THE USE OF PLAY THERAPY BY SCHOOL-BASED MENTAL HEALTH PROFESSIONALS: AN EXAMINATION OF CURRENT TRAINING, PRACTICES, AND MEDIATING FACTORS

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Abstract

The current state of mental health for children living in the United States is a concerning matter. Play therapy is a viable treatment method to serve individuals with various mental health issues (Homeyer & Morrison, 2008). Professionals including school-based mental health counselors (American Counseling Association, 2018), school counselors (American School Counselor association, 2016), and school psychologists (National Association of School Psychology, 2016) all provide mental health services to children in order to assist in their success in all aspects of life and have the ability to use play therapy in this setting. Based on a review of the literature of current training in, use of, and attitude, knowledge, and skills regarding play therapy, a survey was distributed to mental health professionals currently working in the school setting throughout the United States. Analysis of the participants revealed that, of the three groups examined, mental health counselors have the most training in play therapy and use play therapy the most in the school setting. School counselors and school psychologists who are trained more specifically to work in schools, have less training and use it less. As a whole, school-based mental health professionals utilize Child-Centered Play Therapy the most. Further research is recommended for obtaining more information on the demographics of school-based mental health professionals, as well as their training in and use of play therapy in the school setting.

Chapter 1: Introduction

Mental Health Services for Children

Professionals including school-based mental health counselors (American Counseling Association, 2018), school counselors (American School Counselor association, 2016), and school psychologists (National Association of School Psychology, 2016) all provide mental health services to children in order to assist in their success in all aspects of life. These professionals all work within the context of the school setting, whether it be full time or contracted positions, and may be the only professionals providing mental health services to children in need.

Each of these mental health providers are overseen by a professional organization. These organizations hold their professionals to the standards of dedication to promoting mental health, providing necessary services, and assisting clients so that they may be successful. Each national association also discusses the role of the professionals in assisting the specific population of children. Specifically, mental health counselors can be trained in clinical mental health counseling as well as school counseling (CACREP, 2015). They are held to standards in the areas of intervention, prevention, and advocacy for those with mental health needs, and the American Counseling Association (ACA) explains that they "help clients identify goals and potential solutions to problems which cause emotional turmoil; seek to improve communication and coping skills; strengthen self-esteem; and promote behavior change and optimal mental health" (ACA, 2018). The goal of the American School Counselor Association (ASCA, 2016) is to "help students focus on academic, career and social/emotional development so they achieve success in

school and are prepared to lead fulfilling lives as responsible members of society." The National Association of School Psychologists (NASP, 2016) works at "advancing effective practices to improve students' learning, behavior and mental health, and by maintaining essential standards for ethics and practice." Therefore, mental health counselors, school counselors, and school psychologists who interact with children in the school setting contribute to their mental well-being and overall functioning. According to the national organizations for each profession, each group is trained to utilize evidence-based practices in working with the individuals they support (ASCA, 2016; CACREP, 2015; NASP, 2016).

Play Therapy

An evidence-based practice that can be used by mental health professionals in schools is play therapy. "Play therapy is the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (Association for Play Therapy (APT), 2015). Play therapy is a type of psychotherapy typically used with children when the traditional techniques, such as talk therapy, may not be effective due to the client's age. As children play naturally, incorporating this into therapy allows therapists to interact with children at their level (Landreth, Ray, & Bratton, 2009). "Play is essential to the social, emotional, cognitive, and physical well-being of children beginning in early childhood" (Milteer, Ginsburg, & Mulligan, 2012, p. 1). Play at its essence adds to healthy social-emotional development in childhood.

As play therapist Landreth states, “birds fly, fish swim and children play” (Landreth, 2012, p. 27). Landreth discussed the background, use, and art of the concept, referring to toys as children’s words and play as their language. Play therapy is not simply engaging with toys provided by a supervising adult; a play therapist provides space, time, and carefully selected materials for the child to utilize in expressing themselves and their feelings. The therapist also plays a significant role in facilitating the play therapy sessions in being fully present, recognizing the child’s actions and intentions, as well as reflecting insight about them. In general, play therapy focuses on children as individuals in the context of their developmental level. A foundational belief of this model is that play is a natural and automatic ability of children. When children spontaneously play, they are communicating their thoughts and feelings about their experiences. In terms of using play in therapy, it is recommended that the therapist does not have outside goals other than overcoming the issue that brought the child into therapy; the main goal in session is to provide children with a safe and comfortable environment and a relationship with the play therapist so that they can process through their thoughts and feelings in whatever way necessary.

Use of Play Therapy in Schools

School-based mental health professionals are aware of the developmental levels of the children they serve, as well as the topics of behavior, the role of the family in children’s mental health, and mental health in general (ASCA, 2016; CACREP, 2015; NASP, 2016; NASW, 2016). These professionals utilize appropriate interventions to assist this young population. While there are numerous effective interventions that could be implemented, those based on developmental theory and containing theoretical and

evidence-based support are in line with the standards of the field. Children communicate most naturally through play, making play therapy a viable intervention for mental health professionals to use, particularly in the school setting.

As children spend the majority of their days in school, this is an opportune environment in which to provide services. Child-Centered Play Therapy (CCPT), a non-directive type of play therapy based on the humanistic model of counseling, has been shown in research as the most commonly used type of play therapy (Lambert et al., 2005; Ryan et al., 2002). This type of play therapy has a strong empirical support basis for its use in schools with students of different cultural backgrounds and who come into therapy for different reasons (Landreth, 2012). Landreth declared that a question of interest is how play therapy should be conducted within the elementary school setting. Landreth et al. (2009) studied this concept specifically in terms of using CCPT in elementary schools. Landreth and colleagues stated that practicing play therapy in the school setting is simple, and that it has had positive effects for a variety of children in less than fifteen sessions.

Some research has been done on the effectiveness of utilizing play-based activities, as well as play therapy, in schools. This research focused mainly on the value of these in improving behavior in the classroom, as well as some on cultivating academic achievement. There is current research that supported the use of these in both realms, as well as with students with more specific difficulties. Specifically, research has indicated that after the implementation of general play-based activities combined with social skills lessons, off-task behaviors including verbal, motor, and passive behaviors all significantly decreased from pretest to posttest (Allen & Barber, 2015). When Child-Centered Play Therapy was implemented as an intervention with children, academic

achievement improved (Blanco & Ray, 2011). Further, results of a meta-analyses that included 23 studies conducted by Ray et al. (2015) provided both quantitative and qualitative support for the use of CCPT in schools including improvement in externalizing problems, internalizing problems, self-efficacy, social skills, school attitude, academic achievement, and relationship with teachers.

Requirements to Utilize Play Therapy

There are various levels of credentialing for professionals who provide play therapy. There are certification programs to train professionals in specific types of play therapy, such as CCPT (Center for Play Therapy, 2018; National Institute of Relationship Enhancement (NIRE) and Center for Couples, Families and Children, n.d.). The requirements for becoming a certified child-centered play therapist through the Center for Play Therapy and NIRE both require the applicant to have a degree (NIRE) or license (Center for Play Therapy) in a mental health field. They also both require prerequisite training and further supervision to obtain the credential. Other professionals choose to become fully registered in the broader field of play therapy, which is a more in-depth training. This can be done through the Association for Play Therapy. With proper training, it is possible to provide play therapy without being credentialed as a play therapist, but providing play therapy with minimal or no training at all is considered unethical for any mental health professional (APT, 2015).

The minimum requirement for utilizing play therapy in any setting is having a state license in the mental health field (i.e., counseling, psychology, social work) or state certificate if utilized by school counselors and school psychologists in the school setting. From the various meta-analyses on the topic (Bratton et al., 2005; LeBlanc & Ritchie,

1999), it is clear that many researchers have analyzed the use of play therapy in the school setting led by school counselors and some by social workers, but less focus has been on its use by school psychologists. Literature on the use of play therapy conducted by school psychologists in the school setting is much more limited, even though play therapy fits within the domains of practice within this field. Specifically, play therapy fits into the NASP Practice Model in Domain 4: Interventions and Mental Health Services to Develop Social and Life Skills, within the broader category of direct services for children (Skalski et al., 2015). This domain emphasized utilizing evidence-based practices in order to provide these services. While it does not mention specific forms of evidence-based practices, play therapy has this evidence base from current research. Johnson (2011), a NASP leader, suggested that school psychologists keep the power of play in mind and use it instead of scripted techniques and assessments when possible; Johnson emphasized play therapy's effectiveness and value in the school setting.

As previously stated, play therapy can be useful with students who have a variety of presenting issues. However, the vast majority of literature reflects solely school counselors' use of play therapy, as opposed to other mental health professionals within the school setting, because play therapy is more commonly included in their training programs than in others' (Pereira, 2013; Schaefer & Drewes, 2010; Van Horne, 2015). In the work by Schaefer and Drewes (2010), the authors referred to various types of professionals being able to be registered play therapists. However, the authors generally referred to these professionals as *counselors* rather than naming other professional titles in this role.

As school psychologists and school social workers have a role in counseling as

well as other interactions with students in schools, understanding their knowledge and use of play therapy is of interest as well. All mental health professionals in the school setting have connections with students as well as their teachers and parents, which allows them to have the capability of providing play therapy as a potentially effective intervention within the scope of their role. They all have backgrounds in child development, intervention, and building trusting relationships with children; these skills are all important to have in order to successfully provide play therapy as well. Further, all of these professionals have knowledge of both education and mental health, allowing them to bridge the two fields and assist students in being successful emotionally, behaviorally, and academically (ASCA, 2016; CACREP, 2015; NASP, 2016; NASW, 2016). With increases in mental health issues of children, involving more qualified professionals in using evidence-based practices, such as play therapy, could allow more students in schools to receive developmentally appropriate services. Regarding years of experience of these professionals, Leblanc and Ritchie (1999) discussed variables of interest for future research in the area of play therapy. "The relationship between therapist experience or training would be very helpful in establishing appropriate training criteria" (p. 25). From their review of the literature, it was found that these variables are rarely discussed. They also recommended incorporating variables such as age and gender into future studies on those who are practicing play therapy in order to obtain more descriptive information on the population.

Training of Play Therapists

While lack of training is a major reported barrier to providing play therapy in schools, training is found to be one of the most important factors in providing play

therapy effectively. Ray et al. (2005) made it clear that proper training, as well as enough time set aside to carry out sessions, is necessary for play therapy to be successful. Ray et al. found a positive correlation between those counselors with more training and perceived effectiveness in their delivery of play therapy. Bratton et al. (2005) further researched this idea by conducting a meta-analysis. They found that many of the studies included in the analysis did not include information about the type or amount of training that the professionals received. Bratton et al. (2005) found that the studies that went into more detail about how play therapy was implemented had more successful results than those that did not report this information.

In recent decades, there has been limited research in the area of play therapy training in regard to school mental health professionals. Wilson and Rotter (1980) found that of the surveyed school counselors in grades K-8, who serve children with whom play therapy would be most age-appropriate, only 29% had training in play therapy. While some research has been done on the training that mental health professionals have in play therapy since 1980, most research has focused on the graduate-level training programs themselves. Researchers have been interested in the training opportunities that the existing programs offer for their students who are interested in practicing play therapy later on (Cerio, Taggart, & Costa, 1999; Pascarella, 2013). Focusing specifically on school counselor training, Cerio et al. (1999) found that only slightly more than half of the training programs surveyed offered any type of play therapy training. Overall, 83% of trainers believed play therapy should be a part of the school counseling training program, but only 55% of programs included it. Pascarella (2013) expanded research on this topic to include other mental health professionals. She found low amounts of play

therapy instruction across the board in counseling, social work, and school psychology programs, but especially for school psychology students. Earlier studies examined professionals from various disciplines who utilized play therapy in the field and attended a conference for play therapists (Kranz, Kottman & Lund, 1998), as well as members of APT and/or participants at a play therapy training conference (Phillips & Landreth, 1995). It was determined that even those professionals, the majority of whom labeled themselves as play therapists, were limited in the training that they received in the specific area of play therapy.

It is clear that training level of the provider (i.e., taking part of a course, an entire course, professional development, obtaining specific certification, or becoming fully registered) is a variable that could influence the efficacy of play therapy. For example, some school mental health professionals utilize pieces of play therapy they learned from a workshop, a course or part of a course, or a certification program. They are often practicing without proper training in the area (Cerio et al., 1999). Mental health practitioners, including those that work in the school setting, are not required to be registered as a play therapist in order to provide these services. However, by obtaining play therapy credentials, the effective practice of play therapy is fostered and further training to remain an effective therapist can be continued (Association for Play Therapy, 2016).

Factors Related to Use of Play Therapy in Schools

Based on previous research, there are various factors that are likely related to the use of play therapy in the school setting. Attitude, knowledge, and skills about play therapy are three variables that have been researched in relation to the use of play

therapy. Kao and Landreth (1997) created and utilized the Play Therapy Attitude-Knowledge-Skills Survey (PTAKSS) with graduate students in counseling programs, who had no prior experience with play therapy, to determine their attitude, knowledge, and skills in regard to play therapy. By analyzing pretest and posttest results, they found significant increases in the students' positive attitude toward children, overall knowledge about play therapy, and confidence concerning their play therapy skills after the fifteen-week (45 hour) course that involved lectures, reading, discussion, paper writing and practicum experience. After the creation of this measure, various researchers have utilized it to analyze the effectiveness of various forms of play therapy training. For instance, Homeyer and Rae (1998) found that all of the graduate students who took part in a play therapy course increased in each area assessed on the PTAKSS; the different lengths of courses (i.e., mini-semester, summer semester, full semester) did not have a significant effect on the growth they made, as all of the same material was covered. Crane and Brown (2003) found that even undergraduate students who took a course that partially focused on practical skills in working with children improved in their knowledge and skills in play therapy, significantly more so than the control group who did not participate in the course. Kagan and Landreth (2009) also found that play therapy knowledge significantly improved after a short-term training provided to school counselors and teachers; attitudes and skills regarding play therapy did not significantly improve in the short time period. Further, Lindo et al. (2012) conducted a study that involved thirteen graduate students who were taking a fifteen-week course on play therapy. The researchers were the first to use the revised version of the PTAKSS. The participants were given the PTAKSS at the beginning of the semester and at the end

when the course was completed. There were statistically significant improvements in each of the three areas of the survey (Attitude, Knowledge, and Skills) after the completion of the introductory play therapy course. The researchers recommended future research be conducted with a larger sample size in various locations.

Current Study

Based upon the discussion above, this study addressed how the different mental health professionals who work within the school setting are trained in and use play therapy. While research on play therapy in general has increased and its empirical support has been acknowledged, schools are behind in implementing it (Landreth et al., 2009). Specific quantitative data on the actual use of play therapy in schools is limited in the existing research base, so the current study examined this information. Further, participants' knowledge of, attitude toward, and perceived skill in providing play therapy were analyzed as mediators between the training school-based mental-health professionals received and their subsequent amount of play therapy use.

Research hypotheses. For the current study, there were seven hypotheses.

1. The most commonly used type of play therapy within the school setting will be Child-Centered Play Therapy (CCPT).
2. School counselors will receive the highest level of training in play therapy among the mental health professionals who work in the school setting (i.e., mental health counselors, school counselors, and school psychologists).
3. Play therapy will be utilized more frequently in schools by school counselors than mental health counselors and school psychologists.

4. There will be a direct positive relationship between years of experience and amount of play therapy training that the mental health professional has.
5.
    a. Attitude, knowledge, and skills in regard to play therapy will all be correlated with one another.
    b. There will also be direct positive relationships between training and attitude, knowledge, and skills, with the variables of attitude, knowledge, and skills mediating (explaining the relationship between) play therapy training and use.
6. There will be direct positive relationship between play therapy training and play therapy use in schools.
7. Time dedicated to counseling and perceived barriers to using play therapy will mediate (explain the relationship between) the variables of attitude, knowledge, and skills with play therapy use.

Chapter 2: Review of Relevant Literature

Mental Health of Children in the United States

The current state of mental health for children living in the United States is a concerning matter. According to the National Alliance on Mental Illness (NAMI) (2017), about 1 in 5 children between the ages of 13 and 18 living in the United States will experience a severe mental disorder during their lifetime. For younger children between the ages of 8 and 15, it is estimated that 13% experience a mental health disorder. Further, there are reported negative outcomes for children with mental health disorders. For example, over 37% of students between the ages of 14 and 21, who are living with a mental health disorder and are served by special education, drop out of school. This is the highest reported dropout rate of any group of individuals (U.S. Department of Education, 2014). Further, 70% of youth who are placed in juvenile justice systems have at least one mental health condition and are three times more likely to commit suicide than youth in the general population (National Center for Mental Health and Juvenile Justice, 2017). Related, suicide is ranked as the tenth leading cause of death overall in the US; but even more severe, it is the third leading cause of death for young individuals between the ages of 10 and 24 and the second leading cause for individuals ages 15 to 24. Of these individuals, over 90% of those who committed suicide were reported to have a mental health disorder (Suicide Prevention, 2014). It is important to be aware of these statistics when serving children with mental health disorders and knowing treatment

methods that could lower these concerning rates. Play therapy is a viable treatment method to serve individuals with various issues (Homeyer & Morrison, 2008).

History of Play Therapy

Psychoanalytic Roots. Play therapy first emerged from techniques used by Sigmund Freud, who practiced counseling within a psychoanalytic framework. Freud began to use play with a child in counseling sessions in order to analyze the child's experiences and provide appropriate treatment. It was also used by child psychotherapists in the early-mid 1900s, including Melanie Klein, Margaret Lowenfeld, David Levy, and Anna Freud (British Association of Play Therapists [BAPT], 2013). Comparisons were made between psychotherapy for adults and play therapy for children; for example, free association in adult psychotherapy was aligned with spontaneous play for children. Melanie Klein utilized play with children under the age of six in order to obtain access to their unconscious, similar to how psychoanalysts would analyze adults through talk therapy. Klein's use of play in therapy was based on psychoanalytic theory and novel to her time. As previously mentioned, her techniques related to those used in adult psychotherapy. Free association came about in her method of play therapy in allowing the child to express themselves with the toys with which they played, playing out or voicing anything that came to mind, allowing the therapist to analyze the content to inform their treatment. Klein discussed that interpretation was against the usual practice with children, but she used it with various clients. She also utilized techniques like exploring the unconscious and analyzing transference that the child portrayed (Klein, 1955).

Anna Freud followed suit with using play in line with psychoanalytic theory. She used play to assist the child in creating a positive attachment with the therapist and to relate to their inner world (BAPT, 2013). Anna Freud developed her own views on child development that did not coincide with those of Melanie Klein. Anna Freud believed that transference played a vital role in play therapy and that the therapist took on the role of a mother-like figure to the child, being more involved than just acting as a representation of a mother; this idea was a main concept for psychoanalytic play therapy (Fenichel, 1946). While the way each of these psychologists used play in therapy differed, Melanie Klein, Anna Freud, and David Levy utilized play as the main form of therapy with children, finding play to be cathartic in and of itself. Further, a key aspect of psychoanalytic play therapy involves the child repeatedly playing out or experiencing a negative event, such as trauma, to eventually overcome it (Harter, 1977).

Humanistic Transition. Moving away from psychoanalytic theory, Carl Rogers founded client-centered therapy, a humanistic model of therapy, in the 1940s (BAPT, 2013). This client-centered, humanistic focus was dedicated to the genuine relationship between client and therapist rather than on diagnostics. Virginia Axline was highly influenced by this new theory and created her own approach based on Rogers' philosophy. Axline's work focused on children and became known as non-directive play therapy. Axline (1947), as one of the creators of play therapy as its own entity, described it in comparison to traditional psychotherapy. Axline explained that psychotherapy brings to light a learning process for the client. Play therapy has this same capability but is done through playing instead of talking. Axline stated that within play therapy, children experience self-exploration in relation to others (i.e., the therapist), growth, and

the skill of expressing oneself. Axline outlined eight principles of the relationship that continue to apprise the efforts of play therapists. Axline believed that the therapist should: 1) develop a relationship with the child as a base for the rest of therapy; 2) accept and respect the child for who they are; 3) develop an atmosphere of openness for the child to feel able to express themselves fully during therapy; 4) be able to recognize the emotions the child is expressing and successfully reflect these to the child; 5) hold the child to the responsibility to work on change; 6) not direct the child's behavior in any way; 7) not rush therapy; and 8) only place limits on things that are necessary to continue therapy successfully (Axline, 1947).

Following Axline, Clark Moustakas practiced in the mid to late 1900s and also focused his work on the relationship between the child client and the therapist. His view concentrated on using the relationship to guide growth in the child (BAPT, 2013). While Moustakas studied under Axline, he went away from non-directive play therapy and followed his personal way of interacting with children. Moustakas created Relationship Play Therapy around 1950 and molded a theory containing stages that the child moves through, based on his own research data and clinical experience. According to Moustakas, the child begins with negative emotions which become less intense, more positive, and more balanced as the process continues. This occurs when children are given the opportunity to express their feelings. Moustakas found that the attitude the play therapist held in terms of their faith, acceptance, and respect for the child, along with the skills they used, were paramount. Play alone allows the child to be present and for the relationship between the child and therapist to be built. Further, "valid meanings exist only in the child's own perceptions of what is real" (Moustakas, 1997, p. 8). Moustakas

also discussed that the therapist being present is the most important role of the therapist. The therapist can only do so much; the child is the center of the therapy and their perceptions of reality are all that matter. Moustakas discussed challenges play therapists face and these include creating an atmosphere of openness, freedom, tranquility, and caring for the child. Moustakas utilized limit setting as a strategy in order to build the relationship in a healthy way. However, he was careful not to use limit setting as much, if at all, with children who aim to please a great deal, are withdrawn, or lack a general sense of liveliness or energy as there are likely greater issues at hand. The play therapist reflects the actions, statements, or feelings the child portrays, and the child experiences self-exploration in order to work through a problem. Reflection encourages the child to express their own inner feelings (Moustakas, 1997). This history of play therapy has influenced how play therapy has developed, transformed, and is currently used today.

Current Use. In recent years, more research has been published on the general topic of play therapy, especially on new theories and techniques to use within the field. After much work by play therapy practitioners and developers like Moustakas, Landreth, and Schaefer, who will be discussed further in terms of play therapy models and perspectives, other types of play therapy that are based on theories such as Cognitive behavioral therapy, family therapy, and solution-focused therapy have emerged. As there is overlap between the types of play therapy, yet fundamental differences between them as well, it is difficult to make clear-cut comparisons about the effectiveness between them (O'Connor & Braverman, 2009).

Current Play Therapy Models and Perspectives

In the last 70 years, play therapy has grown exponentially. In the 1950s, "only a

handful of mental health professionals utilized play therapy, but now over thousands are; play therapy is an international enterprise" (Moustakas, 1997, p. 6). Currently, it is accepted that in order to effectively practice play therapy, it is necessary for the therapist to have background in the developmental model in order to be able to understand appropriate diagnoses, treatment, and goal-setting for their clients (Drewes & Schaefer, 2016). "Play therapy is an effective means of responding to the mental health needs of young children and is widely accepted as a valuable and developmentally appropriate intervention" (Homeyer & Morrison, 2008, p. 210). Homeyer and Morrison discussed the importance of play in child development. In the 1990s, study of the brain was prominent, and led to knowledge that play for children was critical in healthy brain development.

Further, there is connection between the benefits of play and Piaget's developmental theory. Piaget theorized transitions in cognitive development during four different stages. These stages include sensorimotor, preoperational, concrete operational, and formal operational (Piaget, 1952). At each stage, the child would theoretically think and act according to an underlying point in logical development. Piaget came up with this theory by observing young children from infancy during their play, which he thought was their way of putting thoughts into action. The transition that is especially relevant to the benefits of incorporating play into child therapy is from preoperational to concrete operational which involves thought becoming logical. The development that occurs between these stages is strongly connected to children's ability to comprehend logic and to create an emotional repertoire that aligns with this logic. Particularly, children often have difficulty understanding complex emotional situations, like the concept of feeling

multiple emotions at one given moment, especially when the feelings are contradictory to each other (Harter, 1977). Harter explored a technique in her own play therapy sessions with a child that involved play and visual representation of feelings. Play therapy first allowed the child to act out a situation that was bothering her in school. She played out a role reversal, projecting her feelings onto the therapist (who was acting out the role of the child). Once the child's feelings were clear to Harter, Harter integrated a visual drawing of her guess about how the child was feeling and presented it to the child within the context of their play. The child connected to this visual and began recreating it herself in future sessions, modifying it with her current contradictory, yet simultaneous feelings of the moment. Harter's technique of utilizing play therapy to teach a cognitive-developmental concept of emotions exemplifies how play therapy fits within Piaget's developmental theory. This theoretical foundation provided a strong basis for the use of the various types of play therapy that will be discussed.

Broadly, there are both directive and non-directive forms of play therapy that are currently used in the mental health field (Kenney-Noziska, Schaefer, & Homeyer, 2012). Kenney-Noziska et al. (2012) analyzed the differences between directive and non-directive play therapies due to the fact that there is a debate within the field as to which is more effective. Through a review of current literature, they determined that each type of play therapy has different results when used with different populations; therefore, comparing them is not an applicable way to determine their effectiveness. Individuals are unique; directive play therapy, non-directive play therapy, or a combination of the two could be most helpful for certain individuals based on their presenting problem. Bratton et al. (2005) determined from their meta-analysis that both directive and non-directive

play therapies were similar in effectiveness, with moderate to high effectiveness in children's outcomes. Kenney-Noziska et al. (2012) recommended that play therapists be more open-minded in their choosing of theoretical play therapy models to use with children. A different approach than what the therapist may typically use, or an integrated approach, may be a better option depending on the child's needs. Overall, there are four types of play therapy that are commonly used within the school setting, which include Child-centered play therapy (CCPT), Adlerian, Cognitive-Behavioral, and eclectic (Drewes & Schaefer, 2016).

Ryan et al. (2002) surveyed members of APT and found that CCPT was the most commonly taught form of play therapy in graduate programs (56% of those surveyed), followed by Cognitive-Behavioral play therapy (42%). Consistently, Lambert et al. (2005) studied the theoretical orientations of professionals who identified as play therapists and found that the large majority (66.6%) were oriented as child-centered. Of the other play therapists, 9.2% were oriented as cognitive-behavioral and 6.6% as Adlerian. No other orientation was specified by more than five percent of the sample. While there are other types of play therapy, the most commonly used types will be further discussed.

Child-Centered Play Therapy. CCPT, which has its roots in Carl Rogers' person-centered therapy, was formulated by Virginia Axline in 1947 (Landreth, 2012). CCPT is completely non-directive, but there are many techniques involved in its use. Some of these techniques include reflecting the child's actions and feelings, using limit-setting with the child's actions, encouraging the child, and facilitating the child's decision-making skills. The main underlying theory of non-directive play therapy is that

children are able to act as their true selves in the therapy sessions, which acts as an agent toward becoming the self they desire (Axline, 1947). Landreth (2002) also states that this is the most developmentally appropriate type of play therapy due to its non-directive nature.

CCPT is embedded within the theory of personality. There are three components to this theory and Rogers' person-centered therapy is also grounded in this theory. These components include the person, the phenomenal field, and the self (O'Connor & Braverman, 2009). The person involves everything that makes up the child--their thoughts, emotions, behaviors, and physical presence. The phenomenal field involves everything in the child's environment, both external and internal. It is everything that influences the child and shapes their view of life. Lastly, the self is the essence of the child, the child's inner world that involves their values and judgments. These three things come together and make the child unique.

As the relationship between the child and therapist is paramount in this theory, many play therapists who practice this approach have discussed its importance. Moustakas (1997) discussed how the therapist forming a relationship with the child who is receiving play therapy can impact the child greatly. By building that relationship and having the therapist with the child through the entire process, the child learns to feel comfortable, explore the self, create an identity, and do so while in a supportive environment. Landreth, a play therapy practitioner and researcher, equated the relationship that is created between the child and therapist with a sense of safety; the child can sense this safety when with the therapist and when in the playroom (2002). While in play therapy sessions, the role of the therapist involves accepting all emotions

the child brings forth, reflecting on these in order to empower the child, and helping them to accept themselves.

Play therapy, as defined by Landreth (2000, p. 11), is "a dynamic interpersonal relationship between a child (or person of any age) and a therapist…who provides selected play materials and facilitates the development of a safe relationship for the child…to fully express and explore self…through play…". Since play is the natural way that children communicate to others and can sort out their thoughts, they can successfully build a relationship with the therapist, because the therapist interacts with the child in this medium. This relationship's strength is what allows for the child to be able to grow and develop. The therapist needs to understand that children cannot fully verbalize their thoughts and concerns, but they will likely play them out; they can express their needs and learn to cope through play. When the relationship the therapist has with the child allows for the child to feel welcome and empathically cared for, the child will open up and allow the therapist to view their concerns as they demonstrate them through play, making it so their internal world can be seen in the way they know how to do best, through play.

There are ten "tenets for relating to children" that Landreth (2012, p. 46) discussed. These ten points make up an outline of beliefs that all therapists who work with children should recognize and take into consideration when interacting with them: 1) Play therapists should not treat children like smaller versions of adults; there are many differences in the ways adults and children develop and how they view the world. Responding to a child as if they were an adult will not be effective.

2) Even though children are not yet adults, they are still people who have valuable views; they experience pain as well as joy, and need to be validated in these feelings.

3) It is important to note that all children deserve to be respected. The therapist should not want to change their distinctive characteristics or disrespect their qualities or opinions.

4) Landreth discusses that the resilience children have is amazing. Children have a tendency to bounce back and figure out ways to take care of themselves in devastating situations. This fact should be recognized because sometimes adults do not give children the credit they deserve.

5) It is inherent in children to want to grow; this allows for them to instinctively become more mature with development.

6) Positive self-direction is possible within children's minds; they have a special bond with creativity that allows them to deal with problems the world may throw them.

7) Further, it is a key piece of information that the natural way children communicate is through play. Through play, they can express themselves in a comfortable way, so we should allow and facilitate that.

8) If children choose not to speak about an issue, we cannot force them to; part of respect is upholding this boundary.

9) The therapist should not be the one to determine when a child does or does not play, the child can figure this out and choose for himself (or herself) how to get value from the therapeutic process.

10) The therapist needs to recognize that the child's therapy will take its course at its own particular pace; speeding up the process will not solve anything, and it can even harm the

healing process. While CCPT is the most commonly researched and noted to be utilized the most as an effective type of play therapy, there are other options that are evidenced-based interventions as well.

Adlerian. Adlerian play therapy is an offshoot of Adlerian therapy. The basis of this theory is that individuals seek counseling because they are discouraged in life (Kottman, 2003). Due to this reasoning, therapists who practice this type of play therapy are directive in nature. This is a holistic type of play therapy, which allows for family members or other loved ones of the children to be involved in the therapy process. The first part of this approach is creating a partnership between the child and the therapist, which becomes equal and is maintained throughout the entire process. Then, Adlerian play therapists work to aid the child in exploring their own, personal lifestyle, increase their level of awareness, and reorient themselves in their lives by interacting with them in the play room. Adlerian play therapists use encouragement to help children learn to cope with feelings. They celebrate the child's strengths with them and assist them in setting goals and priorities. They also engage in a great deal of communication with parents and teachers to gain a well-rounded perspective of the child as well as teach the parents and teachers skills to use to better interact with the child. This type of play therapy is particularly useful in schools due to its directive nature and focus on involving important individuals in the child's life (e.g., parents and teachers). The play therapist can provide strategies for these other individuals to use with the child to assist in their continued progress (Drewes & Schaefer, 2016). In general, Adlerian play therapy involves encouraging the child, but also focuses on their goals and unique family background. The Adlerian play therapist comes up with tentative hypotheses which frame how they help

the child work toward meeting the goals that are created. A main goal of Adlerian play therapy is helping the child to cope more successfully with issues in everyday life (Warlick, 2013).

Cognitive-Behavioral. Another potentially beneficial play therapy approach to use in the school setting is Cognitive-Behavioral Play Therapy (CBPT) due its general short-term nature, narrow focus on solving the presenting problem, and use of resources that are typically available in schools (Drewes & Schaefer, 2016). CBPT was developed from behavioral perspectives and was established for use with children by Knell (1993). Like Cognitive behavioral therapy for adults, this approach focuses on structure, direction, and goal-orientation. The general goal of this approach is to assist children in addressing their problems in a way that is focused on solving them and learning new ways to think about things. Cognitive-Behavioral play therapists incorporate structure into their play therapy sessions, utilizing techniques like role-playing, modeling, bibliotherapy, and homework to practice skills are integrated within play sessions to teach and reinforce the concepts that this approach views as necessary to solve the presenting problem (Drewes & Schaefer, 2016). Knell (1993) described that in sessions, the therapist will often lead structured activities that address the issues the child is having. For example, the therapist is able to incorporate toys or games to have the child demonstrate their thoughts and feelings, model healthy behavior for them, and practice healthy behavior together. In this type of play therapy, the child can learn to play to show the therapist about their behaviors, process events in their lives through play, experiment and develop skills by using play. Therapists also incorporate

psychoeducation into sessions through this type of play therapy, therefore teaching the children and their guardians about the child's difficulties and treatment for them.

Eclectic Prescriptive. The eclectic prescriptive play therapy approach, also known as Integrative Play Therapy, incorporates play therapy techniques from various other theories because of the mindset that children and their presenting issues are unique, so one theory alone is not always the best way to address a problem (Drewes & Schaefer, 2016; Rocky Mountain Play Therapy Institute, 2018). One particular theoretical basis is not followed by the therapist for every child that they work with; they utilize whichever approach they deem appropriate depending on each specific child's needs. The therapist focuses on the disorder and the evidence-based techniques that address that specific disorder rather than focusing on only using techniques from one theoretical background. Since there are many children within schools, who are all individuals with different problems, this type of approach can be effective in that setting due its flexible nature, although there is limited research on this type of play therapy. It is reported that more experienced mental health professionals typically lean toward using an eclectic approach to play therapy due to having more knowledge and familiarity with techniques that tend to be most successful for children with different problems (Drewes & Schaefer, 2016). However, it is important to note that some play therapists may report to be eclectic play therapists, while truly just using different techniques unsystematically, which is not effective, as the definition of play therapy includes the point that all play therapists must be grounded within a theoretical model (APT, 2015). Overall, this type of play therapy could be beneficial to use in a school based on the diversity of students who are often served in that environment.

Brief Play Therapy. Moustakas (1997) discussed how play therapy can be used in terms of situational issues. For example, he stated that many children have a difficult time when a new sibling is born, and these difficulties can be seen at home and in school. Through his experience, Moustakas found effectiveness in brief play therapy, typically lasting three sessions with an added group play therapy session. Being able to openly express negative feelings in a safe place and relationship can lead to acceptance of the new child within the family; Moustakas discussed case examples of this situation with multiple child clients with whom he used play therapy. Moustakas (1997) provided anecdotal information on the outcomes of his use of Brief Situation Play Therapy with child clients. In the example he provided, the child, Linda, had difficulty adjusting to therapy, and the brief series was extended to more sessions. Moustakas (1997) discussed qualities and actions that Linda portrayed in session, and described how she went from very quiet to overwhelmingly talkative and spontaneous and even demanding. Moustakas (1997) drew conclusions about the child dealing with intense anxiety and anger. The effectiveness of the brief therapy was determined by his professional judgment. Overall, these are all potential viable options for interventions to utilize with children, including in the school setting.

Effectiveness of Play Therapy

"Play therapy is one of the oldest and most popular forms of child therapy" (Schaefer & Kaduson, 2006, p. xi). As described by Ray et al. (2015), the result of play therapy, if done well, should be to provide children "with an environment in which (they) will release emotional limitations on potential and engage in ways of thinking, feeling, and acting that are self-enhancing" (pp. 120-121). In general, play therapy can be used

with individuals based on their developmental level, but usually with children between the ages of three and twelve. Various meta-analyses have been conducted on the outcomes of play therapy, and each concluded with positive results (Bratton et al., 2005; LeBlanc & Ritchie, 2001; Ray et al., 2015). "The strength of play therapy research appears to be in the history of and continued ability to conduct successful play therapy studies in natural real-world settings of schools, hospitals, clinics, and shelters" (Ray, as cited by Schaefer & Kaduson, 2006, p. 146). The effectiveness of play therapy can be discussed in a variety of ways, from broad effectiveness as an intervention, to specific benefits it provides children in a variety of contexts.

LeBlanc and Ritchie (1999) studied the factors that could predict outcomes of using play therapy through a meta-analysis. Their original study revealed that play therapy has a moderately positive effect on children. While the environment where play therapy was provided was not solely in the school setting, the majority of the studies included in this analysis did provide play therapy in a school. Sound interrater reliability and specific coding characteristics made for a reliable analysis in this study. There was large effect size for the treatment of using play therapy to address childhood problems including emotional, social, or family maladjustment; experience of a past traumatic event; and academic or behavioral problems. The researchers found that children who received play therapy performed twenty-five percentile points higher than those who did not receive play therapy on the outcome measures used, which is of similar effect size to that of non-play therapies used with children. Parental involvement and duration of sessions were also analyzed and both were significantly related to the treatment results. The studies concluded that play therapy sessions that lasted between thirty and thirty-five

minutes resulted in the most effective results for the participating children. The authors reported that "the relationship between therapist experience or training would be very helpful in establishing appropriate training criteria" which was previously "rarely mentioned" (p. 25).

LeBlanc and Ritchie (2001) expanded on their original study by compiling results of 42 studies that were both published and unpublished, but written after 1945 and involved play therapy with children up to age 12. The included studies focused on issues that the children were presenting with, including academic and behavioral difficulties, emotional, social, and family maladjustment, and reaction to or anticipation of a traumatic event. This meta-analysis found that there were two predictor variables of effectiveness of play therapy; these included the involvement of parents in the therapeutic process and the number of play therapy sessions the child underwent. Overall, play therapy was found to be effective for the children with whom it was used; the effect size was 0.66, meaning significantly greater than 0. Play therapy results had a particularly strong effect when parents were involved in the process. Further, it was determined that the number of play therapy sessions provided was a significant predictor of effectiveness. The variable of number of sessions had a curvilinear relationship with the determined effect sizes. Specifically, the effect sizes of play therapy effectiveness increased until about 30 sessions. After 30 sessions, the effectiveness dropped, which LeBlanc and Ritchie attributed to the fact that continued sessions may have been given to children who may not have been benefitting from play therapy at all due to some unidentified characteristics. They found the effect size for play therapy was 0.66, for talk therapy with adults was 0.68, and for non-play therapy with children with 0.71. Overall, it was

determined that "play therapy appears to be as effective as verbal therapies with adults and non-play therapies with children" (p.156).

Bratton et al. (2005) also conducted a meta-analysis on the effectiveness of play therapy. Their analysis included 93 studies on play therapy, which were a mixture of published, as well as unpublished articles. The purpose of conducting this meta-analysis was to target the long-time debated issue of whether play therapy is an effective intervention to use with children as well as to expand the research base of the results from LeBlanc and Ritchie's (2001) previous meta-analysis on the topic. Bratton et al. (2005) found that children who received play therapy performed about ¾ of a standard deviation better than those who did not on the outcome measures used across studies. Generally, these outcome measures included those analyzing internalizing and externalizing behaviors. The effect size of 0.80 was large and in line with that of treatment effects for other types of child therapy. Overall, Bratton et al. (2005) determined through their meta-analyses of 93 existing studies that play therapy is effective across various settings (i.e., clinics, schools, etc.) and both clinical and nonclinical populations.

Further, play therapy has been determined to be effective for children of various levels of ability. From the previously mentioned meta-analyses, the large sample sizes included children at a variety of different developmental levels benefitting from play therapy. However, children with developmental disabilities such as intellectual disability (ID) have also been shown to benefit from various types of play therapy, including CCPT, structured play therapy, unstructured play therapy, Theraplay, and Imaginative play therapy (Astramovich, Lyons, & Hamilton, 2015). The benefits have been shown in both adaptive and social skill areas. Similar positive results have been shown for the

social-emotional growth of children with autism after taking part in play therapy (Salter, Beamish, & Davies, 2016).

The use of play therapy with school-age children has been supported for many decades; it has been shown that its use allows children to express emotions and experiences in their natural mode of communication (Landreth, 2002; Moustakas, 1959). Since time spent on academics is being more emphasized with recent legislation, time for natural play and social interaction has decreased (Allen & Barber, 2015). While some children are able to be successful in school with more time spent on academics, others have a more difficult time. Play therapy is an intervention that can be used to target social skills and emotion regulation, among other areas that children may not have the opportunity to learn outside of the school setting. As CCPT is generally established as the most commonly used type of play therapy, its particular effectiveness will be discussed further.

CCPT. In the meta-analysis conducted by Bratton et al. (2005), the humanistic play therapy models resulted in higher efficacy than the models that were not humanistic. This supports that CCPT, a humanistic type of play therapy, is more effective than other types of play therapy. The results supported that the efficacy of play therapy was stable across age, gender, and issue of child. Recent research outcomes continue to support the idea that play therapy is a suitable counseling style to apply with young children based on their developmental levels (Bratton et al., 2005; Landreth et al., 2009; Ray et al., 2015; Ray et al., 2005). The meta-analysis by Bratton et al. (2005) examined previous studies of play therapy effectiveness. From the analysis, positive effects of play therapy were determined in social maladjustment, conduct, school behavior, emotional maladjustment,

anxiety, self-concept, intelligence, mental challenge, physical disability and learning disabilities. While not all studies analyzed resulted in significant positive results, the majority did. The use of CCPT in particular has been shown to be related to the development of various factors in children. These factors include increases in self-esteem and internal locus of control (Post, 1999), the regulation of negative internalizing behaviors (Flahive & Ray, 2007), decreasing undesired externalizing behaviors (Flahive & Ray, 2007; Garza & Bratton, 2005; Ritzi, Ray, & Schumann, 2017), increasing positive interpersonal relationships (Ray et al., 2015), and improving academic achievement (Blanco & Ray, 2011). These studies, among others, found that play therapy can play a role in nurturing school-age children's self-concept and relationships with adults. It is clear that there are numerous benefits related to the usage of CCPT and that various studies have led to this conclusion. Play therapy is a suitable intervention for children due to the fact that it is based on developmental theory as well as has been shown to be evidence-based (Bratton et al., 2005).

Skill building. There is a large research base supporting that play in general is an activity that allows children to learn important skills. These include things such as social skills, building relationships, and improving impulse control (Chaloner, 2001; Milteer, Ginsburg & Mulligan, 2012). Chaloner also points out twenty-five specific therapeutic factors that develop both within the child and between the child and therapist as play is utilized as an intervention. These include more basic, observable factors within the child that include self-expression, attachment and relationship enhancement, empathy, power/control, competence and self-control, creative problem-solving, and behavioral rehearsal. It also includes direct and indirect teaching, and rapport building between the

child and therapist. However, there are also therapeutic factors that are more abstract and complex that play therapy targets within the child. These include fostering a sense of self, accelerated development, moral judgment, access to the unconscious, abreaction (i.e., gaining control over stressful events they experience), stress inoculation (i.e., working through future, anxiety-rousing events), counterconditioning of negative affect, catharsis, building positive affect, sublimation (i.e., turning behaviors from undesirable into desirable ones), fantasy compensation, and learning the difference between pretend and real life.

One study examined multiple influences of play therapy on students in schools, including academic achievement and self-concept, as well as teacher-child relationships (Blanco, 2010). Blanco, like many others who research play therapy, focused on its use with elementary-aged children. The study found a significant increase in academic achievement, an increase in teacher-child relationship, but not in self-concept, after participating in play therapy. Other studies focused on the variable of student behavior in the classroom. Allen and Barber (2015) examined the use of play to increase desired behaviors in the classroom; they determined that by using play to connect abstract thoughts with more concrete ones, students could ease the stress that the classroom environment can cause. After 10 social skills lessons were incorporated into small-group play sessions, the children's verbal, motor, and passive off-task behaviors significantly decreased.

Working with culturally diverse groups. Other researchers have analyzed the effectiveness of play therapy on variables such as the adjustment of culturally diverse students into the school setting. Cochran (1996) conducted a literature review and

theorized how to apply play therapy practice with culturally diverse groups. As the United States population is ever-changing, Cochran proposed that to address this, school counselors in particular should be trained in interventions like play therapy. This was due to the fact that this type of intervention is not as highly impacted by cultural characteristics. Cochran discussed that students from minority cultures often have more barriers to face in education and that counseling approaches like play therapy can assist in providing them with a better educational experience. "Play and art therapies are less limited by cultural differences between the counselors and the clients than are other forms of interventions" (Cochran, 1996, p. 308). Cochran analyzed some common issues faced by culturally diverse students and from personal case studies and a literature review, provided reasoning behind how play therapy can effectively address these issues. First, culturally diverse students often have communication difficulties with teachers and other students. Cochran discussed how play in play therapy offers another mode of communication for the student that does not have to include verbalizations. Further, play therapy typically includes labeling of emotions and this could work to increase the students' vocabulary. Next, Cochran discussed culturally diverse students' difficulties learning academic skills. Cochran described that play therapy allows for the development of cognitive skills such as decision-making and problem-solving, and allows the student to work on these skills more individually rather than in a full classroom setting. Cochran addressed the social difficulties that culturally diverse students face; play therapy can be conducted in groups, which allows these students to work on building friendship and practicing social skills where talking is not the main avenue. Cochran considered the high amounts of stress due to assimilation that children

from diverse cultures face. It was concluded that play therapy naturally allows for release and expression of emotions and stress. Further, there are many tools and toys that can be incorporated into play therapy to express these emotions in a safe place and then learn skills to express them more appropriately outside of the play room. Lastly, Cochran talked about children from diverse cultures often having issues with low self-esteem due to communication differences and prejudice. Cochran described how play therapists offer a space of acceptance and understanding for children that opens the door for their comfort and allows for them to build their self-esteem. Play therapy allows for expression of all emotions and still receiving respect, which could in turn allow for increases in self-esteem and confidence.

Further, Cochran (1996) provided his thoughts on why counselors within a school setting are more appropriate to provide play therapy to children than outside providers. First, they have access to information about students who have difficulties through direct and indirect observations of them in various settings and engaging in various tasks within the school. They are able to consult with other professionals within the school to obtain even more information. Second, school counselors are in the school during their entire school day, so they are available to work with the student during times of crisis. Lastly, Cochran points out that some families from diverse backgrounds are reluctant to seek outside services, and having access to counseling in the school setting would allow these students to receive the assistance they need.

Perryman and Doran (2010) discussed that play is culturally sensitive and therefore a universal skill. Play therapy can be an effective intervention if there is a language or cultural barrier between the therapist and child. Robles (as cited in Schafer

& Kaduson, 2006) discussed an example of how play therapy can be used with culturally diverse children. While there are often limits to typical toys and games provided in therapy rooms in terms of diversity and cultural sensitivity, there are ways to make them more adaptable for minority cultures. For example, Robles recommends having popular games from other cultures available in the play rooms. Overall, it would be beneficial if play therapists had bilingual skills and foundational understanding of other cultures with whom they work.

As the Hispanic population is the fastest growing in the United States and they are at-risk for school problems, Garza and Bratton (2005) studied the effects of school-based CCPT with Hispanic children. They compared the effects of this treatment against a curriculum-based counseling intervention for students with reported behavioral issues. School counselors provided each intervention, with 29 students in each condition. Pre-test and post-test behavioral assessments indicated that the students who received CCPT as opposed to the other intervention significantly decreased in externalizing behavior problems. CCPT demonstrated a large treatment effect on externalizing behavior problems, as well as a moderate treatment effect on internalizing behavior problems. The recommendations by these authors mirror those of Robles (2006) in terms of incorporating culturally diverse toys and games into sessions as well as utilizing cultural knowledge when working with this population. Overall, this research supports the use of play therapy with children from varying backgrounds and shows that it is broad in its scope of utility.

Further, Milteer et al. (2012) researched the development of children living in families of lower socioeconomic status (SES). From the results of their research, Milteer

et al. (2012) emphasized the importance of recognizing the lasting benefits that play can provide children. Often, children from lower SES have lesser access to resources which includes recess at school and after-school programs. Therefore, educators and parents need to be informed about how play can assist children in their overall development. Overall, this study demonstrated that play works to foster creativity, physical health, social development, and emotional development in children from lower-income families. Milteer et al. reported that play can foster resilience in children; through play, children can learn how to solve problems and practice different roles that they then carry out into their real-life worlds. Further, schools are the place where children of all backgrounds come together and can receive support for their mental health as well as their academic growth.

Use of Play Therapy in Schools

The various types of play therapy that are currently utilized provide many options for use in the school setting. Many types of therapeutic approaches preceded the existence of play therapy in schools; however, when the role of counselors was expanded into elementary schools, play therapy soon followed (Landreth, 2012). As all children undergo development in a variety of areas (i.e., physical, emotional, intellectual, and social), schools attempt to satisfy the needs of children in these areas; play therapy has been used to increase the learning opportunities for children in each one. Due to its success, the use of play therapy is escalating in this context, and its use by school counselors is now one of the highest in comparison to other types of therapies (Landreth, 2012).

Blanco and Ray (2011) conducted a pilot study to analyze the effect of CCPT on academically at-risk students in first grade. This study provided CCPT to one group of students for 30 minutes, biweekly for eight weeks. The twenty-one students who received play therapy, as opposed to children who did not receive any extra intervention, increased a statistically significant amount on the Early Achievement Composite of the Young Children's Achievement Test that was used to assess academic achievement. This study supports the use of play therapy for improving academic achievement for students deemed at-risk. Since aiding in student success in terms of academic achievement is a major role of all school-based professionals, the use of play therapy is a valid intervention to improve this factor.

Ray and colleagues (2015) recently compiled 23 studies in a meta-analysis to evaluate the effectiveness of CCPT in elementary schools. Using a random effects model for mean difference and mean gain effect size estimates to analyze the results of these studies, there were significant results for all of the variables analyzed. Externalizing and internalizing problems, problem behaviors, academic achievement, self-efficacy, and other miscellaneous variables (including social skills, school attitude and relationship with teacher) were all positively affected by experiencing play therapy. Results revealed that the studies on CCPT provided favorable to strong evidence for its beneficial use in schools. The majority of studies analyzed in this meta-analysis involved comparing the treatment group that received CCPT with a control group, but 9 studies compared the treatment group with a comparison group that received another type of intervention; there was a small but significant difference between the treatment and control groups in the studies that compared CCPT to control groups, but not a significant difference between

the treatment and comparison groups in the other studies. This supports the conclusion that CCPT is as viable an intervention as others that are already being used in schools.

Landreth et al. (2009) reviewed the literature on how many play therapy sessions are typically effective for students in schools. He found a range, but that even a few sessions resulted in improvements. From his review, he summarized that as few as four (Post, 1999) or six sessions (Fall, Balvanz, Johnson, & Nelson, 1999) resulted in significant increases in self-esteem and self-efficacy, respectively. When more sessions were provided, other significant effects were found. For example, Flahive and Ray (2007) conducted ten sessions using child-centered play with fourth and fifth grade students, who significantly improved in internalizing and externalizing problems. Further, Garza and Bratton (2005) provided fifteen CCPT sessions with Hispanic students in elementary school and found significant decreases in externalizing behavioral problems, particularly in conduct problems.

As schools are one of the few places where all children, including those with diverse backgrounds, can have mental health services provided to them, play therapy can be beneficial to use in in this setting (Ray et al., 2015). From the meta-analysis and review of literature conducted by Ray et al., it was concluded that "CCPT is an effective intervention in the real-world setting of elementary schools" (2015, p. 121). In comparison to other types of more typical counseling-based interventions used in schools, including social skills lessons, group counseling, and CBT-based counseling, this meta-analysis also concluded that the use of play therapy may result in equal, if not greater, academic achievement and reduction in externalizing problems. Clearly, there is solid evidence to support the use of this intervention with children in the school setting.

Overall, children from all backgrounds go to school to learn, and play therapy is a beneficial intervention to aid in this learning process. Play therapy is a useful intervention that should be transferrable into the school setting. However, there is some research that addresses the reasons as to why it is not being used more in the schools.

Barriers to Providing Play Therapy in Schools

There are various barriers that mental health practitioners encounter when incorporating play therapy into their counseling approach in the school setting. Shen (2008) surveyed school counselors in Texas about their use of play therapy in the school setting. The results from this study of 239 practicing school counselors indicated that those who did not use play therapy kept away from it because they lacked confidence and training in the approach. Other reasons for not utilizing play therapy from this population were lack of time as well as budgetary limitations. The results of Shen's study concluded that school counselors who used play therapy did so for a variety of constructive reasons like the positive outcomes they received, the high quality of it as an intervention, and the empirical support behind it. However, the negative reasons to avoid using play therapy in practice tended to outweigh the positives.

Lack of time. Ray (2005) found that lack of time during the school day was a major barrier reported by school counselors in using play therapy. With time spent on academics becoming more strictly enforced in today's school system, there is less time for teachers to help students learn other important competences such as social skills and less time for students to engage in different aspects of play during the school day (Allen & Barber, 2014). Therefore, issues related to social skills, peer interactions, and emotion regulation may be displayed at school. The mental health professionals will play a role in

assisting these students when issues arise. With already having a lack of time in their schedule to provide counseling, this creates a problem for both those providing the counseling as well as the students. School-based mental health professionals have different responsibilities based on their field, but all spend time consulting with other professionals in the school as well as parents of the students they work with. They may also engage in assessing or evaluating students, crisis response or behavioral support, among other duties. While play therapy is an evidence-based intervention to use with children in the school setting, there are various barriers to using it that are discussed in the literature.

Lack of training. Another reported major barriers is lack of training (Ebrahim, Steen & Paradise, 2012; Peabody, 2014; Ray, 2010; Shen, 2008). An implication of the study conducted by Shen (2008) was the need for more training programs teaching courses on play therapy.

Ray (2005) determined that the barrier of lack of training deters counselors from using play therapy in elementary schools. It was determined that counselors with less training spent significantly fewer hours providing play therapy [x^2 *(N* = 376) = 14.19, p = .0002]. Several years later, research was conducted involving 381 school counselors in order to obtain more information on this topic (Ray, 2010). Ray found that the school counselors who utilized more counseling in general, as well as had more training in play therapy, were also more likely to be using play therapy. Further, those counselors with more years of experience specifically using play therapy were significantly more likely to use play therapy more hours per week than their less experienced counterparts. This research supports that training plays a strong role in whether mental health professionals

utilize this valid and effective intervention, and the lack of this training is limiting its use.

Ray (2010) conversed with graduate students who she taught and were interested in play therapy during graduate school and found that they were not using it in practice in the schools. However, it was clear that the now practicing counselors kept their interest in the topic and were disappointed at the barriers that kept them from putting the skills into practice. In order to determine why graduate students were not using play therapy in practice, Ray (2010) informally surveyed the students and discovered various expressed barriers to providing play therapy particularly in the school setting, including those she had determined from previous research (i.e., lack of time and training), as well as lack of materials and administrative support.

Lack of administrative support. Peabody (2014) discussed the overarching issue of lack of administrative support that is discussed by many previous researchers of play therapy in schools. Peabody stated that if administrators were to acknowledge the benefits of play therapy for students and come to be supportive of its use in schools, then it is possible that the other issues like lack of time, materials, and space could be resolved.

Lack of materials. Landreth (2009) stressed the importance of the presence of appropriate materials being available for children in play therapy. With appropriate materials, the therapist can take an active approach to dealing with the child's presenting problem through the child being actively engaged in demonstrating it in real time. Moustakas (1997) also discussed the importance of materials remaining stable for children from session to session. In 2013, Ray et al. conducted a study on toys and materials that are commonly used by children in child-centered play therapy sessions

because no research had been done on this topic before. Ray et al. wanted to determine these materials in order to assist other play therapists in determining which materials to collect for their own use. In their study, after observing 68 children in therapy, it was determined that the sand box and sand tools were used the most. The toys and materials were split into four categories for the purpose of this study, and children played with objects from each of the four categories (i.e., family/nurturing, expressive, pretend/fantasy, and scary/aggressive) supporting the need for representation of each in the playroom. Landreth (2009) also stated that play therapy can be conducted in any setting. He states that an office, work room, or corner of an area can all work as a space to provide play therapy. With proper time, training, and support, it can be done.

Solutions. Ray (2010) compiled solutions that could be incorporated into schools to increase the use of play therapy, including solutions for each barrier. Ray claimed that lack of training should no longer be a reason for not utilizing play therapy as an intervention in schools. Ray offered suggestions for both universities and mental health professionals; universities should offer at least one course on the topic and professionals could also seek their own information on how to receive training online through APT. Ray did not find it acceptable to use lack of training as an excuse to avoid providing play therapy due to the fact that play therapy should be utilized in order to benefit students. Further, addressing lack of time, Ray offered the hope that as mental health professionals gain experience in the field, they also tend to be able to structure their role within the school to a greater extent. With this comes greater assertion in their roles; over time, Ray believed that counselors should be able to structure more direct intervention with students, allowing them to provide more counseling and therefore play therapy. While

there are various factors that stand in the way of providing play therapy in the school environment, Ray claimed that "most barriers can be addressed in creative and assertive ways that will allow school-based play therapists to implement play therapy in their school settings" (2010, p. 103). She recommended creating a clear role definition of being a play therapist as well as openly defining play therapy in the school setting to overcome barriers more easily.

Ray (as cited in Schaefer & Kaduson, 2006) discussed that for play therapy to be considered as a reputable type of treatment for children, the researchers in the field should determine more specific ways of implementing and reporting research designs. Many play therapy studies are in the form of case studies or lacking true experimental design. To address these issues, Ray recommended that researchers create and follow broad treatment manuals to make the treatment process less ambiguous, replicate past studies to provide more support to the results, and include more descriptions of the populations used in the studies so that more information can be gathered on how effective play therapy is with certain groups. Overall, Ray determined probable solutions to overcome the barriers that are in the way of current mental health professionals using play therapy in schools.

Credentials to be a Registered Play Therapist

As mentioned previously, few graduate training programs offer sufficient coursework or training in play therapy to align with standards of APT or even Landreth's suggestion to be fully credentialed. Landreth (2012) suggests that therapists who utilize play therapy should have at least a master's degree, specific courses in relevant areas, personal counseling, observations of play therapists providing therapy, and supervised

experience in conducting play therapy. Landreth discussed the importance of cultivating concentrated knowledge in play therapy by obtaining 45 hours of instruction in the area. After this, it was recommended that practitioners take part in observation and case analysis of both typically developing children and children facing maladjustment. Landreth emphasized the practicum and supervision aspects of these minimum requirements to become a play therapist, and the APT has a set process to become a registered play therapist.

There are three different credentials available: a registered play therapist (RPT), a registered play therapist supervisor (RPT-S), or a school-based registered play therapist (SB-RPT). It is important to note that there are specific credentials that all mental health professionals must obtain in order to become a Registered Play Therapist (RPT) according to the APT (2021), meaning one must have a state mental health license in order to pursue this extra credential. To become registered in one of these three areas, there are requirements in a variety of categories, which are described below. There is also an application process and membership involved. The purpose of obtaining this credential is to set those play therapists who are registered through the APT apart from those who practice without the superior training.

From the regulations of the APT (2021), there are specifics in training outlined for each credential that is offered through the organization. It is important to note that only one of these credentials can be held at any one time. For the Registered Play Therapist (RPT) credential, the provider must have a state license to provide therapy in a clinical setting. In terms of education, they must have a master's degree or higher in the mental health field, with specific coursework in child development, personality, psychotherapy,

child and adolescent psychopathology, and ethics. For clinical experience and play therapy training, they must have clinical experience as listed by their state licensure (which is typically about two years and 2,000 hours), as well as 150 hours of play therapy instruction from an institution of higher education or specific providers approved by APT. At least 100 of these hours must be direct contact, meaning face-to-face discussion with a supervisor about the play therapy experiences one is having, including going over session notes and videos. This instruction must include four areas: play therapy history, play therapy seminal or historically significant theories, play therapy skills and methods, and play therapy special topics. Each of these areas have minimum hour requirements and should be completed at specific times within three phases of training. For supervision, one must obtain a minimum of 350 direct-client contact hours of play therapy experience. Within this supervision, RPT's must also have minimum of 35 hours of play therapy supervision and five session observations during the time frame they were being supervised by an RPT-S. This supervision must also be completed within three phases outlined by the APT. Lastly, to renew credentials, RPTs must hold a current and active state license to provide services every year and participate in 24 hours of play therapy instruction from institutions of higher education or other approved providers every three years.

For the RPT-S credential, the provider must have all of the same credentials as the RPT, plus some additional credentials. These additional credentials include three more years of clinical experience and 3,000 more hours of general clinical experience after becoming licensed. In terms of supervised play therapy experience, RTS-Ss must also have 500 extra hours of supervised or unsupervised direct play therapy experience after

becoming an RPT. Supervisor training involves having either a state-designated supervisor and completing six hours of play therapy specific supervisor training through an APT-approved provider as well as 24 hours of clinical supervisor instruction, which is not required to be specific to play therapy.

For the SB-RPT credential, providers must have a current and active individual state license or certificate from the State Department of Education to practice specifically as a school counselor or school psychologist. They must hold a minimum of a master's degree in their field and have taken courses in each of main five areas including child development; theories of personality; principles of psychotherapy; child and adolescent psychopathology; and legal, ethical, and professional issues.

Their general clinical experience is that outlined by their specific State Department of Education for their school counselor or school psychologist license/certification. They must also have two years of continuous work in the school setting after they obtained their licensure or certificate. Their play therapy training involves 150 hours of training in an institution of higher education or approved site. The provider is required to be supervised by an RPT-S for at least one full school year. During that time, they must obtain at least 600 hours in direct contact utilizing play therapy with children, as well as 50 more hours of supervision, simultaneously. To renew this credential, SB-RPTs must hold a current and active individual state license or certificate from the State Department of Education and obtain 24 hours of play therapy instruction from institutions of higher education approved sites every three years. Additionally, one must receive three hours of training in diagnosis or psychotherapy, or specific training in the Diagnostic and Statistical Manual (DSM) every three years.

Ann Cattanach (2003) argued that due to the work of play therapists, the training available to them, and the standards that exist for them, *play therapist* could be considered a profession on its own. This, therefore, incorporates continuing professional development and continuous supervision into the practicing of play therapy. Lack of training continues to be an issue for those in this role.

Professionals Qualified to use Play Therapy

Practitioners are not required to be registered in order to practice play therapy, but there are multiple registration options for those who choose to obtain that level of training. While there are individuals in various professions who have the ability to use play therapy in their practices, the current study focuses on those mental health professionals who work within the school setting, but may or may not be registered. In general, any individual who already holds a graduate degree and has a minimum of two years of experience working directly with children can continue their training to earn a qualification in play therapy. For the RPT or RPT-S level, the professional must be licensed by their state, but for SB-RPT level, school counselors or school psychologists can be licensed or certified professionals. Given the variety of practitioners who may be using play therapy in schools, it is important to first understand the typical roles of each school-based mental health professional to determine how their role aligns with providing play therapy.

Mental health counselors. Mental health counselors have a diverse role in the field of health care. Those working in the field are held to the standard of obtaining education, training, and partaking in clinical practices by the American Mental Health Counseling Association (AMHCA). In their current role, they incorporate

psychotherapeutic methods with problem-solving techniques in order to address problems and create change with clients. Their main role involves assessment, diagnosis, counseling and treatment, prevention, and managing crises. Their training focuses on the whole person in terms of overall wellness and prevention of issues. This makes them capable of integrating health care and working with a variety of clients (American Mental Health Counseling Association, 2016). Mental health counselors have the ability to work both part and full-time in the school setting. Specifically, school-based mental health counselors typically partner with schools and there role is meant to accompany that of the school counselor (Brown, 2006). Overall, in 2013 the CDC found that 76% of school districts and 72% of local schools throughout the United States utilized mental health counselors from community mental health agencies to some degree. School counselors can become mental health counselors with additional training that involves clinical aspects (New York Mental Health Counseling Association, 2015).

School counselors. School counselors play an imperative role on educational teams. According to the American School Counselor Association (ASCA; 2016), school counselors "help students focus on academic, career, and social/emotional development so they achieve success in school and are prepared to lead fulfilling lives as responsible members of society." They are well-versed in personal and social development, career development, and academic achievement. They provide both direct and indirect services to students while following the standards of their national organization (ASCA, 2016). They are qualified in their work through having a minimum of a master's degree and are certified/licensed professionals in their field. It is recommended by ASCA that there is a ratio of 1 school counselor to every 250 students in the school. In terms of planning for

future outcomes, school counselors create vision statements with individual students. They also design mission statements that work to create program goals to work toward and measure the school's overall mission. More specifically, they create and provide a curriculum to students in the form of classroom or small group activities that contains structured lessons to help students reach the preferred proficiencies and to provide them with knowledge, attitudes, and skills for their level.

School psychologists. School psychologists, also members of the educational team, have a unique role in terms of their background and qualifications. Overall, according to NASP (2016), the broad role of school psychologists is to support students in their learning and teachers in their teaching. They have expertise in mental health, learning, and behavior, which allows them to assist children in various areas of their lives including academically, behaviorally, socially, and emotionally. They also have a strong role in collaboration with others, including teachers, administrators, other school-based and community professionals, and parents, to help the student in all of the above areas and to create a connection between the school and the community. School psychologists are credentialed based on the state in which they work and have a minimum of a specialist degree (i.e., 2-year master's degree plus 1-year internship). The major skill areas in which they are trained include assessment, progress-monitoring, data collection and analysis, consultation and collaboration, mental health interventions, behavioral interventions, academic interventions, instructional support, special education services, and school-wide practices to promote learning.

School social workers. School social workers are specialized within the broader field of social work, which focuses on helping "individuals, families, and groups restore

or enhance their capacity for social functioning, and work to create societal conditions that support communities in need" (NASW, 2016). Broadly, social workers assist people with psychosocial services; they help them overcome challenges they face in many areas of life. They also have a unique role on the student services team within the school system (School Social Work Association of America (SSWAA), 2012). They are mental health professionals who also specialize in students' behavioral concerns; positive behavioral support; academic support; consultation with teachers, parents, and administrators; and direct counseling to students in groups or individually. School social workers have a particular role in maintaining the collaboration between the school, parents, and the community. In terms of working with families, they provide services that include facilitating support in children's school adjustment, easing family stress in order to enable the child to function more successfully both in school and the community, and assisting parents in accessing programs and resources within the school and community. With a variety of professionals capable of providing play therapy in schools, there is a potential for it to be utilized with a greater number of students.

Training about Play Therapy

Curry (2013) compiled works from various authors into a book dedicated to discussing the need for play therapy in the school setting. She made the point that school counselors work in an environment that is unique for mental health professionals, and that flexibility in counseling practices is necessary to serve the student population; the book gave reasoning for the use of various play therapy techniques in schools. Curry discussed that play therapy courses are not mandated to be a part of counseling graduate programs by the Council for Accreditation of Counseling and Related Education

Programs (CACREP), and therefore numerous school counselors are not trained in the topic. In 2013, there were already over 400 programs in the US for school counseling; however, at the same time there were only eleven training locations to become a certified play therapist. However, on a broader level, there are currently 173 universities in the United States that offer at least a course on the topic of play therapy and this number has increased even in the last several years (APT, 2016).

As there are a variety of ways mental health professionals can receive *training* in play therapy, it is important to analyze the differences in these methods. Pascarella (2013) surveyed 83 training programs within graduate schools in the fields of school counseling, school psychology, and social work. It was found that trainers of school counselors had the most positive views of play therapy and were therefore more likely to offer the training in their programs. It was determined that most programs included in the study offered some level of training in play therapy to their students; however, school counseling programs offered the most training. There was a reported increase in the number of programs that offered training in play therapy in the several years prior to 2007 for both school counselors- and school psychologists-in-training. However, it was still the case that a minority of programs offered enough training opportunities to align with common standards. Specifically, APT requires 150 hours of play therapy instruction in order to obtain the qualification; of the graduate programs surveyed, only 4% of the training programs provided at least 150 hours. After analyzing the difference in instruction between fields, it was determined that counseling students received the most instruction (median of 30 hours), followed by social work students (median of 27 hours), and lastly by school psychology students (median of 15 hours). However, the training

offered by the programs still left students requiring more training in order to become fully registered as a play therapist.

Ryan et al. (2002) surveyed 891 play therapists and found that 40% had play therapy as a part of their practicum or internship experience. Further, 53.5% were found to have had at least some exposure to play therapy in their graduate program. Of the main types of play therapy discussed, the researchers found that counseling students received a significantly greater amount of instruction in Child-Centered, Jungian, and Adlerian play therapy than either social work or psychology graduate students ($F (3, 878) = 8.714$, $p < .001$; $F (3, 878) = 9.917$, $p < .001$; $F (3, 878) = 35.279$, $p < .001$, respectively).

Lambert et al. (2005) surveyed both members of APT and the American Counseling Association (ACA) about the training they have received in play therapy. They furthered the research of Ryan et al. (2002) by including a more representative sample. Lambert et al. acknowledged that at the time, there were 105 graduate programs in the area of counseling that offered one or more graduate courses in play therapy, according to the Center for Play Therapy. This meant that counselors who were not members of APT or registered as play therapists were not included in the past studies and not including this group in research could skew the results. Their research provided information about how members of APT versus members of ACA differed in their training and use of play therapy. From the results of the survey, it was found that those included in the study identified themselves as professional counselors, school counselors, and social workers. In terms of graduate training, there was not a significant difference between the members of APT versus the members of ACA. The average amount of

training in graduate school was 1.5 courses for members of both, but the continuing education received by members of each group received was significantly different. Those who belonged to APT had between 88.29 and 118.64 more Continuing Education Units (CEUs) than those who belonged to ACA, meaning they engaged in a significantly greater amount of continuing education. Regarding supervision received by those practicing play therapy, the researchers found that those who belonged to APT received significantly greater amounts than those who only belonged to ACA. Therefore, those who consider themselves play therapists and take the initiative to become registered through APT seek more training, on average, than those who practice without being a member of APT. There is a gap in research regarding the amount of training beyond graduate school that play therapists receive, which this current study addressed.

Attitude

It is predicted that training in play therapy is related to other variables that influence the use of play therapy by mental health practitioners. Landreth and Bratton (2006) accentuated the importance of attitudes of play therapists by saying, "it is more important to focus the supervision experience on the attitudes of the filial therapist rather than techniques, on feelings rather than content, on the relationship rather than specific responses, and on accepting rather than evaluating" (p. 34). They refer to filial therapist which is typically training parents how to use play therapy with their children. Landreth, Ray, and Bratton (2009) outlined important skills that are necessary for therapists who provide play therapy in schools to have. The first skill that they discussed is a particular type of attitude in regard to working with children. They described this attitude as "*being with* and entering into the child's world. Only when the child begins to feel safe,

accepted, and understood will the child begin to explore and express those experiences that are most emotionally meaningful" (Landreth et al., 2009, p. 285). These authors put so much emphasis on the importance of having this attitude that they described all of the other necessary skills as connected to it.

Crane and Brown (2003), who taught play therapy to undergraduate students to analyze the effect of training on the students' attitudes, knowledge, and skills based much of their research on the previous work of Stollak (1973). Stollak trained undergraduate students in play therapy and discussed the role of attitude in providing play therapy successfully. As part of beneficial training, Stollak emphasized "teaching personal and interpersonal attitudes and skills that the individual can apply to solve present and future psychological problems and enhance his own and others' satisfaction with life" (p. 158).

More recently, Lindo et al. (2012) analyzed student interview results after undergoing a play therapy course. Their attitudes about play therapy significantly improved from before the course to after. One student described her attitude change as: "I learned that I do in fact love working with children. I always said children were my passion, but I never had the opportunity to actually take a play therapy class, so this kind of has solidified the reason why I'm here, because, believe me, I was doubting my reasons in the beginning of this program" (p. 161). Exposure to information and practicing play therapy enhanced the attitude of this practitioner, among others, influencing their use of play therapy in the field, supporting the need for more courses on the topic in graduate school and beyond.

Knowledge

In terms of knowledge about play therapy, Landreth et al. (2009) conducted a literature review in order to provide information about the topic. They discussed practical information about successful play therapy programs for those who provide play therapy. Some of the information they deemed important to consider included the type of place and toys that can be used to provide play therapy, length of sessions, and acquiring support from both teachers and parents of the students. These topics align with the items on the Knowledge subscale of the Play Therapy Attitude-Knowledge-Skills Survey (Kao & Landreth, 1997) that was used in this current study. The use of this original scale was conducted in a pre-test, post-test model and resulted in significantly higher scores in each subscale of those trained in CCPT versus those who did not receive training.

When analyzing the results of training on the knowledge that those providing play therapy gained on the subject, Crane and Brown (2003) found positive outcomes. The researchers determined a significantly higher amount of knowledge gained in the group of students who received play therapy training over the control group. Further, within the experimental group, the knowledge scores from pretest to posttest also significantly improved. The 10-week training, as part of an undergraduate college course, resulted in the conclusion that students "can learn basic play therapy skills, in particular the demonstration of empathy, which are important in any helping relationship to increase knowledge about children and play therapy" (Crane & Brown, 2003, p. 59). Crane and Brown's instruction focused on teaching the students positive forms of child discipline including skills like Landreth's limit-setting, choice-giving, and natural consequences. They also taught about goals of behavior and children's emotional needs. Crane and

Brown provided instruction in the form of lecture, discussion, role-playing, homework, practical experience, and supervision. The areas that were focused on added to the knowledge base of the students that were involved. As the PTAKSS is based specifically on the CCPT approach, Crane and Brown's training is consistent with the topics covered on the Knowledge aspect of the survey.

Skills

Specifically, the other skills Landreth et al. (2009) discussed include modes of communication that are meant to portray the *being with* attitude to the children themselves. These communication skills include both verbal and nonverbal skills. In play therapy, the nonverbal skills are more important as play is thought of to be the language of the child (Landreth et al., 2009). These include depicting genuineness to the child and matching the expression that the child portrays. In terms of verbal skills that are necessary to be an effective play therapist, Landreth et al. (2009) included a list of eight essential skills. Three of these skills are reflecting the child's nonverbal behaviors, their conversation, and the child's feelings. Other skills they included were facilitating both responsibility and creativity of the child as well as the relationship they share. They emphasized the importance of the therapist working to build esteem in the child. Lastly, limit-setting was described as a necessary verbal skill for play therapists to have, which involves acknowledging the feeling that the child has, communicating the limit that needs to be set, and targeting an alternative choice for the child. These skills require teaching and practice to be obtained.

Stollak (1968) examined specific skill attainment in students he was training in play therapy after a 10-week course. Specifically, Stollak noted that the students

improved on skills such as reflecting content of sessions and clarifying feelings of the children. Linden and Stollak (1969) emphasized that communicating empathy was one of the most important skills in providing beneficial play therapy. They had consistent findings with Stollak (1968) in their related research about college students' play therapy training. They found that the skill of reflecting, in the form of reflecting feelings, behaviors, and verbal content, all improved after training was completed. The group that gained the most skill in these areas was the one that was didactically trained, rather than the non-directively trained or control groups. The didactically trained group also provided less direction to the children, as they were trained from a child-centered approach, therefore obtaining skill from that framework as well. Overall, there are many skills that researchers have found to be important in providing appropriate play therapy that results in successful outcomes, and training has been shown to improve these skills in the trainees.

Summary and Statement of the Problem

This chapter provided a comprehensive review of the current literature about play therapy and its relationship with school-based mental health professionals. Play therapy is a widely-recognized intervention and is developmentally appropriate for elementary-age children. Use of play therapy as an intervention is supported by the various mental health professional associations. Mental health counselors, school counselors, and school psychologists are responsible to serve children in schools and to aid them in their overall wellbeing. Research backs the effectiveness of play therapy in the school setting on a multitude of issues that students face including, but not limited to, behavioral issues, academic performance, and self-concept. However, there is still less research about the

use of play therapy in schools as opposed to other settings, and less emphasis on the barriers to doing so in the current literature. As previous research maintained, professionals' training, attitude, knowledge, and skills in providing play therapy all provide a role in the effective implementation of the intervention. There is a lack of research on training that mental health professionals receive beyond graduate school on play therapy, which was addressed by this current study. Further, this current study added to the literature by comparing mental health counselors', school counselors', and school psychologists' training in play therapy with their overall use of it, as well as how their attitudes, knowledge, and skills regarding play therapy impact their use of play therapy.

Chapter 3: Method

This study addressed the relationship between training that school-based mental health professionals receive in the area of play therapy with their use of play therapy, as well as their attitude, knowledge, and skills in using it. Descriptive information about the professionals who currently or have ever utilized play therapy in the school setting were obtained as well. This was examined through the use of a survey and analyzed with Analysis of Variance (ANOVA), correlational statistics, and path analysis.

Participants

The participants in this study were school-based mental health professionals representing three disciplines: mental health counselors, school counselors, and school psychologists. These participants were recruited through several modes. One mode was through online Facebook groups associated with each profession. These groups include the American Mental Health Counselors Association, American Counseling Association (ACA), American School Counselor Association, and the National Association of School Psychologists (or School Psychology Forum). There was access to message the administrators of the Facebook groups or post a message on the wall of each group's webpage as well as to email the professional associations directly. By doing this, every individual who was following the Facebook group or who was a member of their professional association had the opportunity to see the survey being posted or sent. The link to the online survey, along with an explanation of the dissertation project, was shared on each Facebook group's page and in the email to each professional association.

Another mode of obtaining participants was directly through the professional associations for each profession; the associations were emailed to determine if they

would be willing to allow the survey to be distributed to their members via an email list serve or online community. This was completed for two groups--ACA and ASCA. It was not completed through NASP, as the organization would only allow surveys to be distributed by mail, nor AMHCA, as responses were never received after several attempts.

Due to not receiving enough participants via these first two modes, two other modes were initiated later in the data collection phase. First, members of the Association of Play Therapy (APT) were directly emailed a link and explanation of the survey. Next, one school district from each state was randomly selected from an online list of all school districts in the United States and the mental health professionals currently working in that school were directly emailed a link and explanation of the survey. Random selection involved randomly picking a number out of how many school districts were listed for each state and sending the survey to that number school district on the list. By using these groups, which exist at the national level, a large number of mental health professionals who were currently working within the school setting were reached.

As a rule of thumb discussed by Kline (2005) in regard to using structural equation modeling in social sciences, the minimum number of participants that needed to be included in this study was 75, with the goal of having a minimum of 25 participants representing each group of mental health professionals. To be included in this study, the participants had to either be a current member of the Facebook group that aligns with their current profession, a member of their field's professional association, a member of APT, or currently working in one of the randomly selected school districts within the United States because this is the mode of collecting the sample for this study. Of those,

only those who are currently working in the school setting as a mental health professional were included in this study. While play therapy is most commonly used in elementary schools rather than with students in upper grades, school-based mental health professionals at all levels were included in this study; they did not have to be currently using or ever have used play therapy in order to take part in the study.

The participants who responded included 26 mental health counselors, 27 school counselors, 43 school psychologists, and 11 social workers. Originally, school-based social workers were included in this study and data was attempted to be collected from this group. However, not enough responses were able to be obtained from this group after several attempts to acquire participants via several modes. Therefore, the responses from the small number of school-based social workers who did participate were excluded from the study. Learning about social workers' use of play therapy will likely have to be done outside the scope of school-based research.

Of the participants who were included in the study, 61.05% held a master's degree in their field, 27.37% held a specialist degree, and 11.58% held a doctorate degree. According to the NASP 2015 Membership Survey (Walcott, Hyson, McNamara, Charvat, 2018), most school psychologists in the United States have a specialist degree, which is a professional degree between a master's and doctoral degree. School psychologists are more likely than the other professionals to have a specialist degree over a master's degree based on the differing credentials required to obtain a job within each field. According to a College Board survey, 73% of school counselors have a master's degree (Bridgeland & Bruce, 2011). The percentage of mental health counselors with a

master's degree versus doctoral degree could not be obtained within current published literature.

Regarding gender, 91.66% were female and 8.33% were male, overall. According to the American Psychological Association, the majority of those holding degrees and working in the field of psychology, including counseling, are women (Willyard, 2011). The average age of the participants was 37.74 years old and ranged from 24 to 65. Overall, it was a relatively young sample as 67% of the sample was 39 years old or younger. Further, the average years of experience reported by the participants was 7.22 years and ranged from less than one year to 31 years. Thus, this is a relatively inexperienced group of participants. According to the NASP 2015 Membership Survey, the average school psychologist in the United States has 12.2 years of experience (Walcott et al., 2018). Information about school counselors' and mental health counselors' average work experience nationally could not be obtained from the current published literature.

Regarding race, 83.33% described themselves as White, 6.25% described themselves as Multiracial, 3.13% described themselves as Black, 3.13% described themselves as Asian, 2.01% described themselves as Hispanic, and 2.01% described themselves as Other. The locations in which the participants worked were split between rural, urban, or suburban areas. Overall, 42.1% of the population worked in a rural school, 25.26% worked in an urban school, and 32.63% worked in a suburban school. These results can be seen in *Table 1* below:

Table 1

Participants' Demographics

	Frequency				Percent			
	MHC	SC	SP	Total	MHC	SC	SP	Total
Field								
Mental Health Counselor				26				27.1
School Counselor				27				28.1
School Psychologist				43				44.8
Gender								
Male	3	1	4	8	3.1	1.0	4.2	8.3
Female	23	26	39	88	24.0	27.1	40.6	91.7
Age								
25-34	12	4	24	40	12.8	4.3	25.5	42.6
35-44	6	11	15	32	6.3	11.7	16.0	34.0
45-54	5	6	4	15	5.3	6.3	4.3	16.0
55-64	1	5	0	6	1.1	5.3	0.0	6.4
65-74	1	0	0	1	1.1	0.0	0.0	1.1
Race								
White	23	21	36	80	24.0	21.9	37.5	83.3
Black/African American	0	2	1	3	0.0	2.1	1.0	3.1
Hispanic/Latino	0	0	2	2	0.0	0.0	2.1	2.1
Asian	1	1	1	3	1.0	1.0	1.0	3.0
Multiple Races	2	3	1	6	2.1	3.1	1.0	6.2
Other	0	0	2	2	0.0	0.0	2.1	2.1
Highest Degree								
Master's	24	22	12	58	25.3	23.2	12.6	61.1
Specialist	2	3	21	26	2.1	3.2	22.1	27.4
Doctorate	0	2	9	11	0.0	2.1	9.5	11.6
Location								
Rural	12	13	15	40	12.6	13.7	15.8	42.1
Suburban	10	8	13	31	10.5	8.4	13.7	32.6
Urban	4	6	14	24	4.2	6.3	14.7	25.3
Years of Experience								
0-10	23	30	18	71	24.0	31.3	18.8	74.0
11-20	3	6	11	20	3.1	6.3	11.5	20.8
21-30	0	2	2	4	0.0	2.1	2.1	4.2
31-40	0	1	0	1	0.0	1.0	0.0	1.0

Note. MHC = Mental Health Counselor; SC = School Counselor; SP = School Psychologist

Measures

The participants were given an online survey to complete (see Appendix A). The survey included four sections, each of which covered a main component of the study—demographic information, training information, use of play therapy information, and information regarding attitude, knowledge, and skills in using play therapy. The first three sections of the survey were modeled after the *School Psychopharmacology Roles and Training Evaluation* survey used by Shahidullah and Carlson (2014), which was developed to analyze Nationally Certified School Psychologists' role and training in the area of psychopharmacology. The survey that these researchers created was modeled after review of previous studies (Carlson, Demaray, & Hunter-Oehmke, 2006; DuPaul & Carlson, 2005). The language of the survey was altered to be relevant for the mental health field and the topic of play therapy.

Demographics. The first section of the survey asked for demographic information about school-based mental health professionals and their educational and professional background. It also included other demographic information particular to this current study: age, gender, race, profession, degree obtained, years of experience in the field, location in which they work (i.e., rural, urban, suburban), age group of students served, and number of students served. To understand the amount of time the mental health professionals had available in their schedule to even consider providing play therapy, one important question in this part of the survey asked the participants to provide the percentage of time they dedicate to counseling in the school.

Shahidullah and Carlson (2014) conducted a pilot study using the survey instrument, after which the format of the first three sections of this current survey were

modeled. After the pilot study, modifications were made regarding item wording, response options, and overall format to improve its utility. Also, from this pilot study it was determined that this survey took about 10 minutes for participants to complete. The survey utilized in this current study is based on the modified survey by Shahidullah and Carlson.

Training Information. The second section of the survey covered the information about the training the mental health professionals received. Items in this part of the survey allowed the participants to indicate the amount of training they had specifically in play therapy. In this section, play therapy training was regarded as a multi-level concept, as there are various types of training recognized by the APT. These included completing part of a course, a whole course, attending a conference, workshops, or being a fully registered play therapist. Participants were also asked to approximate the total number of training hours they had received in play therapy.

Use of Play Therapy in Schools. The third section of the survey asked questions related to the professionals' current or past use of play therapy in schools in order to obtain information for the dependent variable of interest in the current study. In this section, participants were also asked to indicate which type of play therapy they utilized most often. Additionally, participants were asked to identify barriers they faced in regard to providing play therapy.

Attitude, knowledge, and skills. The final section of the survey addressed the variables of mental health professionals' attitudes, knowledge, and skills regarding play therapy. The revised version of the Play Therapy Attitude-Knowledge-Skills Survey (PTAKSS) (Kao & Landreth, 1997) was utilized. This scale was originally created to

determine the effectiveness of a child-centered play therapy training program. Each variable was addressed through a subscale of the PTAKSS.

Kao and Landreth (1997) determined that the entire PTAKSS has strong validity and reliability. First, the content validity of the scale was examined by having four experts in the field complete the survey and provide an analysis of the items that were included. Each expert completed the survey on the 1 to 5 Likert scale. The average scores calculated on the five-point scale were 4.66 for the total scale, 4.52 for the Attitude subscale, 4.68 for the Knowledge subscale, and 4.78 for the Skill subscale, resulting in agreement on 87 out of the 88 items assessed. Further field-testing was conducted for the scale; 104 graduate students in the field of counseling completed it and reliability coefficients (Cronbach's alpha) were determined to be .98 for the total scale, .73 for the Attitude scale, .94 for the Knowledge scale, and .99 for Skill scale. Correlation coefficients were used to calculate criterion validity of the scale, which consisted of the number of courses in play therapy each participant had and their total PTAKSS score. The correlation coefficients were $r = .70$ ($p < .0001$) for the total scale, .34 ($p < .0001$) for the Attitude scale, .71 ($p < .0001$) for the Knowledge scale, and .68 ($p < .0001$) for the Skills scale.

More recently, researchers utilized the revised version of the PTAKSS to analyze play therapy training on the knowledge, attitudes, and skills of graduate students learning to use play therapy and this revised version was utilized in this current study (Lindo et al., 2012). The authors described that the revised version of the scale had 63 items rather than the original 88. The scale was recognized to have strong internal consistency reliability as well as split-half reliability. The factor analyses that were conducted

revealed three factors representing attitude, knowledge, and skills, accounting for 47.6 percent of variance. There are 23 items on the Attitude section of the scale, 18 items on the Knowledge section, and 22 items on the Skills section. From the results of the survey, averages were calculated for each group of mental health professionals to determine the differences between the professions.

Variables

Several demographic descriptive variables were collected to determine how well the sample represented the population of mental health professionals within their field. These included race, gender, age, degree held (which was a measure of whether the professional holds a master's, specialist, or doctoral degree), school community type (which was a measure of whether the professional works in a rural, urban, or suburban school community), and years of experience (measured by the item "How long have you been serving as a school-based mental health professional, in years? (Please count post-degree and include this current school year))." The variable "Type of Mental Health Professional" was measured by one item on the survey: "Within which mental health field do you currently work?" This was of particular interest within understanding the types of mental health professionals who are more often using play therapy in the school setting over others.

An independent variable of interest was the amount of play therapy training attained by the professionals. This was measured by two items: "Within your university-based graduate program, how many hours total did you spend learning about or practicing play therapy?" and "Please approximate the number of hours of your training in play therapy that has come from any of the before-mentioned categories outside of your

graduate training program." Both of these items were measured in hours and added together to form one independent variable. There were previous items on the survey that addressed the various types and modes of training that professionals could receive; these were for descriptive purposes only.

The independent variables of attitude, knowledge, and skills were each measured by items on the Play Therapy Attitude-Knowledge-Skills-Survey (Kao & Landreth, 1997). The subscale addressing attitudes examined the beliefs and interaction patterns of those providing play therapy. The knowledge subscale addressed the information that those providing play therapy should realistically know after being trained in child-centered play therapy. Lastly, the skill subscale addressed confidence in applying the skills about which providers of play therapy should be trained. The set of items that targets each of these three variables were added together to get an overall score for attitude, knowledge, and skills regarding play therapy for each participant. This was then included in the data set for further analysis. As stated previously, there were 23 items on the Attitude section of the scale, 18 items on the Knowledge section, and 22 items on the Skills section. There was a potential range of scores of 23-115 for the Attitude section, 18-90 for the Knowledge section, 22-110 for the Skills section, and 63-315 for the overall score.

Time dedicated to counseling was measured by one item on the survey: "Currently what percentage of your time is spent counseling children?" Perceived barriers to providing play therapy were measured by the item on the survey: "What do you find to be the biggest challenge to conducting play therapy?" There were five options to choose from that were based on highly reported barriers from the current

literature (i.e., lack of space, lack of time, lack of materials, lack of administrative support, lack of training) as well as an "other" option that allowed for participants to fill in another barrier if their top reason was not listed. This variable was turned into a numerical variable by simply adding up the number of barriers reported by each participant (0-5, or more if they reported other barriers).

The dependent (outcome) variable in this study was the amount of play therapy the mental health professionals utilized in practice. This was measured by the number of hours the professionals reported using play therapy during an average week.

Further, as expected, there were missing values throughout the final data set from participants leaving some survey items unanswered. To address this, two different approaches were taken depending on the item. First, there were 18 missing values from the item asking participants how often they use play therapy. Based on the format of responding to this item requiring participants to type in the number of hours, it was hypothesized that if the participant left the item blank, they were reporting 0 hours of use, so 0 was inputted for this item for these participants. For missing values within the PTAKSS portion of the survey, mean substitution was utilized as a systematic approach to address this. This approach involved replacing the missing value with the mean value of a specific variable, which is done based on the theory that the mean is an appropriate way to estimate a randomly missing observation (Kang, 2013). The missing values from this particular data set were determined to be random as there was no determined pattern to the values that were missing. The missing values were spread out among participants and items. No participant had missing values for more than one of the variables included in the model—there were 14 missing values total for the variables of attitude, knowledge,

and skills included in the path model. Using this systematic approach allowed for the sample to remain as large as possible.

Procedures

Participants were obtained from the previously mentioned online Facebook groups, through the professional associations for each mental health field, from members of APT, and through direct contact of mental health professionals working in randomly selected schools throughout the United States. The sample for this study was made up of mental health professionals in each discipline currently working in the school setting.

A link to the survey, through a secure online platform, was posted within the online Facebook groups for independent access, or emailed to participants directly from the professional association to which they belong, from a list provided by APT, or from randomly selected school websites. A description of the purpose of the survey was provided in the posting or message that was sent along with the link to the survey. Consent to participate in the study was the first question included in the survey. As an incentive for completing the survey, an entry into a drawing for a gift card with a $50 value was provided to all participants after completion of the survey. Each participant could enter their email at the end of their survey if they wished to be entered into the drawing. A follow-up message to the sample was sent at least two weeks after the initial message with the survey in order to increase the response rate of the participants.

Not all school-based mental health professionals who received the offer to participate in this study were currently working in the school setting or engaging in the use of play therapy. Those who were currently working in a school setting were of interest in this study, whether they utilized play therapy or not. If they were not utilizing

play therapy, the reasoning is of interest. An introductory item on the survey stated, "If you work in a school setting, either full-time or part-time please continue. If you DO NOT work in a school setting please DISCONTINUE by checking the box below," which only allowed those who were currently working in a school to continue.

Design

Overall, a nonexperimental survey design was utilized in this study to analyze pre-existing relationships between the variables of interest. The designs that address the first two research hypotheses of this study were descriptive. The differences in both training in and use of play therapy between mental health counselors, school counselors, and school psychologists were analyzed by the means of the amount of training and usage among the groups through an Analysis of Variance (ANOVA).

Further hypotheses were analyzed using correlational statistics. Relationships were analyzed among the different variables of interest. A direct relationship between training in play therapy and use of play therapy was analyzed. A relationship of attitude, knowledge, skills, and variables mediating training and use of play therapy was also analyzed. As various relationships were predicted, a path analysis was utilized to establish how well the model and hypotheses explain the data.

Analyses and Path Model

Path analysis is a type of statistical method that is an extension of a multiple regression in that it allows for the strength and direction of relationships between variables within a model to be analyzed simultaneously. Based on previous research and chronological order, the variables that were included in the model for this current study were arranged to reflect causal relationships. Directional hypotheses (i.e., taking

variables' order of occurrence into account) were created within the model allowing for direct, indirect, and total effects to be calculated. A direct effect signifies the strength of a relationship between two variables; for example, in this current model, a direct effect was predicted between years of experience and play therapy training hours. A straight arrow was drawn from years of experience to play therapy training hours, meaning that it is predicted that years of experience influences the amount of play therapy training received. An indirect effect is different in that it is the result of a mediating variable's influence (i.e., an earlier variable directly influences the mediating variable, which then directly influences another variable). A straight arrow was drawn from variable A to variable B (i.e., mediating variable) and then from variable B to variable C. Lastly, total effects are a combination of all of the predicted direct and indirect effects that are included in the model. The path analysis model also allowed for correlations to be conducted to determine relationships that exist between variables. These are depicted in the path model as curved, multidirectional arrows. Specifically, the correlations between the variables of attitude and knowledge, knowledge and skills, and attitude and skills were included in the model as seen below in *Figure 1*.

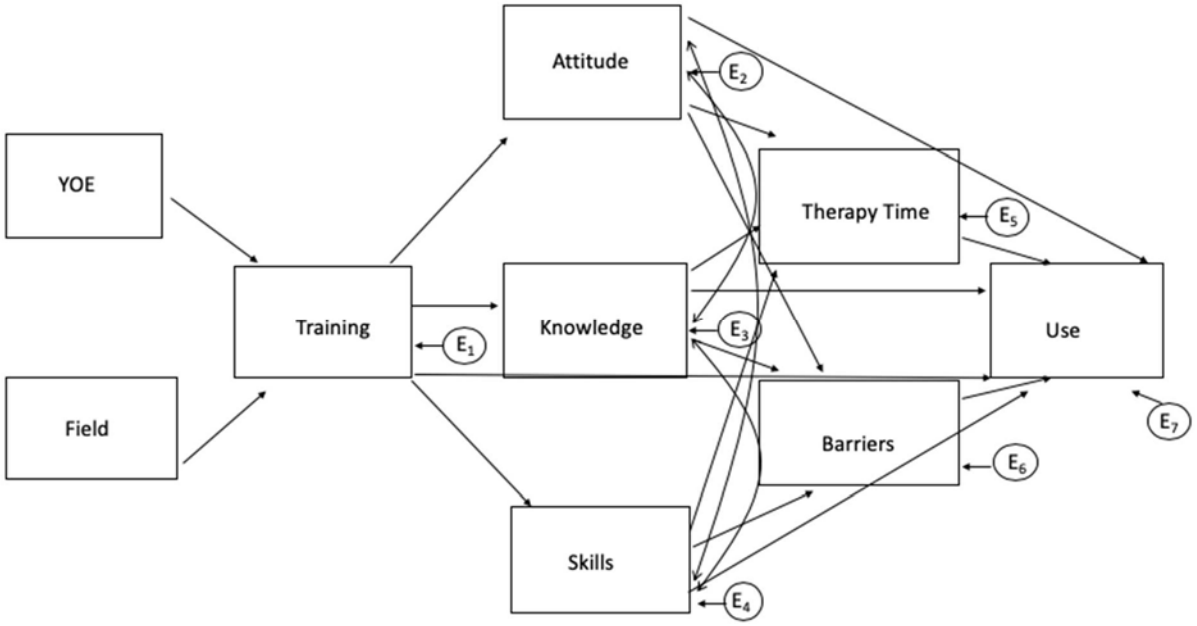

Figure 1. Original Path Model

The first variables in the model were demographic variables of interest that included background characteristics of the school-based mental health professionals. These included the type of mental health professional they are (i.e., mental health counselor, school counselor, or school psychologist) and the years of experience they had in the field. These two variables were predicted to be directly related to the dependent variable and were thought to occur prior to other independent variables of interest, so they were included first in the model. However, in this model, years of experience was not predicted to be directly related to use of play therapy. It is predicted that years of experience alone is not enough to be a cause of greater use of play therapy. With more experience in their field, mental health professionals are not necessarily more likely to use play therapy more often. For example, a mental health professional could have more years of experience working in a school, but not necessarily have any additional training for school-based practices during those years. Just because they have worked in a school

for increasing amounts of time does not mean they are more likely to attempt new techniques, interventions, or use one specific type of counseling more often. An arrow was not included in the model from field to use. This was an oversight when specifying the model, but was addressed when the model was modified to obtain a better fit. Further, due to the fact that the demographic variables were likely to impact both the independent and dependent variables, they were held as controls in the model. Because type of mental health professional is a categorical variable with three levels, this nominal variable was dummy coded in order to include it in the path model. This was done by making 'school counselor' the reference category, as it was hypothesized that school counselors utilize play therapy the most. Within the model, mental health counselors and school psychologists were coded as dummy variables. To do this, two levels of "type of mental health professional" were taken and a variable was created for each of these levels. Each level had the value of yes or no (i.e., 1 or 0, respectively). Specifically, the variables were "mental health counselor," and "school psychologist". Each occurrence of "type of mental health professional" was then recoded into a value for each level. For example, if the person was a school counselor, then "mental health counselor" and "school psychologist" both equaled 0, and "school counselor" equaled 1.

Following the demographic variables of years of experience and type of mental health professional was the independent variable--amount of play therapy training received by the school-based mental health professional. This chronologically followed the demographic variables because, to have training in play therapy, one must typically be certified in one of the mental health fields included in this study and likely has prior years of experience in the field. It was possible to only have play therapy training during

graduate school and no experience in the field, but it was decided to include training early in the model. Further, previous research studied the differences in play therapy training among the various mental health professions, supporting the direct relationship of profession to training (Cerio et al., 1999; Pascarella, 2013).

Variables that were examined as mediators between the independent and dependent variables in this study included the mental health professionals' attitude toward play therapy, knowledge about play therapy, and skills in using play therapy. These were included in the model after play therapy training due to the idea that while each could exist prior to any training in play therapy, they were more likely to be influenced and change after some exposure to play therapy. Further, the model reflected that each of these three variables were correlated with one another.

The potentially confounding variables of time dedicated to counseling and perceived barriers to using play therapy were included in the model after the mediating variables of attitude, knowledge, and skills and before the dependent variable of amount of use of play therapy. This is so because the professionals would require some sort of exposure or training to play therapy, and therefore form some degree of attitude, knowledge, and skills in play therapy, prior to facing any barriers or having time to dedicate toward using it. These two variables are *potentially* confounding variables because they have the ability to influence the effect on the dependent variable.

The dependent variable chronologically occurs last and is therefore included last in the model. Previous research has been conducted regarding the direct influence of training on the improvement of attitude, knowledge, and skills in play therapy (Crane & Brown, 2003; Lindo et al., 2012), but there is no current literature on the direct effect of

each of those on use of play therapy or on the direct effect of training on use of play therapy, which were both examined in this model.

Chapter 4: Results

The aim of the present study was to determine whether there were relationships between (1) years of experience and amount of play therapy training, (2) field and amount of play therapy training, (3) amount of play therapy training and play therapy attitude, knowledge, and skills, (4) amount of play therapy training and overall use of play therapy, (5) play therapy attitude, knowledge, and skills and time dedicated to counseling, (6) play therapy attitude, knowledge, and skills and perceived barriers to using play therapy, (7) play therapy attitude, knowledge, and skills and overall use of play therapy. Thus, variables included years of experience, field, play therapy training hours, play therapy attitude, play therapy knowledge, play therapy skills, time dedicated to counseling, perceived barriers to using play therapy, and overall use of play therapy in schools. Degree type, gender, age, years of experience, race, and school community type were included as control variables.

Goodness of Fit Statistics

To examine the overall model for this study, fit statistics were analyzed. Goodness of fit statistics explain how well a statistical model fits the actual data that was collected by comparing the hypothesized model with that of a baseline model. Fit statistics also provide information about the incongruity that exists between observed values and the values expected, testing if the data that was collected is what was expected or if it was skewed in some way. For this current model, a Chi-Square index, Root Mean Squared Error of Approximation (RMSEA), Root Mean Squared Residual (SRMR), CFI and Tucker-Lewis index (TLI), and coefficient of determination (CD) were analyzed. The standard guidelines that were followed when analyzing these fit statistics were: a Chi-

Square probability value where the p-value > .05 suggests acceptable fit; an RMSEA lower bound value that is < .08 with regard to the 90% confidence interval is an adequate fit, but the fit is considered to be poor if the upper bound is equal to or above 0.10; a SRMR of < 0.08 is a good fit (0 is a perfect fit); a CFI and/or TLI value equal to or above 0.90 is an adequate fit (as close to 1.0 as possible is ideal) (Keith, 2014). It is important to note that goodness of fit statistics may not be as sensitive to a small sample size which is applicable to this study as the sample size was 96 participants.

For this current model, the results taken together generally indicated a poor fit. The Chi-Square index was 28.276 (p = .020). The RMSEA was .097, with a lower bound of .038 and an upper bound of .151. The SRMR was .066. The CFI was .949 and the TLI was .881. Therefore, the only fit statistics that indicated a good fit were the SRMR and CFI.

Reliability

Reliability statistics were conducted in order to determine the level of consistency within each of the Attitude, Knowledge, and Skills scales from the PTAKSS used in this study. Chronbach's alpha, a measure of internal consistency, was used to analyze this. The Chronbach's alpha values for the Attitude, Knowledge, and Skills scales were .934, .953, and .967, respectively. In comparison to the reliability statistics that were run by Kao and Landreth (1997) for their study with the PTKASS, these results are similar. Analyses were also run to determine if the reliability within any scales would become stronger if any items within the scale were deleted. Deleting any item was not found to improve the reliability of any scale, and therefore all items were retained for use in the current study.

Frequency Distribution

Further, prior to running linear regressions, the dependent variable, use of play therapy, was analyzed among all of the participants of the study. All of the variables within the model were checked for normality of distributions. Ideally, the histogram would indicate a normal bell curve, with roughly equal numbers of participants on either side of the mean usage of play therapy. However, the distribution of this variable was negatively skewed, meaning the average use of play therapy overall was low. These results mean that the sample for this study is made up of individuals who use play therapy a relatively small amount. A large number of individuals in the sample reported not using play therapy at all; of the 95 participants who responded to this survey item, 29 responded with using play therapy 0 hours per week. Those who reported higher amounts of use were mental health counselors who typically solely provide counseling in the school setting and therefore have more time for this. The histogram can be seen in *Figure 2* below:

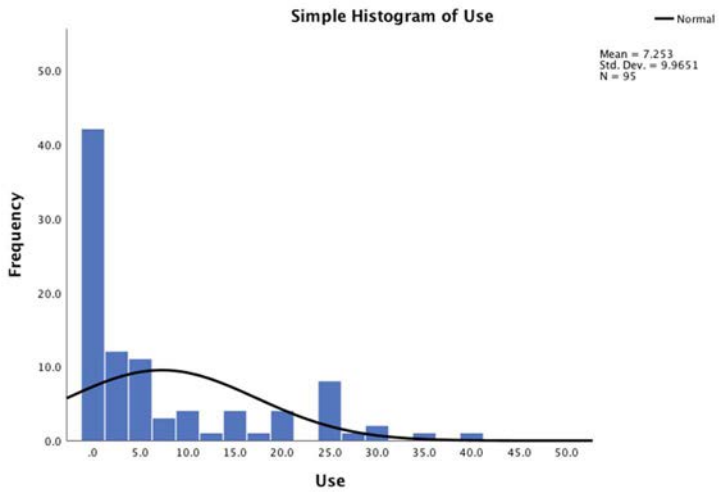

Figure 2. Histogram of Use of Play Therapy

Assumptions

Various assumptions were tested in order to make valid inferences from the data regarding the population. First, a test of linearity was conducted using unstandardized residuals against the predicted values. Linearity means that the predictor variables have a straight-line relationship with the outcome variable. From the scatter plots that were created from analyzing the residuals on the predicted values, the linearity assumption was met. Regarding normality, a Predicted-Probability (P-P) plot was tested with this data set. This analyzed the skewness of the data. The standardized residuals fit the normal curve; therefore, valid inferences can be drawn from the data according to this assumption. Further, residuals were plotted to analyze the distribution of the data and this resulted in more heteroscedasticity rather than homoscedasticity; this unequal scatter is likely the result of outliers in the data, making this assumption not acceptable. Lastly, multicollinearity analyzed if the predictor variables were highly correlated with one another. These statistics, VIF and tolerance, were within acceptable levels.

Analyses of Hypotheses

The goal of the study was to evaluate the strength and direction of the hypothesized direct and indirect effects of the variables included in the model. There were seven research hypotheses included in this study. In order to address each of the research hypotheses, analyses of the path coefficients from the path analysis model were conducted.

The first hypothesis was that the most commonly used type of play therapy within the school setting is Child-Centered Play Therapy (CCPT). In order to determine whether this hypothesis could be accepted, the descriptive statistic of percentage of types

of play therapy used was calculated to determine which type of play therapy is used most compared to others. A percentage was calculated for the use of each type of play therapy indicated in the survey item that addressed this question. Of the 96 participants in this study, 73 of them answered this item on the survey. Some participants reported the use of multiple types of play therapy. It was determined that Child Centered Play Therapy is used most often by professionals (83.6%), followed by Cognitive Behavioral Play Therapy (45.2%), Eclectic Play Therapy (28.8%), Brief Play Therapy (19.2%), and Adlerian Play Therapy (11.0%). All other reported types of play therapy used in schools were used by less than 4.1% of participants. The other types of play therapy that participants reported using included Experiential Play Therapy, Theraplay, Prescriptive Play Therapy, Sand Play, Filial Play Therapy, DIR Floor Time, Integrative Play Therapy, Traumaplay, Somatic Experiential Play Therapy, AutPlay, Synergistic Play Therapy, Expressive Play Therapy, and Jungian Play Therapy.

The second hypothesis was that school counselors receive the highest level of training in play therapy among the mental health professionals who work in the school setting (i.e., mental health counselors, school counselors, and school psychologists). In order to determine if this hypothesis was accepted, the mean amount of training was calculated for each profession. This hypothesis was determined to be not supported because mental health counselors received the highest amount of training in play therapy among the mental health professionals who work in the school setting (M=589.962 hours). There was one mental health counselor recognized to be an outlier in the sample due to reporting 1200 hours training outside of graduate school with only one year of experience. Rather than deleting this participant as their responses are valuable, the mean

was also calculated without this participant. Without this outlier, the mean training that mental health counselors received was still 545.56 hours and still much more than the training that school counselors and school psychologists received. School counselors reported an average of 127.870 hours of training and school psychologists an average of 54.345 hours of training. Then, a one-way ANOVA was conducted to determine if there were statistically significant differences in training among the three professions, which resulted in statistically significant differences among the training that the different mental health professionals receive on the topic of play therapy ($F(2, 92) = 3.566$; $p < 0.05$). Because there were statistically significant differences between the groups, this ANOVA was followed up with three Fisher's LSD post-hoc tests (Hayter, 1986). The difference between the mental health counselor group and school counselor group was statistically significant, $t(2,92) = 2.02$, $p < 0.05$. The difference between the mental health counselor group and school psychologist group was also statistically significant, $t(2,92) = 2.58$, $p < .05$. The difference between the school counselor group and school psychologist group was not significant, $t(2,92) = .358$, $p = .721$. More specifically, the training during one's graduate program and training received after completion of a graduate program was analyzed. Mental health counselors received the most training across both times, followed by school counselors and then school psychologists. However, taken altogether, school-based mental health professionals received more training after their graduate program than during it. Further, play therapy credentials through the APT were analyzed. The results of these analyses can be seen in the tables below:

Table 2

Play Therapy Training

Training during graduate program (Mean hours)		Training after graduate program (Mean hours)	
MHC	218.46	MHC	371.50
SC	55.80	SC	72.07
SP	39.76	SP	13.33
Total	92.67	Total	126.85

Note. MHC = Mental health counselor; SC = School counselor; SP = School psychologist

Table 3

APT Credentials

	SB-RPT	RPT	RPT-S
MHC	0	8	3
SC	1	2	0
SP	0	1	1

Note. MHC = Mental health counselor; SC = School counselor; SP = School psychologist; SB-PRT = School-Based Registered Play Therapist; RPT = Registered Play Therapist; RPT-S = Registered Play Therapist- Supervisor

The third hypothesis was that play therapy is being utilized more frequently in schools by school counselors than mental health counselors or school psychologists. In order to determine if this hypothesis was accepted, the same process was followed as

with the second hypothesis. The mean amount of play therapy use was calculated for each profession. This hypothesis was determined to be not supported because mental health counselors use play therapy the most among the mental health professionals who work in the school setting (M = 17.846 hours per week). School counselors reported an average of 5.352 hours of use per week and school psychologists an average of 1.917 hours of use per week. Then, a one-way ANOVA was conducted to determine if there were statistically significant differences in use among the three professions, which resulted in statistically significant differences ($F(2, 92) = 37.811$; $p < 0.01$). This statistically significant ANOVA was followed up with three Fisher's LSD post-hoc tests. The difference between the mental health counselor group and school counselor group was statistically significant, $t(2,92) = -.488$, $p = 0.00$. The difference between the mental health counselor group and school psychologist group was also statistically significant, $t(2,92) = 8.55$, $p = 0.00$. The difference between the school counselor group and school psychologist group was not significant, $t(2,92) = 1.866$, $p = 0.065$.

Hypotheses 4, 5, 6, and 7 were analyzed with path analysis. Running the model for this study in STATA allowed for the calculation of indirect effects, which seek causal effects between variables where one or more different variables mediate that effect. The results of the original path model are depicted in *Figure 3* below:

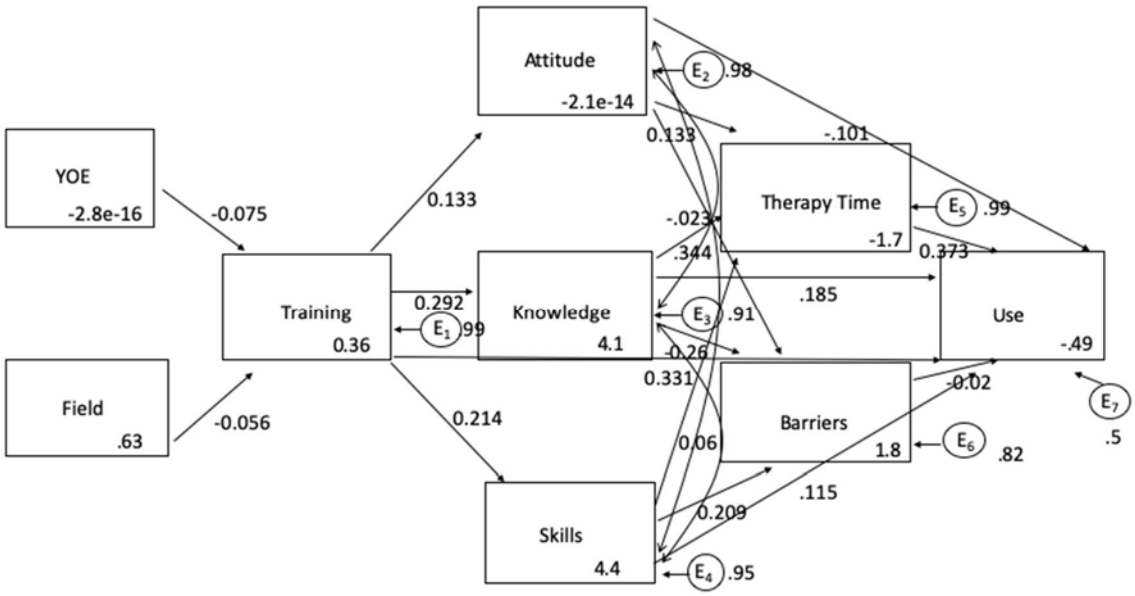

Figure 3. Original Path Model Results

The results of these hypotheses are summarized in *Tables 4 to 6* below, which provide the correlation matrix as well as the direct, indirect, and total effects found in the model:

Table 4

Correlation Matrix

	YOE	Field	Training	Attitude	Knowledge	Skills	Time Ded.	Barriers	Use
YOE	1.00								
Field	0.18	1.00							
Training	-0.09	-0.07	1.00						
Attitude	-0.08	-0.16	0.13	1.00					
Knowledge	0.08	0.05	0.29*	0.15	1.00				
Skills	0.12	0.02	0.21*	0.17	0.90***	1.00			
Time Ded.	-0.11	0.07	0.24*	0.20	0.42*	0.39*	1.00		
Barriers	-0.11	0.20	-0.10	-0.03	-0.07	-0.03	-0.19	1.00	
Use	-0.12	-0.22	0.48*	0.06	0.52*	0.48*	0.55*	-0.14	1.00

Note. YOE = Years of Experience; Time Ded. = Time Dedicated; *p < .05, **p < .01, ***p < .001

Table 5

Direct Effects for Model

Variable	Beta
Dep = Training	
YOE	-.08
Field	.12
Dep = Attitude	
Training	.13
Dep = Knowledge	
Training	.29**
Dep = Skills	
Training	.21*
Dep = Use	
Training	.33***
Attitude	-.10
Knowledge	.19
Skills	.12
Time Dedicated	.37***
Barriers	-.02

Table 5

Direct Effects for Model

Variable	Beta
Dep = Time Dedicated	
Attitude	.13
Knowledge	.34
Skills	.06
Dep = Barriers	
Attitude	-.02
Knowledge	-.26
Skills	.21

Note. Dep = Dependent Variable; YOE = Years of Experience; *p < .05, **p < .01, ***p < .001

Table 6

Total and Indirect Effects for Model

Variable	Beta
Total Effects on Play Therapy Use	
Training	.45***
Attitude	-.05
Knowledge	.32
Skills	.13

Table 6

Total and Indirect Effects for Model

Variable	Beta
Total Effects on Play Therapy Use	
Time Dedicated	.37***
Perceived Barriers	-.02
YOE	-.03
Field	-.03
Indirect effects of Training on Play Therapy Use	
Through Attitude	.049
Through Knowledge	.109*
Through Skills	.080
Indirect effects of Attitude on Play Therapy Use	
Through Time Dedicated	.050
Through Barriers	.0004
Indirect effects of Knowledge on Play Therapy Use	
Through Time Dedicated	.129
Through Barriers	.005
Indirect effects of Skills on Play Therapy Use	
Through Time Dedicated	.023
Through Barriers	-.004

Note. YOE = Years of Experience; *p < .05, **p < .01, ***p < .001

The path values were reported in standardized beta coefficients, which are standardized values. Using these values permits comparison of the various effects of each independent variable on each dependent variable. Larger absolute values of beta coefficients denote stronger effects. Effects (direct, indirect, and total) were calculated by STATA SEM. Direct effects are the standardized beta coefficients; indirect effects are the effects of the independent variables on the dependent variable that go through a mediator variable, which is calculated by taking the product of the beta weights; and total effects are the sum of the direct and indirect effects (Acock, 2016). Regarding direct effects, standardized values less than .10 generally indicate a *small* effect, values around .30 indicate a *medium* effect, and values greater than .50 indicate a *large* effect (Suhr, 1984).

The fourth hypothesis was that there will be a direct positive relationship between years of experience and amount of play therapy training that the mental health professional has. In order to determine if this hypothesis was accepted, the direct effect of years of experience on play therapy training was analyzed. The direct effect was determined based upon the path coefficient of the straight arrow that points to play therapy training from the years of experience variable. A significant path coefficient indicates significant variation in play therapy training based upon the number of years of experience the mental health professional has in their field. The effect of years of experience on play therapy training was not significant ($\beta = -.075$; $p = .468$). There was not significant variation in play therapy training based upon the number of years of experience the mental health professional had in their field.

The fifth hypothesis contained two parts. The first part was that attitude, knowledge, and skills in regard to play therapy will all be correlated with one another. The correlation of play therapy attitude, knowledge, and skills with one another was analyzed by the path coefficients that were calculated and are demonstrated by the curved arrows in the model. Pearson correlation statistics were conducted and resulted in a significant correlation only between play therapy knowledge and play therapy skills (r = 0.905, p = .000). Play therapy attitude was not correlated with play therapy knowledge (r = 0.154, p = .137) or play therapy skills (r = 0.172, p = .095). Further, it was hypothesized that there would also be direct positive relationships between training with each of attitude, knowledge, and skills, with the variables of attitude, knowledge, and skills mediating (explaining the relationship between) play therapy training and use. In order to determine if this hypothesis was accepted, the total effects of training on play therapy use were examined. The total effects were determined based upon a sum of the straight arrows in the model that represent both direct and indirect effects between training in play therapy and play therapy use. Specifically, the straight arrows included in this analysis were those that went from training in play therapy through the three major variables (i.e., attitude, knowledge, and skills) to the play therapy use variable. Significant results would indicate that there is a significant difference between use of play therapy based on varying amounts of training. The mediation effect was analyzed by assessing several indirect effects in each model. First, the indirect effect of play therapy training on use of play therapy based upon the attitude of the professional was assessed. Then the indirect effect of play therapy training on use of play therapy based upon the knowledge of the professional was assessed. Lastly, the indirect effect of play

therapy training on use of play therapy based upon the skills of the professional was assessed. These were all determined based upon the straight arrows that lead from play therapy training to attitude, knowledge, and skills and from attitude, knowledge, and skills to play therapy use. To determine if the mediation occurred, the indirect effects must be significant. There were significant direct positive relationships between training and knowledge ($\beta = 0.29$; $p < 0.01$), as well as between training and skills ($\beta = 0.21$; $p = 0.03$), but not between training and attitude ($\beta = 0.13$; $p = 0.19$). Further, the mediation hypothesis was partly supported. The indirect effect of training on use through attitude ($\beta = .049$, $p = .211$) and through skills ($\beta = .080$, $p = .054$) were not significant, meaning that play therapy attitude and skills do not explain the relationship between play therapy training and play therapy use. However, the indirect effect of training on use through knowledge ($\beta = .109$, $p = .014$) was significant, meaning that play therapy knowledge does partially explain the relationship between play therapy training and play therapy use.

The sixth hypothesis was that there would be a direct positive relationship between play therapy training and play therapy use in schools. In order to determine if this hypothesis was accepted, the total effects of play therapy training on play therapy use were examined. The total effects were determined based upon a sum of the straight arrows in the model that represent both direct and indirect effects between training in play therapy and play therapy use. Specifically, the straight arrows included in this analysis are those that go from training in play therapy directly to the play therapy use variable. The effect of play therapy training on the amount that professionals use play therapy was significant ($\beta = 0.33$; $p = 0.00$). Increased training in play therapy resulted in increased use of play therapy.

The seventh hypothesis contained multiple parts. The first part was that time dedicated to counseling and perceived barriers to using play therapy will mediate (explain the relationship between) the variables of attitude, knowledge, and skills with play therapy use. In order to determine if this hypothesis would be accepted, the mediation effects were analyzed by assessing several indirect effects in the model. The indirect effect of attitude on use of play therapy based upon the time dedicated was assessed. The indirect effect of knowledge on use of play therapy based upon the time dedicated was assessed. The indirect effect of skills on use of play therapy based upon the time dedicated was assessed. These were all determined based upon the straight arrows that led from play therapy attitude, knowledge, and skills to time dedicated and from time dedicated to play therapy use. None of these indirect effects were significant (see *Table 6*).

To analyze the mediating variable of perceived barriers, this categorical variable was turned into a continuous variable. The denoted perceived barriers were coded on a 0-5 scale based on how many perceived barriers the participant reported. Then, the indirect effect of attitude on use of play therapy based upon each of the various perceived barriers was assessed, the indirect effect of knowledge on use of play therapy based on the perceived barriers was assessed, and the indirect of effect of skills on use of play therapy based on the perceived barriers was assessed. These were all determined based upon the straight arrows that led from play therapy attitude, knowledge, and skills to perceived barriers and from perceived barriers to play therapy use. The indirect effects of attitude, knowledge, and skills through the variables of time dedicated and barriers to using play therapy were not significant (see *Table 6*). Time dedicated to counseling and perceived

barriers to using play therapy do not explain the relationship between play therapy attitude, knowledge, or skills and play therapy use.

Additional Descriptive Statistics

Further statistics were run on variables that were not included in the central hypotheses. The variables included in these additional statistics were training, use of play therapy, time dedicated to counseling, perceived barriers to using play therapy, as well as the play therapy attitude, knowledge, and skills of the participants. First, training in play therapy was analyzed more specifically in regards to the types of training that the participants received. The participants received a variety of training both within and outside of their graduate training for their degree. When asked about their graduate programs, only 34 out of the 96 participants reported even having a full play therapy course offered to them. 33 of these participants reported completing a play therapy course during their graduate training. However, 60 participants reported that part of a course offered to them included play therapy as a sub-topic. 40 of the 96 participants reported practicing play therapy with classmates within a course and 39 had the opportunity to practice with real clients. Outside of their graduate training program, many participants engaged in additional coursework, workshops, and independent study as well as received "on the job training" from supervisors or coworkers in the field. Some participants have received this training to a greater extent than others in order to obtain certifications in play therapy. The types of training received outside of their graduate training can be seen in the Table below:

Table 7

Types of Play Therapy Training Received Outside of Graduate Program

	Frequency	Percent
Additional courses	41	42.7
Workshop/Conference/Professional development	64	66.7
Independent study	73	76.0
"On the job training"	56	59.6
Association for Play Therapy credential	16	16.7
Play therapy credential from another organization	3	3.1
Other	29	30.2

Note. N = 96

Regarding use of play therapy, 63 out of 96 total participants reported using play therapy, at least sometimes in their role as a school-based mental health professional. Of the 33 that were not currently using play therapy, 17 of those participants used play therapy at some point in the past.

For time dedicated to counseling, participants were asked what percentage of time in their schedules was allotted to provide counseling to students. On average, the participants reported 43.4% of their time was dedicated to counseling, with responses ranging from 0-100% of the time. More specifically, mental health counselors reported 70.19% of their time was dedicated to counseling, school counselors reported 84.19%, and school psychologists reported 24.98%.

Regarding perceived barriers to providing play therapy in the school setting, the participants were asked to check all that applied from a given list of five barriers including lack of space, lack of time, lack of materials, lack of training, and lack of administrative support. They were also given an opportunity to write in other barriers they face. On average, the participants reported 1.8 barriers, ranging from 0-5. Overall, lack of space was the most commonly reported barrier by mental health counselors, lack of time was the most commonly reported barrier by school counselors, and lack of training was the most commonly reported barrier by school psychologists, with lack of time being a close second. Further, three school psychologists also reported that counseling not being in their current role was a barrier for them. The results of the reported perceived barriers can be seen in the below:

Table 8

Perceived Barriers to Providing Play Therapy

	Frequency				Percent			
	MHC	SC	SP	Total	MHC	SC	SP	Total
Lack of Space	15	13	5	33	45.45	39.40	15.15	100
Lack of Time	5	19	22	46	10.87	41.30	47.83	100
Lack of Materials	11	8	10	29	37.93	27.59	34.48	100
Lack of Training	5	12	23	40	12.50	30.00	57.50	100
Lack of Admin. Support	6	3	6	15	40.00	20.00	40.00	100
Other	3	2	5	10	30.00	20.00	50.00	100

Further, participants' play therapy attitude, knowledge, and skill levels differed. As previously stated, there were 23 items on the Attitude section of the scale, 18 items on the Knowledge section, and 22 items on the Skills section. The highest possible scores were: 125 for attitude, 90 for knowledge, and 110 for skills. Overall, the participants' scores were relatively low overall for knowledge and skills. The average scores for the participants in each field based on their responses to the PTAKSS part of the survey can be seen in the table below:

Table 9

Play Therapy Attitude, Knowledge, and Skills Average Scores

	MHC	SC	SP	Total
Attitude	96.59	96.00	103.19	99.34
Knowledge	53.64	61.95	69.65	63.08
Skills	70.31	79.53	88.56	81.00

Modification Indices

When running a SEM in STATA, STATA allows the researcher to re-specify the model to attempt to obtain a better fit. This is done by offering modification indices, which are suggested changes that could enhance the model fit, usually by adding in a parameter that was not in the original model. In examining the proposed modification indices for this current model, the suggested modifications were to add a pathway between the field variable and use variable, as well between field and perceived barriers as can be seen in *Figure 4*.

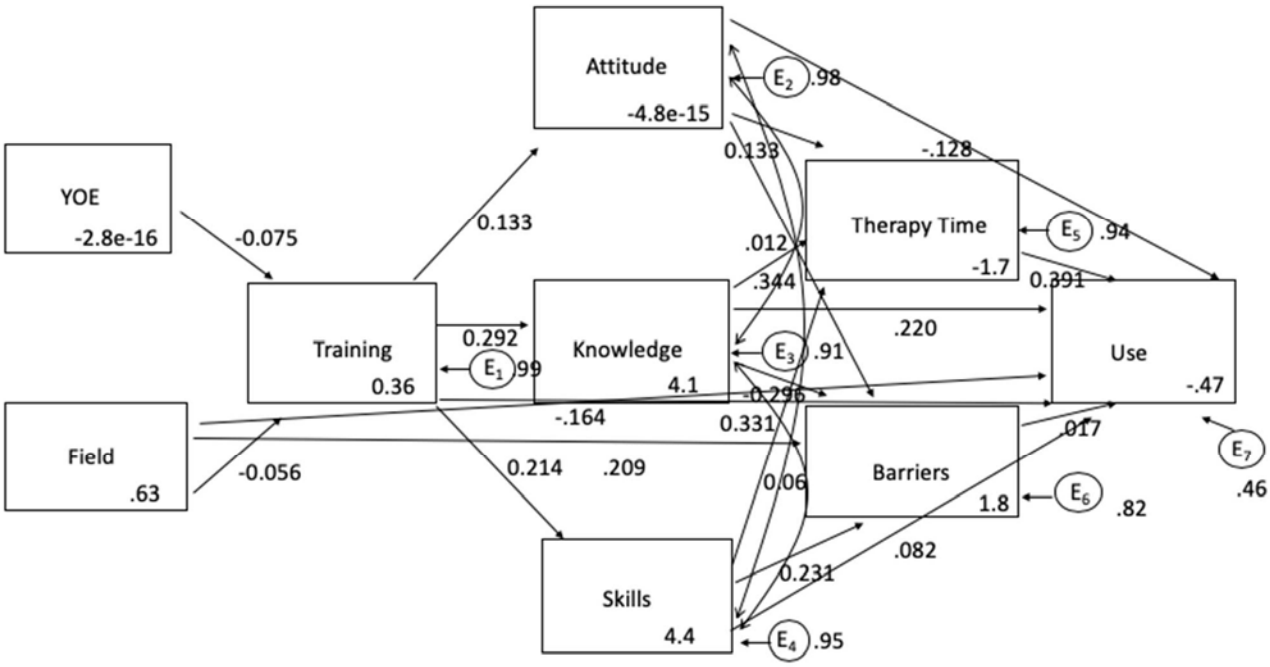

Figure 4. Modified Path Model Results

Adding in these pathways increased the strength of the model by improving the goodness of fit statistics. The Chi-Square index improved to 19.218 (p = .116), which is an acceptable fit. The RMSEA was .071, with a lower bound of .000 and an upper bound of .134. This was an improvement as well, with the lower bound indicating an adequate fit. The upper bound still indicates a poor fit, but it is just barely over 0.1. The SRMR was .059, which is also an improvement, although this was already an acceptable fit prior to the modification. The CFI was .976 and the TLI was .935, making both of these adequate fits after the modification, which can be seen in *Figure 4*. This model was used to analyze the data moving forward.

In the modified model (*Figure 4),* the direct effects of field on use and field on perceived barriers are reflected. Both of these direct effects are significant, meaning that use of play therapy varies based on which field the participant is in and that the perceived

barriers to using play therapy also varies based on the participant's field. The finding that field had a significant effect on use was expected given that it was already determined that mental health counselors use play therapy significantly more than school counselors and school psychologists in this sample. Further, mental health counselors report, on average, 0.5 less barriers than the participants in the other fields ($b = 0.5$, $p < 0.05$). The results from the modified model can be seen in Table 10 below. It is important to note that the results described were based on the modified model as the results were very similar between the original and modified models, with the exception of the additional direct effects that were added into the modified model.

Table 10

Direct Effects for Modified Model

Variable	Beta
Dep = Training	
YOE	-.08
Field	-.06
Dep = Attitude	
Training	.13
Dep = Knowledge	
Training	.29**
Dep = Skills	
Training	.21*

Table 10

Direct Effects for Modified Model

Variable	Beta
Dep = Use	
Training	.33***
Attitude	-.10
Knowledge	.19
Skills	.12
Time Dedicated	.37***
Barriers	-.02
Field	-.16*
Dep = Time Dedicated	
Attitude	.13
Knowledge	.34
Skills	.06
Dep = Barriers	
Attitude	-.01
Knowledge	-.30
Skills	.23
Field	.21*

Note. Dep = Dependent Variable; YOE= Years of Experience; *p < .05, **p < .01, ***p < .001

Table 11

Indirect and Total Effects for Modified Model

Variable	Beta
Total Effects on Play Therapy Use	
Training	.43***
Attitude	-.08
Knowledge	.35
Skills	.11
Time Dedicated	.39***
Perceived Barriers	.12
YOE	-.03
Field	-.18*
Indirect effects of Training on Play Therapy Use	
Through Attitude	-0.017
Through Knowledge	0.064
Through Skills	0.018
Indirect effects of Attitude on Play Therapy Use	
Through Time Dedicated	0.054
Through Barriers	0.0002
Indirect effects of Knowledge on Play Therapy Use	
Through Time Dedicated	0.135
Through Barriers	-0.005

Table 11

Indirect and Total Effects for Modified Model

Variable	Beta
Indirect effects of Skills on Play Therapy Use	
Through Time Dedicated	0.129
Through Barriers	0.004

Note. YOE= Years of Experience; *p < .05, **p < .01, ***p < .001

Chapter 5: Discussion

Play therapy is an evidence-based practice that can be used with children who present with a variety of diagnoses and challenges. Mental health professionals who work in schools have at least some exposure to or training in play therapy and most have the opportunity to utilize this practice in their work with children. However, there are barriers to using play therapy in schools as well as personal variables of the professionals that influence their use of this practice. This study analyzed the relationship between training in play therapy and use of play therapy in schools by various mental health professionals, while considering the professionals' attitude, knowledge, and skills regarding play therapy, as well as their years of experience in the field, their time dedicated to counseling, and the perceived barriers they have toward using play therapy. This complex arrangement of variables has not been examined altogether before. Across the models analyzed, several relationships of interest were found, which will be discussed below.

Structural equation modeling (SEM) was used in this study to analyze the data to address several hypotheses. This analysis allowed for the examination of multifaceted patterns of relationships among the variables included. SEM was able to estimate the variance explained in the dependent variable (use of play therapy) by the multiple independent variables of interest, while also including disturbances which controlled for influences that were not accounted for by pathways in the model (Keith, 2014).

Overarching Findings

This study found that, of the school-based mental health professionals included, mental health counselors have the most training in play therapy and use play therapy the

most. They had significantly more training and use play therapy a significantly greater amount than school counselors and school psychologists. Further, there are significant direct effects of training on several variables within the model. Specifically, participants' training has direct positive effects on their knowledge about play therapy, their skills in play therapy, and their use of play therapy. The more training the school-based mental health professional has, the more knowledgeable they are about play therapy, the more skills they have in play therapy, and the more likely they are to use play therapy in schools.

Lastly, there is also a significant direct effect of time dedicated to counseling on how often play therapy is used. The more time that school-based mental health professionals have in their schedules to provide counseling to students, the more likely they are to use play therapy. On average, school-based mental health professionals dedicate 43.4% of their time to counseling children; however, this differs by field, with school counselors reporting the greatest amount of time in their schedules dedicated to counseling students, even though they do not use play therapy as much as mental health counselors. Further, about one third of the participants reported working with high school students, at least part of the time, who may not benefit as much from play therapy as their younger peers.

The participants in this study reported an average of 1.81 barriers causing them a challenge to practicing play therapy in the school setting. The two most commonly reported barriers overall were lack of time and lack of space, but again this differed by field. Interestingly, school psychologists reported a lack of training as the most common barrier faced and they received the least amount of training when compared to their

mental health counselor and school counselor counterparts. Overall, the barriers reported most often were consistent with the previous research on this topic by Ray (2010).

This study also found significant correlations between several variables that were included. Training was significantly correlated with knowledge, skills, time dedicated, and use. Time dedicated to counseling, knowledge, and skills were also all significantly correlated with use of play therapy. Skills and knowledge were significantly correlated with one another. Time dedicated to counseling was also significantly correlated with knowledge and skills. It was hypothesized that the attitude variable would have at least some correlations with these other variables as well, but that was not the case. Attitude is the most opinion-based variable and dependent on the participants' views of play therapy no matter how much education or experience they actually have with it. School-based mental health professionals could be using play therapy whether or not they really enjoy it, believe in it, or even like working with children, which were all questions asked on the survey as part of the attitude composite. It remains surprising that an increase in knowledge and skills in play therapy was not related to an increase in attitude. However, the attitude scores across participants were higher overall than the scores for knowledge and skills. Further, attitude did have the lowest criterion validity (0.34) from the studies in comparison to knowledge and skills (0.71 and 0.68, respectively). This could also partly explain why attitude is not as related to the amount of training. Further, this sample was not using play therapy a great deal, so perhaps a sample including participants who utilized play therapy more would result in an overall attitude that was more connected to the participants' knowledge and skills of play therapy, due to a stronger belief in it through personal usage.

Regarding the additional descriptive statistics that were run as a part of this study, there were several interesting findings pertaining to the use of play therapy in schools. As discussed previously, this sample used play therapy a relatively small amount. However, more than three quarters of the sample engaged in independent study of play therapy outside of their graduate training program. While types of training such as additional courses, professional development, and "on the job training" might not indicate an interest in play therapy, independent study is typically chosen by the professional as an area they would like to learn more about. It is surprising that more of the sample is not using play therapy a greater amount if 76% of the sample chose to learn about play therapy after they were graduated from their program. While it is the case that many professionals are required to complete continuing education credits, they can choose, at least to some extent, which topics they learn about to obtain these credits. This supports the idea that the perceived barriers to using play therapy are impacting school-based mental health professionals a great deal. For school psychologists in particular, one additional perceived barrier written in by some participants was that counseling was not in their current role. While programs vary, a moderate amount of school psychologists' training is in counseling so it is likely that many professionals in this field would have at least some interest in this role, but many are not currently given the opportunity to provide it, therefore limiting their opportunity to use play therapy.

Findings Regarding Hypotheses

The first hypothesis of this study was supported by the data-- the most commonly used type of play therapy within the school setting is Child-Centered Play Therapy (CCPT). This is a widely accepted type of play therapy and it is discussed as the most

used type of play therapy in previous research (Lambert et al., 2005; Ryan et al., 2002). The use of CCPT in schools has been researched before and has a strong empirical support basis (Blanco & Ray, 2011; Landreth, 2012).

Hypotheses two and three were not supported because the school counselors in this study did not receive the most training in play therapy and do not use it the most in schools. Mental health counselors received the most training and used play therapy the most. This could be due to the fact that mental health counselors can be trained in clinical mental health counseling as well as school counseling (CACREP, 2015). Their training focuses heavily on various counseling theories and practices, while school counselors and school psychologists are also trained in other areas that take time away from focusing on counseling children (e.g., evaluating students, consulting with other school-based professionals and parents, implementing behavioral and academic interventions). For this study, it was difficult to obtain school-based mental health counselors as part of the sample. In order to participate in the study, the participants had to be working in a school and the majority of mental health counselors do not work in the school setting. Since most mental health counselors do not work in schools, it makes sense that the amount of training and experience they have in using play therapy is greater than that of school counselors and psychologists who are trained more specifically to work in the school setting. While mental health counselors also receive training to work with adolescents and adults, they are receiving more specific training in counseling individuals that school counselors and school psychologists do not receive.

Further, the fourth hypothesis was also not supported. Unexpectedly, the years of experience that school-based mental health professionals had in this study was not

directly related to the amount of training they received in play therapy. Those who reported having fewer years of experience in their respective field did not differ greatly from those who reported having more experience in terms of the amount of training they had specifically in play therapy. As time went on, the professionals in this study did not gain significantly more training in the area of play therapy even though the majority of training that the participants in this study received was outside of their graduate training (M = 126.85 hours) rather than during graduate school (M = 92.67 hours). Thus, the school-based mental health professionals in this sample did not seek out more training in play therapy as time went on. One reason for this may be that, overall, this sample was relatively new to working in a school-based mental health field (M = 7.22 years) which may have had an impact on the results of this hypothesis. Perhaps having a sample with more participants who worked in their field for longer would have impacted these results differently. School-based mental health professionals who have worked in their field longer may have the opportunity for more professional development or time over the years to learn new techniques such as play therapy and incorporate those into their practice.

Hypothesis five included several parts. The first part was somewhat supported. It was hypothesized that the variables of attitude, knowledge, and skills in regard to play therapy would all be correlated with one another. The variables of knowledge and skills were correlated with one another, but neither was correlated with attitude. As previously discussed, knowledge, and skills regarding play therapy are more applied variables, while attitude is opinion-based. The participants could feel as if they had strong knowledge about and skills in using play therapy but still not have an overly positive attitude about it

and vice versa. Another part of this hypothesis was that there would be direct positive relationships between training and attitude, knowledge, and skills, with the variables of attitude, knowledge, and skills mediating (explaining the relationship between) play therapy training and use. This part of the hypothesis was also partly supported. There was a significant direct positive relationship between training and knowledge, as well as training and skills, but not between training and attitude. Training, which is learning about play therapy and being taught how to use play therapy, impacts participants' knowledge and skills on the topic like it aims to do. It does not necessarily impact the attitude of those learning about it, though. It can be assumed that even if a person is being trained in something, their views about it will not necessarily change. Further, there was not a significant direct positive relationship between attitude, knowledge, or skills of play therapy and use of play therapy, so it is clear that none of these variables would mediate training and use. The direct positive relationships between training and use were not explained by attitude, knowledge, or skills, meaning that participants with stronger attitude, knowledge, and/or skills in play therapy were just as likely to use it as those with weaker attitude, knowledge, and/or skills. One might assume that those participants who have even a basic understanding of play therapy feel just as confident in using it as those who have dedicated more time and energy in learning about it. The attitude might not differ between those who use play a small amount versus those who use it a large amount because it is possible that attitude impacts the quality of use over the amount of use. It might be the case that increased attitude, knowledge, and skills in play therapy results in higher effectiveness of play therapy delivery, but that variable was not included in this study. It would be beneficial to students if those with stronger

attitude, knowledge and/or skills in play therapy were using it more because it is fair to say those professionals would be providing it in a more effective manner, but that is not the case based on the results of this study. It is important to note that the knowledge and skills variables were the participants' own perceptions of their knowledge and skills in play therapy, not necessarily their actual, unbiased knowledge and skills on the subject.

The sixth hypothesis was supported as there was a direct positive relationship between play therapy training and play therapy use in schools. The more training a participant had in play therapy, the more they used it. It makes sense that a person who puts a great deal of time and energy (and most likely money) into learning more about a therapeutic practice would put it to use more than someone who has dedicated less to be trained in it. To become a School-Based Registered Play Therapist (SB-RPT), the APT requires a degree in a mental health field, as well as 150 hours of training in an institution of higher education or approved site and supervision for at least one full school year, during which they obtain at least 600 hours in direct contact utilizing play therapy with children and 50 more hours of supervision, simultaneously (APT, 2016). Obtaining this credential is exceptionally time-consuming and understandably results in greater use of play therapy than those who have not furthered their education on the topic as much.

The seventh hypothesis was not supported as time dedicated to counseling and perceived barriers to using play therapy did not mediate (explain the relationship between) the variables of attitude, knowledge, and skills with play therapy use. There were no relationships between any of these variables as it was predicted. Use of play therapy was not impacted by these variables. Participants' use of play therapy was impacted by their training in and time dedicated to using counseling, but not other

variables of attitude, knowledge, skills, or even the barriers they perceived standing in their way of using play therapy. Again, as the participants in this sample use play therapy a relatively small amount and very few are officially trained through the APT, it seems as though they could be using play therapy with lesser knowledge and skills, but even with barriers in their way. Since none of the predicted variables mediated training and use of play therapy, it is likely that other variables not included in the model are mediating training and use. One of these variables could be age of students with whom the school-based mental health professionals work. As play therapy is not commonly used with older children, age of students worked with could potentially mediate training and use of play therapy in schools.

Limitations

Overall, the sample size for this study was modest and included 96 participants. While there is not a strict guideline constituting what is an appropriate sample size for SEM, as previously mentioned, a rule of thumb discussed by Kline (2005) in regard to using SEM in social sciences is to have a minimum of 25 participants within each parameter. According to this rule of thumb, the number of participants is sufficient to obtain reliable results (26 mental health counselors, 27 school counselors, and 43 school psychologists). However, it is important to recognize that this study was conducted using a relatively small sample, which makes it difficult to generalize to a larger population.

The sample used in this study was quite homogenous in nature. As 91.66% were female, 67% of the sample was 39 years old or younger, and 83.33% described themselves as white, the majority of the sample was made up of relatively young, white females. While the majority of professionals in the field of psychology at large are

female, the results are less generalizable to places with more ethnic diversity at the very least.

Further, as discussed prior, the histogram of the dependent variable (use of play therapy) was negatively skewed, meaning that the sample may not have been reflective of the overall population. The majority of participants in this study indicated that they only use play therapy a limited amount. Therefore, the results are based on a sample of individuals who do not use play therapy often. This could mean that others in the field use play therapy more often, but were not included in the study or that professionals in schools simply do not use play therapy very often.

During the data collection phase of this study, which occurred from the fall of 2018 through the fall of 2019, the sample procedure utilized changed over time due to difficulty obtaining a sufficient number of participants from the start. Originally, participants were attempted to be obtained through the national organizations associated with each group of mental health professionals. Each group had different criteria and ways of going about accessing group members to participate in surveys. For instance, NASP required an application to access members, while ACA and ASCA allowed postings to specific community group pages. Not enough participants were obtained from this initial plan, partly because the proposal to access members through NASP was rejected. Part of this rejection involved neglecting to define play therapy within the survey itself. This issue will be discussed in more detail below. So, in order to access school psychologists, the survey was posted to various national school psychology Facebook groups. When attempting to post the survey to counseling Facebook groups, access was not obtained in order to do so. Participants were also obtained directly from

the Association of Play Therapy list serve after attempting to gain participants from the national organizations and Facebook groups. While each group of mental health professionals were represented through the sampling from the APT, the participants that were obtained through the national organizations were not as even in representation. The number of participants that were registered with the APT was minimal. All in all, the participants were all obtained from some type of professional organization, which means the sample could be different from the rest of the population for that reason alone. Professionals who are part of organizations and social media pages may be more likely to look for or participate in training opportunities or have similar views regarding aspects of their fields. While it was hoped that this study would be generalizable, the sampling procedure jeopardized that.

Regarding the issue of neglecting to define *play therapy* in the survey itself, the assumption that the participants who completed the survey have the same idea and definition of play therapy may have hindered the results. Some participants may have varying definitions of play therapy, some stricter than others. For example, some may go by the official definition held by the Association of Play Therapy and others may incorporate just a few minutes of play into their sessions and consider that *play therapy.* Play therapy truly is a very specific approach and those who practice it the way it was intended are mindful of what practices specifically constitute play therapy and those that do not. This may be a possible reason that attitude did not become more positive after more years of experience or training in play therapy.

Similarly, "counseling" was also not defined for the participants completing the survey. There are various types and ways to go about counseling and the participants

may have defined it differently for themselves. Some counselors might have been doing guidance counseling, group therapy, or drop-in counseling and included that when reporting how often they engage in counseling. These are all times that play therapy is not likely to be utilized, which could have played a role in the participants reporting lack of time as a barrier to not using play therapy even though they are engaging in counseling.

Future Research

This study provided descriptive and correlational information regarding the relationships between school-based professionals' training in play therapy, attitude, knowledge, and skills in using play therapy, and use of play therapy; however, future research is needed to gain more information about these relationships. As the data for this study was collected via survey, an experimental design may be used to gather more information. For instance, employing a more objective measure of knowledge and skills, or using a competency-based approach with professionals using play therapy rather than their own ratings of themselves in terms of knowledge and skills may foster more objective findings. In addition, using other measures of effectiveness such as outside observers rating play therapy skills or pre- and post-tests for children receiving play therapy would provide richer conclusions in terms of child outcomes.

Further, it was hypothesized that attitude, knowledge, and skills would have direct positive relationships with use of play therapy, but this hypothesis was not supported. It is recommended that this study be conducted with a larger, more diverse population to examine this relationship again. If a large sample of participants with varying backgrounds were included, the results may be different. Other variables, such as age of

students served, might also be included in a future model to examine if that has an effect on use of play therapy in schools. Or, since play therapy is most often used with younger children, a study only including those mental health professionals that work with students in elementary schools could be conducted.

When analyzing the current literature to learn about the demographic information of the population in order to compare it to the sample from this study, information regarding the population of school-based mental health professionals was unavailable. School counselors, school psychologists, and school-based mental health counselors all have a role in counseling children within the school setting. There is a need for published demographic information on these populations. Further research on this topic would provide more information about those who are currently working in schools, their backgrounds, experiences, and training, which can then better inform researchers about the population they are studying. Learning more about this currently missing information can also provide schools with information about where they could increase professional development for their staff. School administrators are tasked with hiring and making sure school-based mental health professionals are providing evidence-based services to their students. They should be interested in having this information about their employees to continue to support them, which then indirectly supports the students in their schools.

Interestingly, school counselors reported to be using counseling quite often, but many reported lack of time as a barrier to providing play therapy. Play therapy does not take any longer to provide than other types of counseling, so it would be interesting to learn more about this finding. If school counselors are engaging in counseling often, it would be interesting to know what type of counseling they are providing, especially with

very young students. Further, since play therapy has a strong research-base for use with children, it would be helpful to find out more specifically why school counselors are choosing other types of counseling.

Studying how social workers are using play therapy, or counseling in general, in the school setting is also an area of recommended future research. As social workers were eliminated from this study partway through due to a lack of participants, this study was not able to obtain information about their training in or use of play therapy. Their training in and use of play therapy compared to other school-based mental health professionals could be studied in the future.

Lastly, since play therapy is a strongly supported practice, but is not being used very much in the school setting, future research is recommended to be conducted on how to increase its use in schools. The barriers to providing play therapy in schools were briefly addressed by this study, but they could be analyzed more deeply and problem-solving to confront those barriers could be piloted. Research to address these barriers could work to empower school-based mental health professionals to utilize play therapy more often for students who would it would benefit.

Implications

The participants in this study were school-based mental health professionals in the fields of mental health counseling, school counseling, and school psychology. All of these professionals have training, to some extent, in counseling practices including play therapy. Most, if not all, also have the responsibility of providing counseling in schools as part of their job description. It was found that mental health counselors utilize play therapy significantly more than both school counselors and school psychologists in the

school setting. Learning about the training in play therapy that professionals in each of these groups have helps to understand the level of knowledge and skills they have while implementing it with children in schools. Mental health counselors also have the most training of the school-based mental health professionals studied. While an increased amount of training in play therapy does positively impact the amount of knowledge and skills one has on the topic, increased knowledge and skills do not necessarily positively impact the amount it is used. Therefore, those with a lesser amount of perceived knowledge and skills are using play therapy in schools about the same amount as those with a larger amount of knowledge and skills. However, increased training does lead to greater use of play therapy. Further, the current sample reported relatively low scores for knowledge and skills in play therapy, overall. If those with stronger attitude, knowledge and/or skills in play therapy were using it more, students would benefit because it is likely that those professionals would be providing it in a more effective manner. It is important to be informed about this if schools are looking to hire professionals to carry out practices such as play therapy effectively. It is also helpful to know which professionals are using this practice most often as well as why they not using it if that is the case.

Overall, most school-based mental health professionals reported not having a great deal of training in play therapy, or using play therapy, even though it is an effective practice with children. Those who had more training do use it more. However, most mental health counselors do not work in schools, which provides insight into why their training in and experience using play therapy is greater than that of school counselors and psychologists who are trained to work in the school setting. While mental health

counselors are trained to work with a range of ages, their training is focused on counseling practices, which may allow for more time to focus on counseling with children, including play therapy. This might imply that training programs, especially for school counselors and school psychologists, could increase the play therapy training they provide and incorporate stronger practices to motivate their students to use it. Currently school psychologists and school counselors have less training in and use play therapy less than mental health counselors even though they are being trained to work in schools. Further, since school psychologists and school counselors are working in the school setting, administrators may also want to provide training opportunities specifically related to play therapy or provide funding for their staff to become SB-RPTs if they are interested in doing so. From the barriers reported by the participants in this study, it is clear that school psychologists and school counselors both felt lack of training was a major reason standing in their way of using play therapy more. This is possible to change based on receiving more training provided by graduate programs or the schools they work in.

Lack of training was not the only barrier to providing play therapy reported by school counselors and school psychologists. The other barriers they reported could also be addressed to increase their use of play therapy in schools. Both reported lack of time as another barrier in their way. It could be possible to increase the time each of these professionals has to dedicate to counseling by sharing some of their other duties with capable coworkers within the school setting. With the mental health needs of children so high, having school-based mental health professionals spend more time providing these

services to students may be a more effective use of time than some other tasks they are currently doing during their days that could be done by others in the school setting.

Summary

This study examined the relationship between play therapy training and use of play therapy in schools while considering the attitude, knowledge, and skills in play therapy, as well as the school-based mental health professionals' field, years of experience, time dedicated to counseling, and perceived barriers to using play therapy. Several statistically significant relationships were found. From the results of the path model, significant direct effects were found between training on knowledge, training on skills, training on use, and time dedicated on use. Other significant relationships were found between variables of interest with correlation statistics, but no other significant direct or indirect effects were found within the original path model. After taking the modification indices into consideration and adjusting the model to add in paths from field to perceived barriers and use of play therapy, significant direct effects between those respective variables were found as well. Further research on these relationships is suggested to better understand the population of mental health professionals in the school setting, especially regarding their training in and use of play therapy. It is important for those working in schools to be aware of the current levels of training their mental health staff receive in practices such as play therapy and how they are utilizing these with their students. It could also determine, more specifically, why play therapy is not being used. This could better inform the training that school-based mental health professionals receive as well as bring to light the barriers that stand in the way of using play therapy in

schools. This information could help lead to an increased use of play therapy in the school setting with students who could benefit from it.

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Appendix A
Survey
(Kao & Landreth, 1997; Shahidullah & Carlson, 2014)

If you wish NOT to complete this survey, please check the box below and discontinue.

☐ **I do not wish to take this survey.**

If you CURRENTLY work in a school setting, please continue. If you DO NOT work in school setting please DISCONTINUE by checking the box below.

☐ **I do not work in a school and utilize play therapy.**

Section 1: Background Information

Respond to all items based on your personal identity and past and/or present school practice.

1. **What is your gender? (please check):**
   - ☐ Male
   - ☐ Female
   - ☐ Other
   - ☐ Prefer not to disclose

2. **What is your race/ethnicity (please check)?**
   - ☐ White
   - ☐ Black or African American
   - ☐ Hispanic or Latino
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ Other

3. **What is your age (in years)? _____**

4. **Within which mental health field do you currently work?**
   - ☐ Mental Health Counseling
   - ☐ School Counseling
   - ☐ School Psychology
   - ☐ Social Work

5. **What is your highest degree obtained in a mental health field? (please check one)**
   - ☐ Masters
   - ☐ Specialist

- Doctorate

6. **What year did you earn this degree? (Please specify): _____**

7. **What is the primary location of your current work site?**
   - Rural
   - Urban
   - Suburban

8. **What is the approximate number of students you serve? _____**

9. **How long have you been serving as a school-based mental health professional, in years? (Please count post-degree and include this current school year): _____**

10. **Currently, what percentage of your time is spent working with students in the following grade levels? *Please make sure the percentages equal 100%.***

    Pre-K_____ K-3 _____ 4-5 _____ 6-8 _____ 9-12_____

11. **Currently, what percentage of your time is spent counseling children? _____%**

Section 2: Training Information

*The following questions pertain to the play therapy-related training and education you have received throughout your **entire career.** Please answer each question and be aware of the specific format for each.*

Within your university-based graduate training program…

12. **Was there a graduate course available in which the main focus was play therapy?**
    - Yes
    - No

13. **Did you take a graduate course in which the main focus was play therapy?**
    - Yes
    - No

14. **Did you take a graduate course in which play therapy was covered as a sub-topic?**
    - Yes
    - No

15. Was there an opportunity to practice play therapy with practice clients?

- Yes
- No

16. Was there an opportunity to practice play therapy with real clients?

- Yes
- No

17. How many hours total did you spend learning about or practicing play therapy?

____ hours

Outside of your university-based program…

18. Have you taken other courses on the topic of play therapy?

- Yes
- No

19. Have you taken other workshops/ conferences/ professional development opportunities on the topic of play therapy?

- Yes
- No

20. Have you engaged in independent study (e.g., books, academic journals, videos) on the topic of play therapy?

- Yes
- No

21. Have you received "on the job training" (e.g., supervision in the field, discussion with other mental health professionals)?

- Yes
- No

22. What type of registration do you have in play therapy by the Association of Play Therapy?

- Registered Play Therapist (RPT)
- Registered Play Therapist- Supervisor (RPT-S)
- School Based-Registered Play Therapist (SB-RPT)
- None

23. Are you hold play therapy credentials from any other organization?

- National Institute of Relationship Enhancement and Center for Couples, Families and Children
- Center for Play Therapy
- Other: _____

24. What other types of training have you received in play therapy?

_____

_____

25. Please approximate the number of hours of your training in play therapy that has come from any of the before-mentioned categories outside of your graduate training program:
____ hours

Section 3: Use of Play Therapy

26. Do you currently utilize play therapy in the school setting?
- **Yes**
- **No**

27. If you answered "No" to question #26, have you ever utilized play therapy in the school setting?
- **Yes**
- **No**

28. What grade-level students have you used/ do you currently use play therapy with? (Check all that apply):
- Pre-K
- K-3
- 4-5
- 6-8
- 9-12

29. What type(s) of play therapy do you currently use the most in schools? Check only ONE:
- Child-Centered Play Therapy
- Adlerian Play Therapy
- Cognitive-Behavioral Play Therapy
- Eclectic Play Therapy
- Brief Play Therapy
- Other: _____

30. What is the typical length of play therapy sessions you conduct, in minutes?
_____minutes

31. How often on average, in hours per week, do you utilize play therapy in the school setting?
____ hours

32. How satisfied are you with the amount of play therapy training you received, overall?

- Very satisfied
- Somewhat satisfied
- Neither satisfied nor dissatisfied
- Somewhat dissatisfied
- Very dissatisfied

33. How satisfied are you with the amount of play therapy you have been able to utilize in the school setting?

- Very satisfied
- Somewhat satisfied
- Neither satisfied nor dissatisfied
- Somewhat dissatisfied
- Very dissatisfied

34. What do you find to be the biggest challenge to conducting play therapy?

- Lack of space
- Lack of time
- Lack of materials
- Lack of administrative support
- Lack of training
- Other: _____

Section 4: Play Therapy Attitude-Knowledge-Skills Survey

From the available choices, please circle one that best fits your response to each question.

	strongly disagree	disagree	neither agree or disagree	agree	strongly agree
35. I am willing to and like to work with children.	1	2	3	4	5
36. I am accepting of the child part of myself.	1	2	3	4	5
37. I enter new relationships with children with confidence and relaxation.	1	2	3	4	5
38. I am a warm and friendly person to children.	1	2	3	4	5
39. Children need to be given correct answers to questions.	1	2	3	4	5
40. I have a high tolerance for ambiguity.	1	2	3	4	5
41. I know myself and accept myself as who I am.	1	2	3	4	5
42. I greatly respect children's basic rights.	1	2	3	4	5
43. I have a sense that children trust me.	1	2	3	4	5
44. Children possess a tremendous capacity to overcome obstacles and circumstances in their lives.	1	2	3	4	5
45. Children experience the depth of inner emotions that adults are capable of experiencing.	1	2	3	4	5
46. Children are capable of positive self-direction if given an opportunity to do so.	1	2	3	4	5
47. Children are capable of figuring things out.	1	2	3	4	5
48. Children tend to make the right decision.	1	2	3	4	5
49. I have more patience with children than other people do.	1	2	3	4	5
50. A good therapeutic relationship is the most important foundation for helping children change.	1	2	3	4	5
51. I find joy in helping people when working with children.	1	2	3	4	5

52. I look forward with pleasure to helping children grow.	1	2	3	4	5
53. I think highly of remaining curious and open to new and playful things.	1	2	3	4	5
54. Play is good for physical and mental health.	1	2	3	4	5
55. Children's emotional disturbance problems are not due to lack of education and training.	1	2	3	4	5
56. I often get great inspiration from children.	1	2	3	4	5
57. Children don't need direction from a counselor to work out solutions to their own problems in a counseling relationship.	1	2	3	4	5

	1 – None	2 - Very Limited	3- Limited	4 - Good	5 - Very Good
58. How would you rate your knowledge of play therapy as an approach for counseling with children?	1	2	3	4	5
59. How would you rate your understanding of the reasons for selecting and excluding toys and materials in play therapy?	1	2	3	4	5
60. How would you rate your knowledge of how children communicate?	1	2	3	4	5
61. How would you rate your knowledge of identifying areas where limits should be set?	1	2	3	4	5
62. How would you rate your understanding of symbolic play in play therapy?	1	2	3	4	5
63. How would you rate your ability to consider the underlying meanings of children's questions?	1	2	3	4	5
How do you rate your understanding of the following terms?					
64. Play theme.	1	2	3	4	5
65. Tracking.	1	2	3	4	5
66. Returning responsibility.	1	2	3	4	5
67. Therapeutic limit setting.	1	2	3	4	5

68. Choice giving.	1	2	3	4	5
69. Play materials.	1	2	3	4	5
70. Directive play therapy.	1	2	3	4	5
71. Non-directive play therapy.	1	2	3	4	5
72. Group play therapy.	1	2	3	4	5
73. Family play therapy.	1	2	3	4	5
74. Play therapy with adults.	1	2	3	4	5
75. Parent consultation.	1	2	3	4	5
76. How would you rate your ability to effectively assess the mental health needs of a child?	1	2	3	4	5
77. How would you rate your ability to distinguish differences in counseling adults and children?	1	2	3	4	5
78. How would you rate your ability to conduct a play therapy session with a child?	1	2	3	4	5
79. How would you rate your overall ability to relate to children?	1	2	3	4	5
80. How would you rate yourself in terms of being able to effectively deal with a silent child in play therapy?	1	2	3	4	5
81. How would you rate yourself in terms of being able to effectively deal with an aggressive child in play therapy?	1	2	3	4	5
82. How would you rate yourself in terms of being able to effectively deal with a reluctant or anxious child in play therapy.	1	2	3	4	5
83. How would you rate your ability to provide consultation to parents?	1	2	3	4	5
84. How would you rate your ability to help parents understand their children?	1	2	3	4	5
85. How would you rate your ability to critique a play therapy session?	1	2	3	4	5
86. How well do you think you could identify play themes?	1	2	3	4	5
87. How would you rate your ability to help children understand themselves in play therapy?	1	2	3	4	5
88. How would you rate your ability to set limits on children's behavior in play therapy?	1	2	3	4	5

89. How would you rate your ability to establish a facilitative relationship with a child in play therapy?	1	2	3	4	5
90. How would you rate your ability to track a child's behaviors in play therapy?	1	2	3	4	5
91. How would you rate your ability to reflect children's feelings in play therapy?	1	2	3	4	5
92. How would you rate your ability to reflect the content of children's play in play therapy?	1	2	3	4	5
93. How would you rate your ability to facilitate children's spontaneity and creativity in play therapy?	1	2	3	4	5
94. How would you rate your ability to facilitate decision-making and responsibility by children in play therapy?	1	2	3	4	5
95. How would you rate your ability to verbally match the affective and activity pace of a child in play therapy?	1	2	3	4	5
96. How would you rate your ability to be succinct and specific in communicating with children in play therapy?	1	2	3	4	5
97. How would you rate your ability for self-supervision of counseling relationships with children?	1	2	3	4	5

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Education

Bachelor of Arts, Psychology December 2013
Minors: Bioethics and Religious Studies
Nazareth College of Rochester, Rochester, NY

Master of Arts, School Psychology May 2016
Alfred University, Alfred, NY

Certificate of Advanced Study, School Psychology May 2018
Alfred University, Alfred, NY

PsyD, School Psychology August 2021
Alfred University, Alfred, NY

Certifications

New York State Certified School Psychologist
Nationally Certified School Psychologist

Professional Affiliations

New York Association of School Psychologists (NYASP)
National Association of School Psychologists (NASP)

Experience

Psychologist Intern
Letchworth Central School District

- Responsibilities within the Letchworth Central School District (Pre-K through 12th grade) included psychological assessment, individual and group counseling, Functional Behavioral Assessment and Behavior Intervention Plan creation and monitoring, academic intervention administration, consultation with school personnel, participating in CSE meetings and student support team meetings

School Psychologist
Mary Cariola Center

- Responsibilities at the Mary Cariola Center included psychological assessment of preschool students, Functional Behavioral Assessment and Behavior Intervention Plan creation and monitoring, crisis support, consultation with school personnel, and leading professional development workshops

School Psychologist
Victor Central School District- Early Childhood School

- Responsibilities within the Victor Early Childhood School include psychological assessment, counseling, Functional Behavioral Assessment and Behavior Intervention Plan creation and monitoring, academic intervention assistance, consultation with school personnel, leading student support/ RTI meetings, participating in and chairing CSE meetings, crisis support, and aiding in student transitions into Kindergarten