ("What we do," n.d.). A psychiatrist from British Columbia Children's Hospital visits the CYMH agency in Quesnel, B.C., every six to eight weeks, to assess children presenting with more complex mental health issues. The local CYMH agency provides referrals to other resources within the community, as well as making regional and provincial referrals.

Learning Goals

Three learning goals directed my practicum placement. The first of these involved the development of my clinical social work skills within the context of therapeutic play. This goal was accomplished by accessing education and experience in the areas of psychosocial intake, assessment, treatment planning, and case closure within the context of evidence-based modalities such as Cognitive Behavioural Therapy and by engaging in clinical practice with clients under the supervision of the agency supervisor.

The second goal pertained to increasing my knowledge of resources relevant to mental health practice with children and youth. The learning objective was fulfilled by reviewing websites, reports, policy and procedures manuals, and resources; the continued study and review of the literature relevant to play as a therapeutic medium and intervention; and participation in professional development activities for the purpose of gaining

knowledge. Included in this learning objective was the enhancement of skills relevant to therapeutic intervention involving children and the use of play.

The third learning goal involved understanding play as a therapeutic modality. This was facilitated through observing, co-facilitating, and facilitating various established child and youth mental health programs involving play as an intervention. This learning objective was met by documenting the learning gained through interactions with agency staff, colleagues, supervisor(s), instructors, clients, and their parents. My learning experience was critiqued and viewed from the foundational principles of structural social work theory. The specific tasks associated with the fulfilment and completion of the learning goals are described and outlined in Appendix 1.

The practicum activities associated with developing clinical social work skills involved: client screening, intake, assessment, documentation, the development of treatment plans, and client follow-up. It also entailed the use of, and familiarity with, the fourth edition of the Diagnostic Statistical Manual of Mental Disorders 4th Edition, Text Revision (DSM IV – TR), government websites and reports relevant to child and youth mental health interventions, and community-based, and other resources relevant to the development of effective treatment plans. Clinical social work skills were further developed and enhanced within the context of a supervised caseload of four clients, the facilitation of an intervention-based children's group, and the co-facilitation of a parent education group.

The practicum activities associated with increasing knowledge of resources relevant to mental health practice with children and youth involved: the continued study and review of the literature relevant to therapeutic play, development of a play-based intervention group

utilizing an approved mental health intervention program, attendance at agency-based professional development sessions, and the observation of therapeutic assessments conducted by a psychiatrist. The practicum activities associated with understanding play as a therapeutic modality incorporated the use of journaling the practicum experience and critiquing the learning gained based on the theoretical perspective of structural social work.

Theoretical Orientation

Radical and structural social work theory, as presented and described by authors such as Fook (1993) and Mullaly (1997, 2007), influenced my assumptions and beliefs that social, structural and historical contexts interact with, and impact client issues and therapeutic interventions with children and the experience of play. Fook (1993) describes critical social work as the "analysis of social structures in understanding a person's situation" (p. 15). Mullaly (1997) expounds on the description of structural social work theory as encompassing an egalitarian view of society based on a socialist ideology that seeks to change and transform the political and socioeconomic structures of society to reflect principles of social justice and freedom from oppression. The goals of structural social work are two-fold: (1) to address and meet the needs that arise as a consequence of the inequities inherent within capitalist based socio-economic structures of society, and (2) seek the transformation of society to reflect the principles of social justice, equity and equality for all (Mullaly, 1997, p. 107, 108).

According to Mullaly (1997) structural theory best fits with the values and goals of socialism. Nine common themes describe the socialist views pertaining to social change. (1) Socialism is the preferred socio-political reality – rejecting capitalist based society. (2) Reform as viewed from a liberal perspective is rejected as a means of solving social

problems. (3) The present distributive social welfare system enables the political mechanisms of capitalism. (4) Principles of social justice are in direct opposition to the liberal/conservative ideology of a capitalist based society. (5) Traditional social work practice perpetuates social ills. (6) Personal and political realities are interconnected – a contrast to the liberal separatist view of individual and state. (7) A feminist orientation is essential to structural social work practice as it links the personal and the political, facilitates an awareness of the oppressive socio-economic and political conditions within society and focuses on social change as a solution. (8) Oppression encompasses a broad spectrum of structures such as: patriarchy, classism, racism, ageism, imperialism, ableism, and heterosexism. (9) The present construct of professionalism creates a gap between professionals and service users (Mullaly, 1997, p. 107, 108).

The feminist, anti-racist, and anti-oppressive perspectives as components of structural social work theory inform structural social work practice (Mullaly, 2007). These orientations seek social change by empowering those marginalized within society. Consistent with social work values of egalitarianism and humanism these perspectives are motivated by the pursuit of social justice through empowerment, building on personal and collective strengths, and social action (Mullally, 1997, 2007). Mullaly (1997) describes the need for transformative structural change (socio-political structures and systems) within society. Fook (1993) incorporates radical feminist principles related to connecting and linking personal (individual) and political (structural) beliefs, and the experience of the world, in a process of consciousness-raising to assist in understanding oppressive "patriarchal social structures" (Fook, 1993, p. 15).

Theory Guiding Clinical Interventions

CYMH services utilize Cognitive Behavioural Therapy (CBT), among other evidence-based modalities, to facilitate the process of change. CBT Connections, a subsidiary of P.D. McLean Consulting & Associates Inc., provided the training utilized by CYMH clinicians in Quesnel, BC, the location of my practicum placement (G. Grunau, personal communication, January 23, 2012). The *Treatment of Childhood Disorders* (Barkley & Mash, 1998) is a primary resource used by CYMH clinicians, in addition to, The *Coping Cat* (Kendall & Hedtke, 2006) the *Cool Kids Program* (Cool Kids, 2003) and resources originating from the *Friends for Life* Program (Friends for Life – Friends for Children, Barrett, 2005).

The cognitive model is based on the premise that an individual's emotions and behaviours are influenced by the perception of experience rather than the actual event or situation in and of itself (Beck, 1995). Perceptions are in turn based on beliefs developed over time about themselves, others, and the world. These beliefs influence thoughts, feelings and behaviours. Therapeutic interventions are directed towards understanding the cognitive distortions reinforcing client behaviours associated with conditions of depression and anxiety. Through the process of education, distortions are identified, examined, and modified to facilitate a reduction in symptoms (Beck, 1995).

Cognitive Behavioural Therapy is an integration of cognitive and social psychology, behaviour therapy, and cognitive therapy. CBT emphasizes thinking processes (cognition) and is founded on social learning theory. Social learning theory suggests there is a reciprocal interaction between the affect, thinking and actions of an individual and the environment,

which in turn influences behaviour (Cooper & Lesser, 2011).

According to Beck (1995) the following ten principles guide CBT interventions. (1) Assessment and problem formulation is an ongoing process. (2) CBT is based on a solid therapeutic relationship. (3) Collaboration and client participation are important components. (4) CBT is problem focused and goal oriented, and (5) is primarily focused on the present. (6) It relies on education and enables the client to assume the role of therapist. (7) CBT is a time limited process, and (8) sessions are structured. (9) CBT teaches the identification, and evaluation of distorted thinking patterns. (10) CBT relies on an assortment of strategies and techniques to facilitate change in affect, thinking, and behaviour (Beck, 1995, p. 5 – 9).

Cognitive Behavioural Play Therapy with children echoes CBT principles with a focus on developing goals and modeling effective coping skills. Behavioural interventions include: positive reinforcement, shaping, stimulus fading (transfer of skills to other settings), extinction and differential reinforcement of other behaviours, time-out, self-monitoring, activity scheduling, recording dysfunctional thoughts, cognitive change strategies, coping self-statements, and bibliotherapy (Knell, 2003).

Filial Play, an additional modality of focus, was developed during the 1960s as an approach directed to enhancing family functioning (VanFleet, 2005). The term is also associated with Filial Family Therapy (FFT) and Child Relationship Enhancement Family Therapy (CREFT). It was created by Dr. Bernard Guerney and Dr. Louise Guerney as a form of intervention with children addressing social, emotional and behavioural difficulties (VanFleet, 2005). This approach to therapy engages the parents as change agents in the lives of their children by utilizing a psycho-educational approach involving the teaching and

mastery of skills. The intervention targets families with children ranging from 3 – 12 years of age and involves equipping parents to engage in structured play sessions with their children (VanFleet, 2005).

An underlying principle of Filial Play is the belief that play is in and of itself therapeutic (Schaefer, 1993: VanFleet, 2005). It is considered an essential component of healthy child development, providing a natural venue from which to engage in and understand the world of the child. Change is facilitated through education and the attentiveness of the therapist to the emotional interchange between parents and their children (VanFleet, 2005). Filial Play is based on two theoretical constructs: the child-centered theory of Virginia Axline and behavioural reinforcement theory developed by B.F. Skinner (Guerney, 2003). Behavioural theory acknowledges the reciprocal interaction between the individual and their environment and utilizes the interventions of shaping, chaining, and modelling. Shaping involves teaching a new behaviour through gradual reinforcement. Chaining is related to reinforcing steps required to achieving a desired behaviour and modelling involves a demonstration of the anticipated behaviour (Bronson, 2002). The child-centered, non-directive, approach to Filial Play is founded on the premise that the individual is innately motivated to seek personal growth and has the natural ability to solve problems within the context of an accepting, non-judgmental, therapeutic relationship (Axline, 1974).

Johnson et al. (1999) provides a description of Filial Play as a natural link between individually based child therapy and family intervention. Johnson et al. (1999) also validate family change at the systemic level noting gains in communication between parents and their children. There are six explanations for systemic change in the use of filial therapy. Filial Therapy as an approach: (1) encourages family involvement, (2) engages parents as partners

in the change process, (3) is solution focused, and (4) as a therapeutic process facilitates an increased awareness of parental roles in child related problem behaviours. (5) It strengthens the parent child relationship reducing the tendency to react rather than respond to behaviours, and lastly (6) the intervention provides a venue for identifying and changing negative patterns of parent child interaction (Johnson et al., 1999, p. 3, 4).

Theoretical Synthesis

Structural social work theory (Mullaly, 1997) and social learning theory (Bandura, 1977) both account for the effect of the environment on the individual. CBT, as founded on social learning theory, shares a commonality with the goal of structural social work in the pursuit of change. The difference between the approaches is the target of change; structural social work seeks societal (messo, macro) transformation, while CBT is focused on change at the micro, intra-psychic, or individual level. Filial play is similar to CBT in that change is targeted at the level of the individual, but views the process of change as initiated by, and involving, the system of the family. The feminist orientation inherent in structural theory is strength-based, focused on an analysis of power structures and can be utilized as a lens to critique any theoretical orientation, environmental context or therapeutic modality. Synthesizing the micro and macro levels of intervention during CBT therapy involves applying the strategies from a radical social work perspective which incorporates an understanding of the "interaction between psychological and social factors" (Fook, 1993, p. 33). It involves being ever mindful during assessments and interventions of the reality that social factors, as part of the larger social structures, influence client issues (Fook, 1993, p. 32, 33).

Summary of the Practicum Placement

I completed a practicum with MCFD's Child and Youth Mental Health services in the context of clinical social work involving play. The learning experience was directed by three learning goals and guided by questions designed to facilitate an understanding of play as a therapeutic intervention. Structural social work provided the theoretical base and lens for the critique of the practicum placement. Cognitive Behavioral Therapy and Filial Play Therapy were the approaches that guided client interventions. The concepts and principles of social learning theory provided a theoretical synthesis for the practicum learning experience in the focus on, and pursuit of, positive change and emphasis on understanding the effects of the environment on client experience.

CHAPTER TWO: LITERATURE REVIEW

The literature examined in this section is relevant to the subject area of play and its relationship to child development and play therapy. In querying a university library database on the subject of play the term was primarily associated with the disciplines of education and psychology and pertained to either recreational or symbolic play. Many of the articles and text resources in the category of symbolic play related to play therapy and the role of play within child development. The majority of the written resources reviewed here reflect the theoretical perspectives and research findings specific to the disciplines of education and psychology due to a scarcity of research-based writings related specifically to social work interventions involving play. Therefore, the focus of the chapter will be on an overview of the literature on play from multiple disciplines. This chapter will incorporate a review of the literature from a social work perspective and a brief overview of progressive social work research on Play Therapy. Included are descriptions pertaining to: Holistic Expressive Play Therapy, definitions and characteristics of play, directive and non-directive play therapy, the efficacy of play therapy, the role of play in human development, and the use of games. This chapter concludes with research on the benefits of play therapy.

Social Work Research on Play Therapy

A review of social work found that articles on therapeutic play primarily reflected traditional or conventional social work values rather than a balance of both conventional and progressive social work interventions as they pertain to therapeutic approaches involving play. Mullaly (1997) describes the two primary approaches to social work intervention as conventional and progressive, noting that, "all social work activity is concerned with social problems, that is, with alleviating, eliminating, or preventing social problems and the

deleterious effects they have on people" (p. 2 - 3). Progressive social work is described as an approach that addresses social issues by challenging the political, economic, and social, conditions that contribute to inequity and inequality. Traditional or conventional social work practice is focused on problem amelioration within the context of the 'social milieu' of the individual rather than on the impact of the external socio-economic structures (Fook, 1993, p. 21).

Progressive Social Work Research on Play Therapy

Although research on play therapy typically comes from a conventional approach there is one study that has a progressive perspective. Wickstrom (2009), in a phenomenological study of a filial therapy program, provides an example of the progressive social work perspective on play through an examination of parent child relationships based on parental beliefs as viewed from the dimensions of culture, power, and gender. The study is noted as a first for qualitative research involving the parent-child experience within the context of play and the process of change as viewed from a systemic perspective. The use of a systemic lens allowed for the examination of the family unit amidst the larger social context. The model of filial intervention utilized in the study is described as Child Parent Relationship Therapy, a group approach entailing 10 weeks of parent focused education. The methodology involved the use of two focus groups, where group discussions and interactions were videotaped. All participants had received prior training in filial play. The analysis resulted in four themes related to improvements in multiple relationships. Findings indicated improvements in parent-child relationships, marital relationships, sibling interactions, and relationships involving family of origin.

Holistic Expressive Play Therapy

A recent naturalistic inquiry into a branch of play therapy described as Holistic Expressive Therapy attempted to answer the question, how has the approach influenced therapists in their practice (Sather, D., 2011)? Expressive Therapy is associated with the professions of psychology, social work, counselling, and psychiatry and is described as the umbrella for play therapy, art therapy and sand therapy (Sather, 2011). These therapies utilize the mediums of creative writing, poetry, dance, music, story-telling, and drama. The use of pet-assisted therapy can also be incorporated into expressive therapy (Sather, 2011). A unique attribute of Expressive Therapy is the encouragement of full sensory involvement within the therapeutic experience. Sather (2011) describes holistic therapy as the focus on the emotional, mental, physical, and spiritual areas of a person's life as an integrated whole during treatment.

Holistic Expressive Therapy, a therapeutic approach developed by Marie-Jose´Dhaese, is a self-healing process involving both the intellect (thinking) and the emotions (heart). Both aspects of the person are viewed as equally important and essential to recovery (Sather, 2011). It is a client-centered, strength-based approach to intervention in which the client/therapist relationship is viewed as foundational and essential to the self-healing process. Holistic Expressive Therapy is based on four primary components: 1) client-therapist relationship; 2) therapeutic environment (milieu); 3) expressive therapy; and 4) family therapy (Sather, 2011). The milieu, or therapeutic environment, is composed of the space allocated to the helping relationship. A primary focus of selecting and establishing the milieu is to create a sense of safety and create an environment conducive to healing and personal growth. Expressive Therapy pertains to the techniques utilized by the therapist and

the client during the healing process. The involvement of family members is welcomed and encouraged throughout therapy to support and reinforce the process of positive change.

Definitions and Characteristics of Play

Scholars representing the disciplines of education, zoology, history, anthropology, and psychology have approached the study of play from many theoretical perspectives and research methodologies. Despite the different perspectives of play presented within the literature, a consistent commonality is that play is seen as easily recognizable yet difficult to define (Pelligrini, 2009). Schaefer (1993) echoes this observation and reiterates that though there are many definitions of play, seven common attributes characterize play behaviours. (1) It is intrinsically motivated. (2) The process is more important than results. (3) It is associated with positive emotions and pleasure. (4) It is an activity that incorporates complete sensory involvement and (5) has a pretend – as if – component. (6) It also inspires creativity and innovative thinking while (7) asking the question, "What can I do with this object?" (p.1). Landreth (2001) describes play as, "the most complete form of self-expression developed by the human organism" (p. 4), further noting that play is a complex behaviour encompassing many dimensions of human behaviour and child development.

Landreth (1991) describes play as a universal and natural form of communication for children, defining it as a venue that allows them to play out their feelings and experiences. He reports that children often lack the necessary verbal and cognitive abilities to engage in a conversation that fully expresses thoughts, feelings, and experiences. The author further notes, "play is to the child what verbalization is to the adult" (p. 14). The Association for Play Therapy provides a definition of play as therapy:

Play therapy consists of a cluster of treatment modalities. It involves the systematic

> use of a theoretical model to establish process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties, achieve optimal growth and development, and re-establish the child's ability to engage in play behaviours as they are classically defined in childhood (Cooper & Lesser, 2011, pp. 204, 205).

Schaefer (1993) identifies 14 therapeutic factors attributed to play. The factors that are most applicable to the clinical learning experience are: overcoming resistance (to the therapeutic alliance), catharsis (release of emotion), mastery of child's environment, creative thinking (problem solving), role play, understanding the communication process of play, the use of fantasy (imagination), attachment formation, enhancement and strengthening of the therapeutic relationship, enjoyment (pleasure), and game playing.

Directive and Non-Directive Play Therapy

There are two styles of engaging in therapeutic play, directive or non-directive. The non-directive approach mirrors the principles of client-centered intervention, a perspective associated with Carl Rogers (Schaefer, 1993, p. 12). Virginia Axline (1974), a pioneer in the application of non-directive child-centered play therapy, adopted the style of intervention based on its promotion of, and reliance on, the development of personal responsibility. She differentiates between the two approaches to play therapy, noting that the therapist assumes responsibility for directing and interpreting the process within the framework of the directive model (Gil, 1994, p. 12). According to Guerney (1983), a proponent of child-centered play therapy, "The realization of self-hood via one's own map is the goal of non-directive play therapy" (Guerney, 1983 in Gil, 1994 p. 13).

Directive approaches are associated with Gestalt therapies, behavioural models of

intervention, games, family therapy and filial therapy (Gil, 1994, p. 13). Gil (1994) notes that though other play therapists suggest a "rigid separation between the directive and non-directive approaches"(p. 14), the use of both directive and non-directive approaches can be utilized as an integrated model of approach based on the individual, or familial, goals of intervention. A diversity of opinion exists among proponents of play therapy as to which of the two primary approaches is the most beneficial as a play-based intervention. The choice of intervention is related to the theoretical stance of the play therapist, the role of the therapist, and the needs of the individuals and families served (Axline, 1974; Gil, 1994).

Despite the differences underlying directive and non-directive play-based interventions, the therapeutic relationship is commonly identified by social workers and practitioners in other disciplines as the key to successful outcomes in the diverse field of play therapy (Landreth, 2001). Though play therapy is recognized as an effective therapeutic approach with children and families it is not recommended with children impacted by relationship trauma or children living with autism or schizophrenia. Play therapy relies on the capacity to establish a trusting relationship, or therapeutic alliance, a state of being lacking or compromised in the conditions mentioned (Lin, 2003; Landreth, 1991). Virginia Axline (1974) and Garry Landreth (2001) are noted advocates for child-centered play therapy and have contributed extensive knowledge and experience pertaining to the non-directive approach to both individual and family interventions involving play.

Efficacy of Play Therapy

Play therapy, in all its various modalities, has been established as an effective approach to intervention within the scientific community though no one approach has proven to be more effective in problem amelioration than another. Most of the research has involved

the use of case studies. Many projects involving experimental inquiry have been limited due to the lack of a control group for comparison purposes (Carroll, 2000). Scientific objectivity and the ability to generalize research results/findings are also noted deficits (Carroll, 2000). Children, as the primary recipients of play therapy, are notably absent as full participants within the research – a deficit reported as affecting the efficacy of research design (Carroll, 2000).

Filial Play, as a directed form of play intervention involving parents and their children, has demonstrated efficacy in the research as an effective approach in identifying problems and facilitating positive family change (VanFleet, 2005). It has been associated with: reducing parent child stress, strengthening the bond between parent and child, facilitating effective problem solving and communication among family members, promoting the input and involvement of children, the provision of a warm, empathic, relaxed, safe, accepting, and non-threatening environment conducive to exploring the process of change (Johnson, 1999; Walker, 2002; & Van Fleet, 2005).

The Role of Play in Human Development

In addressing the functional contributions of both structured and unstructured (spontaneous) play to healthy child development Timberlake and Cutler (2001) suggest the activity provides a venue for physical expression, intellectual stimulation, entertainment and social interaction. The authors suggest that play is culturally specific reflecting the history, values, and norms, of a unique "social heritage" (Timberlake & Cutler, 2001, p. 4). Play is presented as a window from which to view the emotional and cognitive processes of child development (Slade & Wolf, 1994).

Play is a process in representation and meaning making drawing from social and

cultural influences. Greenspan and Lieberman (1994) draw attention to two predominate yet diverse perspectives on play, the developmental (cognitive) and psychoanalytical (emotional) approaches. The developmental approach, based on the works of Piaget, views play as reflective of naturally occurring stages in child development, a process that can be studied and observed. Meaning making, or representational capacity, is presented as occurring in predictable patterns and is linked with distinct developmental stages (Slade & Wolfe, 1994).

Scarlett (1994) suggests, in contrast to the psychoanalytic perspective, the inability to play is related to undeveloped capacities rather than arising from repressed emotional conflicts. Psychoanalytic theory perceives play as a window to viewing the unconscious processes. The clinical focus is related to assessment and interpretation (Slade, 1994). Greenspan and Lieberman (1994) note the absence of a conceptual framework that incorporates both cognitive and emotional development and the interaction between the two processes. Greenspan is credited for constructing a developmental/structuralist approach to child development that integrates both cognitive and emotional processes (Slade & Wolfe, 1994).

The Use of Games

Game Play is a new branch of play therapy. Games can consist of well known childhood games and include games designed for particular therapeutic interventions. They are often used with older school age children, adolescents, and young adults. Games are often competitive in nature and based on distinct rules. In contrast to free play they are usually directive in nature and require cognitive ability. Games can assist with expressing painful emotions, enhancing the therapeutic relationship and providing diagnostic information regarding functioning, impulse control, intellectual strengths and weaknesses, locus of

control, and concentration. They also facilitate improved problem solving and insight into personal difficulties (Reid, 2001).

Games mirror cultural values and beliefs. Reid (2001) suggests, "Games of a particular culture reflect the prevailing societal concerns, pressures, and conflicts of its members and of the societal group as a whole" (p. 4, 5). Historically, game playing allowed the opportunity to exert control and mastery over an unstable and threatening reality. Games provide the opportunity to express aggression in socially acceptable ways. Reid (2001) notes that most games involve competition and provide an acceptable medium for the expression of aggression, dominance, and power (p. 6).

The therapeutic elements of game play involve: establishing the therapeutic relationship, pleasure, diagnosis, communication, reality testing, insight, sublimation, rational thinking, and socialization (Reid, 2001). The three types of games are games of strategy, games of chance, and games that utilize physical skill (Reid, 2001). Therapeutic games fall into four categories: communication (less focus on competition), problem-solving (behavioural theory), ego-enhancing (strategy and competition), and socialization (usually involves group work). Therapeutic games are based on specific theoretical orientations and are categorized in four distinct areas: psycho educational, client-centered, clarification of values, psychodynamic, and cognitive-behavioural (Reid, 2001). After the 1970s therapeutic games began to promote communication and the expression of thoughts and feelings (Reid, 2001). Research is beginning to validate the efficacy of game play with games involving social skills, divorce and changing families, and reducing anxiety (Reid, 2001).

Research on the Benefits of Play Therapy

Landreth (1991) cites various research studies in validating play therapy as an

effective therapeutic intervention. In particular, he focuses on the studies that have demonstrated improvements in the areas of academic performance, emotional adjustments, social functioning and self-esteem. He further notes that overall play therapy has proven "effective with children of all diagnostic categories except the completely autistic and the out-of-contact schizophrenic" (Landreth, 1991, p. 42).

Pellegrini (2009), in examining trends within the research on the subject of play, suggests that the predominant focus of study has been related to fantasy and pretend play. The author recommends research that explores various types of play, investigating the time spent engaging in specific activities while also inquiring into the immediate and deferred benefits of play. He advocates the need for research that informs educational policy based on the various forms of play and their outcomes.

Wilson (2001) concluded that individual child therapy with ongoing parental involvement can positively impact family functioning. Carroll (2002), in a qualitative study, reports on the children's views as they pertain to play within the therapeutic relationship. In a study involving interviews with 18 children ranging from 9 – 14 years, the author draws attention to the emergence of four common themes. These themes pertain to: the value of the therapeutic relationship, termination of the relationship between therapist and child, children's perceptions of talk/verbal therapy, and the importance of engaging in fun activities. Carroll (2002) noted that overall the findings indicated children value the therapeutic alliance and that fun itself is beneficial as a therapeutic endeavour. She concludes that children have much to teach if there is an ear to listen.

Ray (2008) studied archival data pertaining to 202 children, which details the impact of non-directed, child-centered play therapy on parent child relationship stress. The findings

indicated success in both long and short term interventions with noted benefits associated with increased participation in therapeutic sessions. Success was defined as reductions in externalizing and internalizing behaviours. Externalizing behaviours were identified as: aggressive behaviours, conflicts with others, non-compliance and rule-breaking. Internalizing behaviours were noted as: withdrawal, anxiety, depression, and somatic symptoms. Limitations of the inquiry pertained to instrument administration (use of a single instrument) and the lack of a control group for comparison purposes. Ray recommends continued research involving mental health facilities due to the availability of multiple clients and the diversity of problems requiring long-term intervention. He also identifies the issue of ethnicity as an under-researched area in play therapy due to "the high concentration of Caucasian participants" and lack of data to explore the differences (p. 183). Ethnicity is an area of research inviting further inquiry.

Another area for future research involves exploring the interrelation between program attendance and parent social support in filial play intervention. Topham and Wampler (2008) examined factors predicting dropout rates for 41 families in a 10-session filial therapy program for mothers and children and discovered a higher dropout rate than reflected in previous research involving other programs involving filial therapy. According to the researchers, this difference may be related to parents' perceptions of a lack of support during the therapeutic process. Additional factors that may explain the differing results could be related to a reliance on individual intervention rather than the group focus utilized in other similar studies, and the extensive assessment involved in the study. Clinical implications noted for future inquiry pertained to assessing parental acceptance of their children at the beginning of filial therapy and offering additional support to the parent throughout the

process of intervention.

Carroll (2000) examined research trends as they relate to the efficacy of therapeutic play and reports on the lack of evidence supporting any particular model of play therapy as an effective intervention. She draws attention to the pressure on clinicians to provide measureable data related to the viability of selected treatment modalities. Her investigation identified the challenges and limitations of the research designs of both process and outcome inquiry in play therapy intervention. The author noted that narrative case studies have been relied on historically to establish the scientific efficacy of play therapy as a treatment modality, and the common challenges involved in case study analysis pertain to ensuring objectivity and an inability to generalize findings. Carroll reports that the greatest omission in the research involving play therapy is the voices of the children, a deficit that, in her opinion, compromises the viability of research design. Areas for future study suggested by Carroll include the correlation between program attendance and parent support within filial play, the use of games as a therapeutic tool, the issue and experience of ethnicity in play therapy, the various types of play and the time spent on these activities in conjunction with the associated benefits, both immediate and deferred. Inquiry reflective of progressive social work is also an area of inquiry in the realm of play therapy. To date, there is scant research pertaining to the intersection of power and the role of parenting in the context of play. With the exception of a study initiated by Wickstrom (2009) the systemic influences of gender, culture and power and their impact on the perception and experience of play have been relatively unexplored (Crawford, 2010).

What remains unknown in the research on play is how to best integrate directive and non-directive forms of play therapy, which prescriptive approaches to follow and how to

apply them most effectively, and information on the active mechanisms in play therapy. More systematic studies are required to determine the clinical effectiveness of play, the applicability with certain disorders, and the power/impact of combined modalities (Meichenbaum, 2009; Schaefer, 1993).

Summary of the Literature Review

In conclusion, play is described as a multi-dimensional concept, experience, and phenomena, difficult to define, yet easily recognized (Pelligrini, 2009; Schaefer, 1993). It has been defined based on observable and inferred characteristics, and is commonly viewed as an important medium facilitating the natural communication of the child (Schaefer, 1993; Landreth, 1991, 2001). Play is validated in the research as an effective therapeutic intervention (Carroll, 2000; Landreth, 1991), yet further inquiry is needed to determine its clinical effectiveness and proscriptive elements (Meichenbaum, 2009; Schaefer, 1993). Filial Play is reported in the research as an effective approach to promoting attachment, reducing parent child stress and facilitating positive family growth and change (Johnson, 1999; Walker, 2002; VanFleet, 2005). The voices of children themselves are an area lacking in the research (Carroll, 2000). Play is considered to be an essential component of healthy human development, providing a window from which to view and assess the emotional and cognitive stages of personal growth in children (Slade, 1994; Slade & Wolfe, 1994). Play is also depicted as a process in meaning-making (Slade & Wolfe, 1994), an expression reflecting the influences of the social environment, which in turn is viewed as culturally specific (Timberlake & Cutler, 2001), and can be used as an intervention to assist children in the healing process (Schaefer, 1993).

The therapeutic approaches of focus for this field placement are Filial Play and

Cognitive Behavioural Play Therapy (Schaefer, 2003). They are selected modalities based on their use as interventions in Child and Youth Mental Health services. Schaefer (1993) suggests that the most beneficial models of play therapy are those in which the process of change is documented as detailed descriptions pertaining to the steps, strategies, and techniques, utilized to facilitate positive change. The process of client assessment, intervention, and change, is documented in child and youth mental health services.

CHAPTER THREE: THE PRACTICUM LEARNING EXPERIENCE

The focus of this chapter is to define my practicum learning goals and questions guiding the learning experience. It incorporates a discussion of the development of clinical social work skills in the contexts of clinical and group interventions, child and youth mental health screening and assessment tools, increasing knowledge of resources relevant to CYMH interventions, play as a therapeutic medium. These are discussed in the context of a review of the literature on Play Therapy.

Learning Goals and Questions Guiding the Practicum Placement

I completed a supervised social work practicum placement consisting of 560 hours at a Child and Youth Mental Health center in the province of British Columbia. The practicum involved meeting learning goals related to: (1) developing clinical social work skills within the context of therapeutic play, (2) increasing knowledge of resources relevant to mental health practice with children and youth, and (3) understanding play as a therapeutic modality. These learning goals were guided by three questions: How is play used in clinical interventions to facilitate wellness and healing in children and parents? How is play impacted by the structural influences of gender, ethnicity and culture? What are the implications of the knowledge gained for my professional social work development in clinical work with children and families? This chapter describes my learning experiences in the context of the practicum learning objectives and associated tasks.

Development of Clinical Social Work Skills

I was involved in a variety of activities that enhanced the development of my clinical social work skills. The final evaluation of my practicum noted the successful

implementation of skills in the following areas: facilitation of the intake process, competent use of the Community and Residential Information System (CARIS) used by CYMHS to document case activity, clear and succinct documentation of client case files, successful completion of comprehensive mental health assessments and treatment plans. Included were the formulation of provisional diagnosis based on DSM IV – TR criteria, consistent use of observation and interviewing skills, an incorporated awareness of social and structural issues that impact child, youth and family mental health, and the effective use of community and other resources. Additional skills noted pertained to making appropriate referrals, effective group facilitation and presentation, and the professional representation of social work values and attributes.

Play in the Context of the Therapeutic Relationship

I had the privilege of successfully engaging in clinical interventions with four clients and their families including the activities of assessment, treatment planning, intervention, session documentation, and either case transfer, or case closure. The clients represented an equal blend of both girls and boys. The youngest was 8 years of age and the oldest was 13 years. All of these individuals presented with cognitive challenges related to impaired executive functioning due to a combination of either genetic and /or pre and post natal influences. These difficulties with cognitive processing made it especially challenging to provide intervention through the modality of traditional cognitive behavioural therapy. There was the additional barrier of client resistance. All the clients expressed a concern that there was something wrong with them if they attended CYMH intervention sessions. As the student mental health clinician I attempted to normalize the experience of both anxiety and depression as part of being human. Family members (parents and siblings) were in

attendance with all clients throughout most of the scheduled sessions to support and assist in the intervention (change) process.

The non-directed play interventions of choice for two clients involved scrapbooking activities and on occasion the playing of a rapport building and communication effectiveness game entitled, *Out of Your Mind.* These sessions were designed to facilitate self-expression and build on client strengths (creative expression). One of the clients participated in a therapeutic playgroup I developed in consultation with a child and youth mental health psychologist and a social work clinician based on the Fun Friends curriculum. The Fun Friends program is an early intervention program designed to address anxiety by teaching resiliency building skills to children, parents, and teachers. A goal of treatment for this individual was the enhancement of social skills and she responded to both the directed and non-directed group play interventions by increasing her willingness to take risks in social situations and share her feelings with others. Due to the need for social stimulation, ongoing assessment, and possible impairment to executive functioning, one client was referred to the next intake of the Fun Friends group. A consulting psychiatrist recommended a case management approach to intervention for this particular child.

Another client responded to a combination of both directed and non-directed play in the medium of a sand tray. The concepts of Cognitive Behavioural Therapy were presented to this individual in the form of a narrative and with the use of metaphor. I utilized concepts based in the teachings of the *Worry Dragon* program. The Worry Dragon program is based on the principles of CBT and is adapted for children with the use of creative imagery to teach anxious children, with the support of their parents, to face, challenge, and cope with, their worries. During therapeutic sessions I assumed the role of a 'magic' therapist and entered the

realm of play when invited to participate. When the invitation was extended by this client to join in the sand play I would assume both a directive and non-directive approach based on the input of the client. It was interesting to note that observations of non-directed play involved watching this individual play out conflicts that appeared to be related to attempts to gain personal power.

One particular client was in the process of ongoing assessment and presented with oppositional behaviours that were impacting this individual's ability to develop the necessary life skills required to cope successfully in all environments. This teenager responded to game play (board games) on occasion, and was assigned the services of a youth care worker to help facilitate appropriate social interactions. Play with this person involved encouraging the use of game play with parent participation in the home environment and access to the community for recreational purposes. This individual chose and enjoyed a game of strategy (Risk) and the observed interactions during game play reinforced the findings of Reid (2001) in the enhancement of ego functioning and improved socialization skills with family members.

Engaging with clients in non-directed play activities within the context of individual therapy sessions echoed the findings of Landreth (1991) and Axline (1974) and was experienced as foundational to the establishing of a client-centered therapeutic relationship. The episodes of non-directive play encouraged client self-direction and self-actualization, and were empowering. Directive play facilitated the teaching of the basic tenets of CBT. A primary resource utilized that incorporated directed play activities was the Coping Cat Program, a skill-building program designed to help reduce symptoms of anxiety in child and youth mental health clients. The use of play is encouraged within the program as a means to engage children in the therapeutic relationship and intervention process while influencing the

child or youth's perception of the experience as positive (Podell, J., et al., 2009).

The experience of engaging in directed and non-directed play activities reinforced some of the benefits of therapeutic play noted in the literature review (Schaefer, 1993). According to Schaefer (1993), "Beneficial outcomes refer to desired changes that occur in the client because of the effectiveness of the therapeutic factors (p. 5)." The beneficial outcomes associated with play in the context of the therapeutic relationship were: the establishing of a working alliance, growth and development in the area of mastering developmental fears, improved socials skills, enhanced ego strength (resiliency building), and increased positive self-esteem (Schaefer, 1993, p. 6). The development and enhancement of social and coping skills, in conjunction with resiliency building were common goals in the CYMH treatment plans. Overall, the treatment outcomes reflected the commonly reported benefits of therapeutic play.

Play in the Context of Group Intervention

I adapted a play-focused intervention program in consultation with CYMHS Team Leader Skye Perry and psychologist, Dr. Joanne Crandall, based on the Fun Friends resiliency-building program developed by Dr. Paula Barrett. It was established to assist children on the CYMH waitlist, specifically girls, in developing coping skills and building resiliency. The program involved 12, weekly, 90-minute sessions that utilized the principles of CBT. An appreciation of difference and diversity was promoted along with learning to: identify and validate feelings, engage in relaxation activities involving correct breathing and movement (Yoga poses), engage in self-care, and empathize with the feelings of others. Additional skills encouraged were to identify helpful and unhelpful thoughts, reframe negative thinking patterns, and develop/enhance friendship skills. There was emphasis placed

on understanding and appreciating the value of maintaining a support network consisting of family, friends, and members of one's community. Weekly assignments involving home play activities were provided to facilitate family involvement and the reinforcement of learning and skills. The home play activities were reported by one of the parents as helpful in reinforcing the learning of resiliency building skills and in strengthening the parent-child relationship. The daily allotting of time was a barrier for the majority of the parents in reviewing and completing the home based activities.

The sessions involved 'free play' activities to facilitate the benefits of non-directed play (empowerment, creativity, relaxation, emotional expression), structured teaching and directed play activities to facilitate learning and skills building, the provision of a healthy snack, and Yoga exercises/poses to reinforce the importance of relaxation as a coping strategy. The *Kid's Yoga* program was the resource used to teach body positioning, correct breathing, mindfulness (focus on the present), and an awareness of the minds influence on the functioning of the body. Free play activities involved painting, drawing, crafts, scrapbooking, dressing-up and dollhouse play (fantasy/pretend play), and sand play. Directed play activities involved the use of board games, Yoga activity games (reinforced correct breathing techniques), journaling, and specific arts/crafts (reinforced lessons). The final session included a wrap-up party that involved the parents of the participants. The party provided an opportunity for the girls to observe networking in action and experience the value of facilitating community contact. Friendships were developed between the girls and their parents that would enhance their social networks/supports. Overall, the participants echoed the findings of Timberlake and Cutler (2001) in experiencing the group play interactions as physically and intellectually stimulating, entertaining, and a source of social

interaction.

The implementation of both directed and non-directed play within the context of the group setting resulted in an effective program. Directed play activities reinforced the learning of skills associated with CBT. Non-directed play facilitated the development of social skills, personal empowerment, and encouraged the expression of emotion and creativity, all validated outcomes of therapeutic play (Schaefer, 1993).

In conjunction with the development of clinical social work skills, I gained an increased understanding of, and experience with, Holistic Expressive Therapy through the process of facilitating a mental health intervention group. The group activities aligned with some of the foundational philosophies of Holistic Expressive Therapy in utilizing the creative mediums of writing, story-telling, and drama while encouraging full sensory involvement in the mental, emotional, and physical areas of the participants lives (Sather, 2011). The group interactions were strength-based, client centered, and encouraged the involvement of families amidst the medium of a safe, and respectful, therapeutic environment (Sather, 2011).

The Incredible Years Parent Education Program

I assisted in co-facilitating the Incredible Years program with a mental health clinician and another professional at a agency within the community. The Incredible Years program is a 10-week parenting program that incorporates an emphasis on non-directed filial play. I assumed responsibility for some of the weekly brainstorming sessions. One of these sessions involved a discussion pertaining to the benefits of, and barriers to, engaging in non-directed play with one's children. Common barriers reported were time management and fatigue as many families have demanding and sporadic work schedules, often involving shift work, amidst the management of household responsibilities and childcare.

Involvement in the program increased my understanding of the importance of play as a daily occurrence between parents and their children. I was most impacted by the weekly parent reports of positive behavioural change and strengthened filial relationships directly related to the daily inclusion of non-directed play. The weekly discussions and reports often served to stimulate thoughts pertaining to the structural influences on filial play. I assumed that the changes were due to the application of new learning, a consequence of challenging previously held beliefs directing parent-child interactions. I was curious as to the nature of present and past beliefs underlying play-based interactions between the parent participants and their children. My assumptions reflected structural social work theory (Mullaly, 1997) and the influences of a neo-conservative political climate that encourage an economic paradigm reflective of competition and accumulation, values associated with capitalism (Mullaly, 1997). The conservative values of capitalism and productivity may have been a dominant underlying belief initially influencing parental views pertaining to play. This critique of structural influences on play prompted further thoughts on the impact of culture, and the Canadian political, socio-economic, climate as components of culture.

In conjunction with enhancing my group facilitation skills, I gained a greater understanding about the therapeutic benefits of play. My observations of, and interactions, with the parent participants echoed the some of the research on filial play. Parent reports during the sessions noted a reduction in parent stress, and the strengthening of the parent-child relationship as a direct result of engaging in non-directed play activities (Johnson, 1999; Walker, 2002; & Van Fleet, 2005).

In viewing filial play from the perspective of progressive social work practice, I was reminded of the qualitative inquiry initiated by Wickstrom (2009) and the attempts to

document the changes in the parent child relationship from a systemic perspective that incorporated the influences of the "greater social context (p. 195)" amidst the dimensions of culture, gender, and power (p. 198, 202 – 207). The research and findings encouraged an acknowledgment of the societal structures that impact the experience of filial play. It is my intention to maintain a critical awareness of structural influences during clinical and group interactions, and with the consent and willingness of the client(s) and parents/guardians, identify these structural influences in future therapeutic endeavours involving play as based on developmental and cognitive abilities/capacities. For example, symptoms of anxiety that are exacerbated by societal expectations as promoted by the media (a structural influence) pertaining to personal appearance, presentation, and productivity, can be explored through the various modes of expressive art and play.

Child and Youth Mental Health Screening and Assessment Tools

The Brief Child and Family Phone Interview (BCFPI) is a screening tool utilized by CYMH Clinicians to determine eligibility for service provision. Questions are divided into sections to determine behavioural or emotional concerns, child functioning and impact on the family, risk factors, readiness for service, barriers to service provision, and demographic information. In assuming a structural social work perspective, it was observed that information gathering incorporated the micro (individual) and messo (family and community) systems, but did not allot for questions that provided information related to specific structural factors such as historical, cultural, and economic influences. There were questions designed to elicit information on family income, but questions were not designed to determine the impact of family economics on family functioning. Some individuals interviewed chose not to answer the questions pertaining to family income. Play as a concept

and activity were not referred to directly in the questions, but time spent as a family or engaged in community based clubs and activities were included to determine protective factors (social involvement).

The formal psychosocial assessment is designed to acquire information pertaining to biological and psychological factors, child development, medical information, spirituality, and social aspects of an individual client. The questions primarily focused on gaining information about the individual, the family, and community and other resources supporting the client. There are questions related to cultural influences in the BCFPI and psychosocial assessment. Queries inquiring as to ethnicity, specifically an aboriginal heritage, were included in both the intake screening and assessment forms. Accessing additional information related to culture and ethnicity is related to the openness of the client and the interviewing skills of the clinician.

The CYMH assessment is designed to elicit information pertaining to the individual amidst the context of family and community. In contrast, a psycho-social assessment reflective of a structural social work perspective would approach the process of inquiry from the perspective of linking causation of the client's problem to "particular aspects of the social structure" rather than attempt to describe the presenting problem as originating with the individual or their family (Fook, 1993, p. 22). To engage in casework from a progressive (or radical) social work framework entails a different model of practice; one that incorporates a focus on change to the structures impacting the client to address the needs of the individual and family (Fook, 1993, p. 24, 25).

The knowledge that has been reinforced for me is progressive social work practice involves extending present conventional psycho-social assessments to incorporate an

examination of a particular case from the context of dominant past and present social practices and beliefs and their relation to inequalities and imbalances of power (Fook, 1993). As this pertains to clinical social work and play therapy I have reaffirmed that play is culturally defined and shaped by the political and socio-economic beliefs of society. Acknowledging and identifying the beliefs around play and play as therapy contributes to empowerment and greater control of the person(s) in therapy, a fundamental aim of progressive social work practice (Fook, 1993).

Play as a Therapeutic Modality in Child and Youth Mental Health Services

Upon reviewing the 2003 Mental Health Plan and the Child and Youth Mental Health policies directing service provision, play as therapy was not documented as evidence-based mental health intervention, though programs such as The Coping Cat and Fun Friends that build resilience in children through play are utilized by CYMHS as resources. The Fun Friends Program is strongly supported by Child and Youth Mental Health services and is offered as an intervention program in the schools of Quesnel and other communities in British Columbia. Child and Youth Mental Health clinicians in Quesnel have participated in the training and maintain ongoing assistance and collaboration with local school-based counsellors. Information pertaining to the Fun Friends program is on the Ministry of Children and Family Development website in the area of Child and Youth Mental Health services. The Fun Friends program is supported by the World Health Organization and is reported as "scientifically validated" (Barrett, 2009, p. v.). These programs are based on the principles of behavioural science, specifically cognitive behavioural therapy and social learning theory. Play is incorporated to engage young clients in the therapeutic relationship and enhance the impact of the psycho-educational and skill building components of CBT.

Professional Development Activities

Throughout the duration of my practicum I was able to attend various teleconferences offered through British Columbia Children's Hospital at the Child and Youth Mental Health Center. The focus of the one-hour sessions was related to specific forms of anxiety and depression involving children and youth. I participated in ten webinar sessions hosted by Dr. Bruce Perry, founder and member of The Child Trauma Academy, involving an introduction to the Neurosequential Model of Therapy. Participating in these learning sessions increased my understanding of the organization and function of the brain in infant and child development. The importance of positive learning experiences for healthy child development was reinforced throughout the sessions. The sessions focused on the impact of both positive and adverse experiences on brain development within the formative years. The Neurosequential Model provides a template for assessing and mapping brain development involving children adversely affected by trauma and neglect. Dr. Bruce Perry emphasized several core principles as essential to healthy child development: safe, respectful, nurturing relationships; exposure to developmentally appropriate experiences, repetitive and rewarding learning experiences, and activities that involve rhythmic patterns to stimulate neural activity (Perry, B., & Hambrick, E., 2008).

Dr. Perry promotes the use of creative therapies, such as touch, rhythm, movement (dance), and storytelling, to enhance resiliency and prevent problems related to the experience of trauma. He invites a revisiting of historical healing practices reminiscent of aboriginal and other cultures (Perry, B., 2008). I was influenced by Dr. Bruce Perry and the teachings of Marie José (Sathers, 2011) in the establishing of a safe, respectful, therapeutic environment, the nurturing of relationship, storytelling, repetitive learning, and the inclusion

of movement, specifically Yoga, in the facilitation of the play-based mental health intervention group.

Continued Review of the Literature Relevant to Play and Play Therapy

During the course of the practicum I continued to explore and review the written resources on play therapy. There were helpful readings on play therapy within the context of CBT (Drews, 2009), writings by notable authors on the therapeutic powers of play (Schaefer, 1993), and on the therapeutic use of games (Schaefer & Reid, 2001). The use of expressive play in the creative forms of art, drama, music, and movement informed both clinical and group interventions (Malchiodi, 2008: Sather, 2011).

Play was an integral component of the Incredible Years Parent Education Program and was presented as a foundational element in developing and enhancing the parent-child relationship. Non-directed play was promoted as a means to engage children in a safe, respectful, supportive, and empowering relationship (Webster-Stratton, 2005). Play, occurring as directed activities between parents and children in the home environment for the reinforcement and enhancement of resiliency building and coping skills, was presented as weekly home play assignments within the Fun Friends Program (Barrett, P., 2009).

A common theme that arose for me during the ongoing review of the literature on play was the power of play in developing, building, strengthening, and enhancing relationships between parents and children and the therapist/clinician and child clients (Landreth, 1991, VanFleet, 2005, Gil, 1994, Guerney, 2003, Sather, 2011). Non-directed play is a key component of filial therapy and therapeutic play based on its ability to promote acceptance of the child and self-determination (Axline, 1974, Landreth, 1991, Guerney, 2003, Sather, 2011). My observations of non-directed play in a therapeutic environment were

interpreted as empowering to the children served. Schaefer (1993) refers to this process of empowerment and self-determination as the therapeutic factor of 'mastery' and links it with the beneficial outcome of competence and self-efficacy (pp. 6, 7). In facilitating activities involving non-directive play, I gained an appreciation for its suitability as method of social work intervention. Non-directive play reflects the social work value of respecting "the inherent dignity and worth of persons" and the principle of upholding "each person's right to self-determination" (CASW, Code of Ethics, 2005, p. 4).

Summary of the Practicum Learning Experience

The practicum learning experience reaffirmed for me the therapeutic powers associated with play in the research. Directive and non-directive play facilitated the development of the therapeutic relationship, the enhancement of social skills, coping skills, and resiliency building. Non-directed play encouraged personal empowerment, the expression of creativity, and self-determination in both clinical and group settings. The use of games during clinical and group interventions echoed research findings and assisted in improving social skills and ego functioning.

Chapter Four: Acquired Learning and Implications for Social Work Practice

The focus of this chapter will be on the three questions that guided the practicum learning experience. It will also include the knowledge gained during the practicum and the implications for social work practice.

How is Play Used in Clinical Interventions to Facilitate Wellness and Healing in Children and Their Parents?

My experiences involving play within clinical social work practice echoed some of the 14 therapeutic factors reported by Schaefer (1993). Throughout therapy involving play in both individual and group sessions, I observed the following factors and associated benefits: less client resistance to clinical interventions, enhanced communication and an increased understanding of the concepts presented, catharsis and emotional release, strengthening of relationships, positive emotion, effective use of metaphor and the development of insight, the development of confidence and increased self-esteem, effective game play and enhanced social skills, and strengthened attachments between parents and their children (Schaefer, 1993, p. 6). Adherents to the philosophies of play therapy, holistic expressive therapies and the principles of neurosequential interventions emphasize the presence of safe, respectful, nurturing relationships to facilitate healing and promote healthy child development. I was able to experience the therapeutic relationship as a core element in the use of play therapy. Play, specifically child led, non-directed play, was observed as a foundational element in the establishing of a healthy parent/child relationship. Non-directed play was observed as a means to facilitate client empowerment within a supportive therapeutic relationship.

How is Play Impacted by the Structural Influences of Gender, Ethnicity and Culture?

The literature on games as a branch of play therapy suggests that games reflect the

beliefs, conflicts, and concerns, of a particular culture (Reid, 2001, p. 4). Many of the common childhood games and therapeutic games are based on competition, which, in turn, is based on establishing power and dominance (p. 2, 6). This reaffirmed for me that structural influences in the form of societal (cultural) beliefs are reflected in games. Play is well founded within the literature as an effective mental health intervention, yet appears to be utilized in most mental health resources as a means to facilitate client engagement. This may suggest that play is in and of itself not a highly valued activity in Canadian culture, which in turn prompts questions as to the underlying societal beliefs pertaining to play.

In open discussions that occurred during sessions of the Incredible Years Parenting Education Program many parents in attendance shared that they did not often engage in play with their children and when they did it often involved directed rather than non-directed play. Further sharing disclosed that many parents had been socialized to not value play as an activity involving parents and children. The Incredible Years Program is based on social learning theory and the premise that human behaviour is influenced, learned, and modelled, within a social environment and thus can be shaped, changed, or adapted to reflect new learning. This process was observed as parents reported successes in the reductions of acting out behaviours as they engaged in daily non-directed play sessions with their children. This is supported by Ray (2008) in his findings involving filial play and the decrease in externalizing/internalizing behaviours. Many parents expressed amazement at the power of play to influence positive behavioural change and facilitate attachment (the bond between parent and child). Some of the parent participants spoke about child rearing practices experienced with their own parents and how those experiences influenced present approaches to both play and parenting.

A common theme that arose during the parent education group discussions was that work and production rather than play was a dominant societal/cultural value. The influences of gender and ethnicity did not appear as topics of focus during discussions nor did they arise as observable themes during clinical social work interventions, though this does not negate their influence on the therapeutic or group intervention process. The clients, their parents and siblings, identified themselves in the assessments as Caucasian and identification with other ethnic groupings did not appear during the ongoing assessments or during therapeutic interventions. According to Ray (2008), as documented in the literature review, there is a notable representation of Caucasian clients in mental health services.

Though gender did not appear as a topic of focus my verbal interactions with other staff members regarding clients and their families were experienced as gender-neutral and empowering in content. The expression of stereotypes and biases pertaining to males or females did not occur during staff meetings or discussions. Gender issues were not raised during most of my interactions with clients and their parents with the exception of a few comments made by one of the female clients during a clinical intervention. The client talked about body image and the appearance of having excess body fat. The comments were possibly indicative of the impact of sexism and the influence of patriarchy.

What are the Implications of the Knowledge Gained for My Professional Social Work Practice in Clinical Interventions with Children and Families?

Although the research does provide evidence to support the therapeutic use of play it is not promoted and reflected in mental health policy as an evidence-based approach to mental health intervention. The structural elements informing beliefs on play is relatively unexplored in the research on play therapy. One of my goals as a developing professional is

to continue to learn about the therapeutic and healthy developmental attributes of play in therapy and within the parent-child relationship. An additional objective is to engage in, and promote, an ongoing examination of the cultural influences informing policy development within the context of play as both a medium and modality for developing resiliency in children and youth.

The experience of social work in my practicum placement primarily involved traditional social work with a focus on problem exploration and symptom amelioration. Social work within a system reflective of our present provincial liberal ideology promotes interventions that assist individuals and their families to adjust to the resulting 'disorganization' that sometimes arises as the result of "industrialized capitalist society and a globalized economy" (Mullaly, 2007, p. 101, 102). Change is viewed within a liberal paradigm as helping people adapt, or develop skills (coping and/or effective communication), to adjust to a system that has some flaws but is basically okay (Mullaly, 2007, p. 104, 105). One of the goals of traditional social work in a liberal or neo-liberal political system is to help individuals to accept society as it is (2007, p. 109).

In contrast the social work ideal is to promote a structural model of intervention that involves equality, solidarity, and community (Mullaly, 2007, p. 108). In taking a progressive view of social work practice, I was able to facilitate one of its two functions and that involved tending to the some of the needs of individuals and their families who had experienced hardship/impoverishment due to a lack of access to adequate resources (Mullaly, 2007, p. 130). I was able to incorporate the values of progressive social work by maintaining an awareness of the impact of structural influences on the situations of the various clients and their families. For example, one client and family presented with mental health problems that

were exacerbated – and possibly caused by – conditions of poverty. By focusing on resource allocation, accessing appropriate community contacts, and relevant referrals I was able to assist in alleviating some of the presenting mental health symptoms (Fook, 1993, p. 21).

Implications for Social Work Practice

As a result of the practicum learning opportunity, I gained additional experience in the development of clinical social work skills. At the completion of the supervised practicum placement I was able to demonstrate competence in the areas of client screenings, intakes, assessments, treatment plans, documentation, case file closures, and client follow-up. I gained further experience in facilitating small groups within the context of child and youth mental health intervention. The use of, and access to, a variety of mental health resources involving play increased my knowledge and experience in working with play as a therapeutic medium and modality. These experiences have better equipped me for clinical social work practice.

The practicum learning experience resulted in a greater understanding of the therapeutic elements of play and reinforced my desire to gain further experience involving the integration of directive and non-directive play in therapy. I am interested in seeking training in the area of non-directive play. Most of the resources utilized involving play in the context of CYMH services involved directed play activities to facilitate client engagement, skill development, or building resiliency. Though non-directed play is validated within the research as effective in promoting self-efficacy and empowerment, with the exception of parenting education, it is not directly reported as a recommended strategy in current clinical child and youth mental health interventions. This does not negate its use or effectiveness as a mental health intervention. Child and Youth Mental Health services have provided the

funding for various play therapy supplies in the Quesnel office and the majority of the clinicians in that location of CYMH utilize play therapy as a mode of intervention with children. Joanne Crandall, the regional CYMH clinical team leader for the north region, advocates for the use of play therapy in child and youth mental health interventions and teaches clinical play therapy skills and techniques. My experience of non-directed play was as a component of clinical and structured group interventions. The underlying philosophy and principles of non-directed play align with the values of social work practice and its emphasis on self-determination, and empowerment. This encourages me to pursue further training and study in this area of play therapy.

Learning in a supervised clinical setting within the context of evidence-based interventions reinforced the professional motivation to remain abreast of the literature relevant to play and social work practice. It promoted an ongoing appraisal of issues related to practice and policy (Cooper & Lesser, 2011). Evidence-based practice is the integration of client values and clinical experience with best practices suggested by research within the context of social work practice (Cooper & Lesser, 2011). As a developing professional in the field of structural social work I plan to contribute to policy development in CYMH through the continued validation of play therapy as an effective approach to mental health intervention through its application in clinical practice. I plan to mindfully select strategies (such as games) that promote and build upon client strengths, encourage consensus, communication, cooperation, and critical thinking. I also hope to inform future research through the continued study and exploration of play within the context of North American culture and the underlying socio-political structures that inform societal beliefs.

Progressive social work practice, with its foundations in critical theory, has "only

recently become part of the social work theory landscape" (Mullaly, 2007, p. 65). In critiquing the practicum learning experience through a critical and progressive lens, the outcome as a student learner has been to strengthen, validate, and continue to inform, structural social work practice within clinical mental health interventions. As this pertains to play, or play as therapy, in the context of progressive clinical social work practice the implications are to maintain a continued awareness and exploration of the structural beliefs that influence and impact the experience of play.

CHAPTER FIVE: CONCLUSION

I have completed a supervised practicum placement in a Child and Youth Mental Health centre and met the objectives of my three learning goals. I have developed clinical social work skills within the context of therapeutic play, increased my knowledge of resources relevant to mental health practice with children, youth, and their families, and gained a greater understanding of play as a therapeutic modality.

The experience of engaging in clinical social work practice in the context of therapeutic play has reinforced its therapeutic powers as validated in the literature and has encouraged further learning. The therapeutic factors and benefits observed and experienced in clinical and group mental health interventions pertained to: overcoming client resistance and developing a therapeutic relationship, engaging in creative activities to enhance problem solving abilities and improved social skills, the enhancement of relationships and the outcome of increased positive esteem/self-actualization.

My involvement with clients, their families, and CYMH staff, within the context of play, has encouraged me to continue to learn about therapeutic play, including game play. The use of games facilitated the processes of relationship and skill building while providing insight into the dominant culturally driven themes of competition and power. Throughout the duration of the practicum I gained a greater understanding of the structural elements in society that influence the perception and experience of play.

REFERENCES

Axline, V. (1974). *Play therapy*. New York, NY: Random House Publishing Group.

Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice-Hall.

Bandura, A. (1986). *Social foundations of thought and action*. Englewood Cliffs, NJ: Prentice-Hall.

Barrett, P. (2009). *Fun friends: A facilitator's guide for building resilience in 4 to 7 year-old children through play* (2nd Ed.). WEST END QLD, Australia: Barrett Research Resources.

Beck, J. (1995). *Cognitive therapy: basics and beyond*. New York, NY: The Guildford Press.

British Columbia Government, Ministry of Children and Family Development, Child and Youth Mental Health Services. (n.d.). *What we do*. Retrieved from http://www.mcf.gov.bc.ca/mental_health/what_we_do.htm.

Bronson, D. (2002). A behavioural approach to social work treatment. In Roberts, A., & Greene, J. (Eds.). *Social worker's desk reference* (pp. 137 – 143). New York, NY: Oxford University Press.

Canadian Association of Social Workers: *Code of Ethics* 2005.

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

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

Cooper, M., & Lesser, J. (2011). *Clinical social work practice: An integrated approach* (4th. Ed.). Boston, MA: Allyn & Bacon.

Crawford, L. (2010). *A study of play: Literature review*. Unpublished manuscript, Department of Social Work, University of Northern British Columbia, Prince George, Canada.

Fook, J. (1993). *Radical casework: A theory of practice*. NSW, Australia: Allen & Unwin.

Gambrill, E. (2004). Concepts and methods of behavioural treatment. In D. Granvold (Ed.), *Cognitive and behavioural treatment* (pp. 36 – 62). Pacific Grove, CA: Brooks/Cole.

Gil, E. (1994). *Play in family therapy*. New York, NY: The Guilford Press.

Guerney, L. (2003). Filial play therapy. In C. Schaefer (Ed.). *Foundations of play therapy*. Hoboken, New Jersey: Wiley & Sons, Inc.

Greenspan, S., & Lieberman, A. (1994). Representational elaboration and differentiation: A clinical-quantitative approach to the clinical assessment of 2 – 4 year olds. In A. Slade & D. Wolf (Eds.). *Children at play: Clinical and developmental approaches to meaning and representation* (pp. 4 – 33). New York, New York: Oxford University Press.

Johnson, L., Bruhn, R. Winek, J., Krepps, J., & Wiley, K. (1999). The use of child-centered play therapy and filial therapy with Head Start families: A brief report. [Electronic version] *Journal of Marital and Family Therapy, 25*: 169-176. Retrieved February 15, 2010 from http://vnweb.hwwilsonweb.com/hww/results/results_single_fulltext.jhtml;hwwilsonid=JA.

Kendall, P., & Hedtke, K. (2006). *Coping cat workbook* (2nd. Ed.). Ardmore, PA: Workbook Publishing.

Knell, S. M. (2003). Cognitive behavioural play therapy. In C. Schaefer (Ed.). *Foundations of play therapy*. Hoboken, New Jersey: Wiley & Sons, Inc.

Landreth, G. (1991). *Play therapy: The art of the relationship*. Bristol, PA: Accelerated Development, Taylor & Francis Group.

Landreth, G. (2001). *Innovations in play therapy: Issues, process, and special populations*. (Ed.) Philadelphia, Pa: Brunner-Routledge.

Lin, S. (2003). Facilitating constructive parent child play: Family therapy with young children. *Journal of Family Psychotherapy, 14*: 19-31.

Malchiodi, C., (2008). *Creative interventions with traumatized children*. New York, NY: The Guildford Press.

Mash, E.J., & Barkley, R.A. (1998). *Treatment of childhood disorders* (2nd. Ed.). The Guildford Press, A division of Guildford Publications, Inc., New York: NY.

Michenbaum, D. (2009). Forward. In Drewes, A. (Ed.), *Blending play therapy with cognitive behavioral therapy* (pp. xxi-xxiii). New Jersey, USA: Wiley & Sons, Inc.

Mullaly, B. (1997). Chapter 7: Structural social work theory (pp. 99 – 133). *Structural social work: ideology, theory, and practice*. (2nd Ed.). Ontario, Canada: Oxford University Press.

Mullaly, B. (2007). *The new structural social work* (3rd. Ed.). Ontario, Canada: Oxford

University Press.

Pellegrini, A. (2009). *The role of play in human development*. New York, NY: Oxford University Press.

Perry, B. (2008). Foreward. In C. Malchiodi (Ed.). *Creative interventions with traumatized children.* New York, NY: The Guildford Press.

Perry, B. & Hambrick, E. (2008). *The neurosequential model of therapeutics*. Reclaiming children and youth (Fall 2008, volume 17, (3) pp. 39-43). Retrieved from http://www.childtrauma.org/images/stories/Articles/nmt_article_08.pdf

Podell, J., Martin, E., & Kendall, P. (2009). Incorporating play within a manual-based treatment for children and adolescents with anxiety disorders. In Drewes, A. (Ed.). *Blending play therapy with cognitive behavioral therapy.* (pp. 165-179). New Jersey, USA: Wiley & Sons, Inc.

Queensland Government, Department of Education and Training, Student Services, Social and Emotional Learning Programs. (2003). *Cool Kids*. Retrieved from http://www.education.qld.gov.au/studentservices/protection/sel/cool-kids.html

Queensland Government, Department of Education and Training, Student Services, Social and Emotional Learning Programs. (2005). *Friends for Life – Friends for Children.* Retrieved from http://www.education.qld.gov.au/studentservices/protection/sel/friends-life.html

Ray, D. (2008). Impact of play therapy on parent-child relationship stress at a mental health training setting. [Electronic version] *British Journal of Guidance & Counselling, 36*: 165–187.

Redl, S.E. (1958). The impact of game ingredients on childrens' play behaviour. *Proceedings of the Fourth Conference on Group Processes*, 4, 33 – 81.

Reid, S. (2001). Introduction: The psychology of play and games. In Schaefer, C., & Reid, S. (Eds.). *Game play: therapeutic use of childhood games* (2nd. Ed.). (pp. 1 – 39). Toronto, Canada: John Wiley & Sons, Inc.

Sather, D. M. (2011). *Marie-Jose'Dhaese and holistic expressive therapy: A naturalistic inquiry*. Retrieved from University of Northern British Columbia.

Scarlett, G. (1994). Play, cure, and development: A developmental perspective on the psychoanalytic treatment of young children. In A. Slade & D. Wolf (Eds.). *Children at play: Clinical and developmental approaches to meaning and representation*. New York, New York: Oxford University Press.

Schaefer, C. (1993). *The therapeutic powers of play.* (Ed.). New Jersey: Jason Aronson Inc.

Schaefer, C. (1993). Preface. In Schaefer, C. (Ed.). *The therapeutic powers of play.* (pp. xi, xii). New Jersey: Jason Aronson Inc.

Schaefer, E. (2003). *Foundations of play therapy.* (Ed.). New Jersey: John Wiley & Sons Inc.

Slade, A., & Wolf, D. (1994). *Children at play: Clinical and developmental approaches to meaning and representation.* (Eds.). New York, NY: Oxford University Press.

Timberlake, E., & Cutler, M. (2001). *Developmental play therapy in clinical social work.* Needham Heights, Massachusetts, U.S.A.: Allyn & Bacon.

Thompson. D. (Ed.). (1995). *The concise Oxford dictionary.* (ninth ed.). Oxford, New York: Oxford University Press.

Topham, G., & Wampler, K. (2008). Predicting dropout in a filial therapy program for parents and young children. [Electronic version] *American Journal of Family Therapy, 36*: 60-78.

VanFleet, R. (2004). *Filial therapy: Strengthening parent-child relationship through play.* (2nd. Ed.). Sarasota, Fl: Professional Resources Press.

Walker, K. (2002). *Filial therapy with parents court-referred for child maltreatment* (Doctoral dissertation). Retrieved from digital library and archives http://scholar.lib.vt.edu/theses/available/etd-10022002-091952/

Webster-Stratton, C. (2005). *The Incredible Years: A trouble-shooting guide for parents of children aged 2-8 years* (Revised). Seattle, WA: Incredible Years.

Wickstrom, A. (2009). The process of systemic change in filial therapy: A phenomenological study of parent experience. *Contemporary Family Therapy, 31*: 193-208.

Wilson, K., & Ryan, V. (2001). Helping parents by working with their children in individual child therapy. [Electronic version] *Child & Family Social Work, 6*: 209-217.

APPENDICES

Appendix One: Practicum Activities

The following activities were derived from the practicum learning goals:

1). Review the following resources:

(a) The British Columbia Ministry of Children & Families website with a particular focus on links to Child and Youth Mental Health Services.

(b) The 2003 Mental Health Plan, including the document entitled Healthy Minds, Healthy People: A 10-year plan addressing mental health and substance use across the lifespan and, and the 2008 Child and Youth Mental Health Plan Review.

(c) The Policies and Procedures Manual(s) directing child and mental health services.

(d) Written, taped, and digitized materials/resources informing clinical interventions based on Cognitive Behavioural Therapy.

(e) Community based, and other, resources utilized in the development of effective treatment plans.

2). Access learning and demonstrate competence in the following areas:

(a) Operation of CARIS[1] (documentation) and BCFPI [2] (screening) the two primary computer programs utilized for screening new referrals, documentation, client intake, assessment, the development of treatment plans, and client follow-up.

(b) Manage a supervised caseload of four or more clients involving: assessment, the development of treatment plans, treatment, case closure, and client follow-up.

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[1] CARIS is an acronym for Community and Residential Information System

[2] BCFPI is an acronym for Brief Child and Family Phone Interview

(c) Use of DSM IV – TR[3] as a tool for forming clinical impressions.

(d) Use of resources related to the application of Cognitive Behavioural Therapy within the context of clinical practice.

(e) Co-facilitating play-based activities with clients in *The Incredible Years,* a parent education program utilizing play as a teaching component, and engaging with clients and their families in clinical sessions involving the use of therapeutic board games and the development of treatment plans utilizing recreational activities or home play.

(f) Develop and facilitate an intervention group involving 2 or more child participants using the format of the play based Fun Friends program designed by Dr. Paula Barrett.

(g) Facilitate play-based therapeutic sessions with clients one-on-one.

(h) Utilize library resources through the University of Northern British Columbia and other relevant institutions for the purposes of completing the practicum report.

(i) Continue the study and review of the literature relevant to play as a therapeutic medium and intervention to prepare and present an agency-based presentation on the subject area of play.

(j) Initiate and maintain documentation relevant to practicum learning question in a journal format and critique the experience as viewed from the foundational principles of Critical and Structural Social Work Theories.

(k) Attend agency, and community based professional development activities for the purpose of gaining knowledge and the enhancement of skills relevant to therapeutic

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[3] DSM IV – TR is an acronym for Diagnostic Statistical Manual, Fourth Edition, Text Revision

interventions involving children and the use of play as an approach to treatment.

(l) Observe therapeutic assessments conducted by Dr. K. Marriage at the CYMH Centre in Quesnel, BC.