PLAY THERAPY TRAINING AMONG SCHOOL PSYCHOLOGY, SOCIAL WORK, AND SCHOOL COUNSELING GRADUATE TRAINING PROGRAMS

BY

CHRISTINA BECHLE PASCARELLA

A DISSERTATION
SUBMITTED TO THE FACULTY OF

ALFRED UNIVERSITY

IN PARTIAL FULFULLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF

DOCTOR OF PSYCHOLOGY

IN

SCHOOL PSYCHOLOGY

ALFRED, NY

JANUARY, 2012

PLAY THERAPY TRAINING AMONG SCHOOL PSYCHOLOGY, SOCIAL WORK, AND SCHOOL COUNSELING GRADUATE TRAINING PROGRAMS

BY

CHRISTINA BECHLE PASCARELLA

STATE UNIVERSITY OF NEW YORK AT FREDONIA. B.A. (1996)

ALFRED UNIVERSITY, M.A./C.A.S. (2000)

SIGNATURE OF AUTHOR_____

APPROVED BY John D. Cerio, Ph.D.
Committee Chairperson

Nancy E. Furlong, Ph.D.
Committee Member

Mary T. Taggart, Psy.D.
Committee Member

_____
Committee Member

ACCEPTED BY Lynn M. O'Connell, Psy.D.
Chairperson, Division of School Psychology

ACCEPTED BY Nancy J. Evangelista, Ph.D.
Associate Provost and Director of Graduate Studies

ACCEPTED BY William M. Hall, Ph.D.
Provost & Vice President for Academic Affairs

(blank page)

Acknowledgements

I am incredibly humbled by the support of my dissertation chairperson, Dr. John D. Cerio. He stuck with me through this long and trying process, and I would not have had the courage to prevail without his guidance and support. He provided knowledge, structure, feedback, hope, and encouragement when I needed it most. More importantly, he provided these things in a way that made me feel worthy of his help. I know Dr. Cerio agrees that it is the relationship that makes the difference. I will always remember how meaningful his kindness and commitment was to me when I was most vulnerable. The character he showed is what I try to emulate as a school psychologist. I am tremendously grateful to Dr. Cerio for the impact he has had on me, both professionally and personally.

From the beginning, Dr. Nancy E. Furlong took a true interest in my research. She graciously took the time to share her expertise and review my work with a keen eye and an inquisitive mind. Her feedback helped me grow as a researcher. Though statistical analysis was the aspect I felt most unsure of, she provided guidance in a way that made me feel comfortable and competent. She shared the joy of discovery that comes with research. Much of the pride of accomplishment I feel is owed to Dr. Furlong. I am very fortunate to have had her guidance.

Early in my graduate schooling, Dr. Mary T. Taggart saw potential in me. Her warmth and support have been a source of encouragement to me as I completed my doctoral work. Her comments and questions have kept me focused on the application of my research and what it means to me as a practitioner. I am honored to have had Dr. Taggart's support.

Finally, I am thankful to family and friends who have endured and supported me through this time. Not only did you encourage my achievement, but you shared in my experience.

Table of Contents

List of Tables

Abstract

This study examined play therapy training across the nation among school psychology, social work, and school counseling graduate training programs. It also compared current training to previous training among school psychology and school counseling programs. A random sample of trainers was selected from lists of graduate programs provided by National Association of School Psychologists, Council on Social Work Education, and American School Counselor Association. Eighty three graduate trainers completed a survey regarding play therapy training. Results indicated that graduate trainers view play therapy positively, with school counselor trainers expressing the most favorable attitude toward play therapy. Trainers who expressed more positive attitudes about play therapy were generally more likely to offer play therapy training. Overall, the majority of programs reported offering some sort of training in play therapy, with school counseling trainers indicating the highest percentage of programs offering play therapy instruction. When compared to previous research on school counseling trainers, results indicated a significant increase in the frequency of offering play therapy training between 1999 and 2007. When compared to previous research on school psychology trainers, results revealed a trend suggesting that the frequency of offering play therapy training increased between 1997 and 2007. An examination of the type of play therapy training revealed that very few programs required a course in play therapy or provided the number of training hours needed to meet standards set by Garry Landreth (2001) or Association for Play Therapy (2006). Main barriers to play therapy training included lack of faculty with play therapy expertise and lack of time within the curriculum. In addition, school psychology trainers reported research-based and

philosophical reservations, and social work trainers reported funding to be a barrier. Findings suggest that as the play therapy research base has grown, there has been some growth in offering play therapy training. However, the format and amount of training offered does not adequately prepare graduate students to use play therapy with competence. More substantial training and field experience is required to train practitioners to meet the needs of children through play therapy.

Chapter One: Introduction and Review of Relevant Literature

With the increasing demand on practitioners to respond to the needs of children today, it is essential for them to be prepared with skills that are tailored to the population they serve. Play therapy is considered a developmentally appropriate mode of treatment for children. It is based on a belief that play is the natural language of children, and that they can use it to express and work through issues that are troubling them (Axline, 1947; Landreth, 1991). Though play therapy is a suitable treatment modality for work with children, it has been underutilized. Practitioners report that their use of play therapy is dependent upon their training in the modality, but also their perception of play therapy as an effective treatment (Taggart & Cerio, 1996; Ray, Armstrong, Warren, & Balkin (2005). Lack of sufficient play therapy training among graduate programs has been suggested in the past (Cerio, Taggart, & Costa, 1999) and may be a main factor inhibiting use of this modality. Also, lack of strong research in the area likely contributes to the underutilization of play therapy. However, efforts have been made over the last decade to improve research documenting the efficacy of play therapy. Better research is likely to result in a more positive perception of play therapy and an increase in the training provided. As perception and training improve, better utilization of play therapy by practitioners should occur, resulting in more children receiving a treatment that is appropriate to their developmental level.

History and Development of Play Therapy

Play therapy has been practiced for nearly a century. The original foundation of play therapy was psychoanalytic, based on the work of Sigmund Freud (1909/1955), who adapted his model of psychotherapy to children. Freud believed that play has an important role in child

development, and was the first to document the therapeutic use of play in the case of “Little Hans”, a five-year-old boy demonstrating phobic symptoms. As interest in the approach grew, play therapy was applied more intentionally as an intervention with children. Hermine Hug-Hellmuth (1921) used play materials with children to promote self-expression and assist in analysis. A student of Freud’s, Melanie Klein began working with young children in 1919 using a psychoanalytic play technique (1955). She considered play a vehicle of free association for children; a way to access and explore the unconscious part of the mind. Her approach involved the active interpretation of the preconscious and unconscious meaning of the child’s play and the analysis of transference to the psychoanalyst. Anna Freud’s work involving psychoanalysis of children also utilized a play-based approach (1946). She used play to build positive relationships with children and interpret their unconscious motivations. These early approaches varied in structure, but all involved the use of play in applying psychoanalytic principals to work with children.

Other play therapy approaches focused on relationships. With a de-emphasis on analysis of past events, Jesse Taft (1933) and Frederick Allen (1942) created Relationship Play Therapy. This approach used play to focus on present relationships. Healing was believed to result from positive child-therapist relationships (Pehrsson & Aguilera, 2007). Clark Moustakas (1955) also focused on positive interpersonal relationships between therapist and child in play therapy. He believed the relationship created through play therapy allowed the child to express and explore their own emotional process, resulting in growth, maturity, and improved social-emotional adjustment. Ann Jernberg developed Theraplay in the 1970s, a play-based approach that aimed to establish secure attachment relationships, typically between child and parent (Jernberg & Booth, 2001). Theraplay also focused on enhancing self-esteem, and developing appropriate

behaviors. The approach addressed "behavior problems that have their origin in children's early experiences of not having received adequate response to their needs" (p. 28). The treatment actively involves parents, first as observers, and later as co-therapists. The therapist and/or parent deliberately engages the child in activities that are described as playful, fun, physical, intimate, and focused on the present relationship. In Theraplay, the therapist provides the four factors identified as necessary for children to establish healthy attachments: structure, engagement, nurture, and challenge. The importance of a positive and trusting adult-child relationship was highlighted through these play-based approaches.

The field of play therapy became better known with the emergence of non-directive play therapy. This approach developed out of the work of Virginia Axline (1947), who applied the principles of Carl Rogers' (1951) non-directive/client-centered therapy to her play therapy work with children. Non-directive play therapy distinguished itself by its belief system and methodology. It is based on a belief in children's ability to solve their own problems, when given permission to fully express themselves through play activities. It is also based on a belief in a "growth impulse that makes mature behavior more satisfying than immature behavior" (Axline, 1974, p. 15). The role of the non-directive therapist is to reflect the child's feelings and provide insight, while communicating warmth and acceptance. The child is responsible for leading the sessions, in his or her own way and time, and the therapist only sets limits when necessary. Garry Landreth (1991) expanded on Axline's work and continued the development of child-centered play therapy. His approach is "based on a belief in the capacity and resiliency of children" (p. 55). Through child-centered play therapy, children "play out" feelings and experiences, while the therapist shows interest in and recognition for what they are doing. This demonstrates acceptance and allows children to be responsible for their own self-discovery and

social-emotional growth. These approaches focused on the child's capacity for healing with the therapist providing an environment of acceptance and understanding.

Other approaches expanded a child-centered approach beyond the structure of one therapist to one child. Bernard and Louise Guerney are credited with the development of Filial Therapy, an approach that involves the training of parents to conduct play sessions with their own children according to a non-directive or client-centered approach (B. Guerney, 1964; L. Guerney, 1997). Though traditional client-centered play therapy is useful in promoting social-emotional growth, there are several additional advantages of directly involving parents in delivering the treatment. First, having an integral role in helping the child is likely to motivate the parent to accept, engage, and sustain treatment. Also, practicing a new way of interacting with the child provides the parent with alternatives to already established patterns of negative interaction. Lastly, the parent is in a position to develop a better understanding of the child firsthand. While the ultimate goal of treatment is the growth of the child, the approach focuses on both the direct teaching of play therapy techniques to parents and the experience and feelings of the parents during the process. An extension of the child-centered approach to group work is described by Haim Ginott (1961). He developed an approach in which groups of children interact with each other in the playroom. Through this process, children learn about themselves and others. Through their interaction, they come to assume responsibility in interpersonal relationships, and generalize this sense of interpersonal responsibility beyond the playroom. These approaches allow for more direct connections between the child-centered play therapy setting and reality.

Other play therapy approaches have encouraged therapists to take more of a directive stance in making interpretations and providing guidance. Terry Kottman (1997) developed

Adlerian play therapy, an approach that combined the theory and strategies of Adlerian psychology with the techniques of play therapy. Adlerian Play Therapy is based on the psychological theory of Individual Psychology developed by Alfred Adler. Adlerians believe that individuals are motivated by the need to belong, and that they form a subjective view of themselves and the world based on their social experiences. Based on these external experiences, the personality or identity of a child is formed. It can be constructive or destructive, but is considered fixed and confining, defining the boundaries of the child's lifestyle. The Adlerian play therapist attempts to understand the child's lifestyle and the goals of his behaviors. The therapist works with the child in play therapy and with the parents in consultation, including teaching parenting skills and counseling. The therapist begins with relationship-building, then asking questions to understand the child's lifestyle. Once the Adlerian play therapist understands the child and family, she can provide insight and guidance. She interprets the play and verbalizations of the child and encourages shifts in beliefs, feelings, and goal-oriented behaviors towards those that are more constructive and affirming.

Susan Knell developed Cognitive Behavioral Play Therapy, which utilizes play techniques with children, applying cognitive-behavioral principles in a developmentally sensitive way (O'Connor & Braverman, 1997). This model understands disturbances in emotions and behavior to be expressions of irrational thinking or cognitive distortions. The medium of play allows the cognitive-behavioral play therapist to build rapport with the child, identify a treatment plan based on observed maladaptive thoughts and behaviors, and teach and reinforce more adaptive responses.

Charles Schaeffer and Steven Reid (1986) highlighted the therapeutic use of formal games in working with children. Games were used to engage children and also to work towards

specific treatment goals. Communication games were used to promote verbal expression in therapy in a way that seemed nonthreatening and fun. Problem-solving games were used to increase ability to use strategy and make logical decisions, either in general or as these skills were needed to address specific problems. Ego-enhancing games involved competition and were used to encourage growth in self-esteem and cognitive skills needed for academic learning. Socialization games were usually played in a group therapy setting and used to practice social skills and modify behavior. These approaches gave play therapists more control over directing sessions to work toward specific treatment goals.

Although, throughout history, play therapy approaches have varied in philosophy and structure, similarities remain. Almost all approaches consider play to be a developmentally appropriate way to build rapport and communicate with children in a therapeutic way.

The Effectiveness of Play Therapy

In an attempt to substantiate the effectiveness of play therapy, Bratton and Ray (2000) reviewed available research spanning the past several decades. They discovered a shift in the research over the years, with regard to how effectiveness was measured. Early on, research focused on outcome measures of intelligence and academic achievement. In the 1970s, there was an interest in social adjustment and self-concept. Later research targeted societal ills, such as abuse and divorce. With this in mind, Bratton and Ray considered various outcome measures in drawing conclusions about the effectiveness of play therapy. They also insured that the studies selected evaluated play therapy using pre- and post-measures, and yielded significant findings. Results supported the general usefulness of play therapy with various presenting problems. Support was strongest for the effectiveness of play therapy in addressing issues of social maladjustment, aggression, behavioral disruptions, self concept, anxiety, and depression.

Some improvements in academic skills and intellectual scores were reported, but likely due to improved social-emotional functioning allowing for better availability to learn and perform. Though limitations of this study included minimal use of a comparison group and simplistic statistical procedures, it lent credibility to the field and opened the door for future research.

In response to a need to scientifically substantiate the value of play therapy, additional research required more advanced statistical procedures. Since play therapy research was limited by small sample sizes, Ray, Bratton, Rhine, and Jones (2001) applied meta-analytic statistical procedures to combine the results from many smaller individual studies and determine an overall, or average, treatment effect. Ninety-four articles, spanning six decades (1940-2000), were included in the meta-analysis based on the following criteria: use of play therapy, measured outcome, use of statistics, control/comparison group, and pre/post test measure. Results revealed a large overall effect size for treatment (ES=0.80), indicating that play therapy treatments were effective across settings, modalities, age, gender, clinical/nonclinical populations. Thus, treatment groups performed 0.80 standard deviations better than non-treatment groups. The effect size for play therapy without parent involvement (n=70) was .73. The effect size for play therapy that included parent involvement, as in filial therapy, (n=28) was 1.06, suggesting that parent involvement increased the effectiveness of play therapy intervention. Parent involvement was found to be a significant predictor of treatment outcome (p=.008). Effectiveness also increased with the number of sessions provided, with peak effect size reached between 35 to 45 sessions. However, a large effect size was also reported for some studies with fewer sessions. A significant difference (p=.037) was revealed between modalities that were considered humanistic/nondirective (n=74, ES=0.93) and modalities that were considered behavioral/directive (n=12, ES=0.73), though the result was likely influenced by the difference

in the number of studies in each category. Significant differences in effect sizes were not found for the type of population (clinical vs. analog), type of setting (individual vs. group), age of subjects (ranging from 3 to 16 years old), or gender of subjects. Limitations of this study included various aspects of the articles reviewed, including: missing factors (e.g., training level of play therapists), ill-defined presenting problems, incomplete protocol procedures, and varied outcome measures. Despite the limitations, the advancements in this methodology allowed researchers to demonstrate empirical evidence for the value of play therapy.

LeBlanc and Ritchie (2001) also conducted a meta-analysis of play therapy outcomes. Studies were included if they used a no-treatment control group and statistics that could be transformed into standardized effect sizes. Forty-two of the reviewed studies were retained, including journal articles, dissertations, and unpublished documents. Many factors of the studies were analyzed in order to investigate variables related to effectiveness. Results revealed a medium to large overall effect size (ES=0.66), indicating that children who received play therapy performed better on the outcome measures than children receiving no treatment. Two variables stood out as being significantly related to effect sizes. First, treatment modalities that used "parents as therapists" (filial therapy, parent-child interaction therapy) yielded significantly higher outcomes than the average of all other treatments (p=.044). Second, the strongest outcomes were found among studies that ranged from 30 to 35 therapy sessions. Several remaining variables were not significant predictors of play therapy outcome, including: sex of the clients, presenting problems, use of other therapies in conjunction with play therapy, group versus individual therapy, and age of participants. Limitations included undefined aspects of the studies, including therapist characteristics and quality of the therapeutic process. This meta-

analysis provided further support for play therapy, particularly when utilizing parental involvement and the optimal number of sessions.

In 2005, Bratton, Ray, Rhine, and Jones further discussed and published findings related to their meta-analysis of play therapy outcomes spanning six decades of research (1942-2000). Ninety three of the reviewed studies were retained. In addition to the results previously discussed (Ray et al., 2001), this article reported specific results related to treatment characteristics (e.g., provider, setting) and child participant characteristics (age, target problem behaviors, outcome measures). Analyses compared treatment outcomes by type of treatment provider. Play therapy had a moderate-to-large effect size (ES=0.72) when provided by a mental health professional, a very large effect size (ES=1.05) when provided by a paraprofessional (e.g., parent, teacher, or peer mentor), and an even larger effect size (ES=1.15) when provided by a parent (filial therapy). In fact, the mean effect size for parent-provided filial therapy was significantly greater ($p<.01$) than the mean effect size for play therapy provided by a mental health professional. It should be noted that the favorable outcomes produced by paraprofessionals were possible because of the training and supervision they received from mental health professionals. Additional factors to consider in understanding this result involve the likelihood of parents as raters of outcome measures, and the assignment of difficult cases based on level of expertise. Analyses compared treatment outcomes by treatment setting. Though play therapy was considered effective across settings, play therapy conducted in critical-incident (n=12, ES=1.00) or residential settings (n=6, ES=1.10) produced significantly larger treatment effects ($ps<.02$) than play therapy conducted in schools (n=36, ES=0.69) and outpatient clinic settings (n=34, ES=0.81). However, differences between groups may also be impacted by the difference in the number of studies in each category, and the differences in

duration of treatment based on setting. The age of the child participant was not found to be a significant predictor of treatment outcomes. However, it should be noted that the majority of studies that reported the mean age of child participants to be greater than 10 years, described the children as cognitively delayed or mentally retarded. Thus, play therapy may not be as effective with older children of at least average cognitive ability. In comparing outcomes based on target problem behaviors, play therapy was equally effective for all types of presenting problems, revealing moderate to large effect sizes across the board. No significant differences were found for problems that were considered internalizing (ES=0.81), externalizing (ES=0.78), internalizing and externalizing (ES=0.93), and other types of target problems (ES=0.79). With regard to the type of outcome measure used, there was considerable variance in effect size, ranging from medium to very large. Outcome measures included the following: behavior (n=80, ES=0.81), social adjustment (n=16, ES=0.83), personality (n=19, ES=0.80), self-concept (n=23, ES=0.51), anxiety-fear (n=7, ES=0.69), family functioning/relationships (n=36, ES=1.12), developmental-adaptive (n=12, ES=0.90), and other (n=35, ES=0.55). Behavioral outcomes were used most, which explains the similarity between their effect size and the overall treatment effect size for play therapy (ES=0.80). Significantly larger effect sizes were calculated for the family functioning/relationships outcome measure, compared to other outcome measures. However, studies that used this outcome measure often used parents as the treatment provider and as raters of outcome measures. The additional analyses provided in this article highlighted some of the specific factors related to positive outcomes of play therapy treatment and provided direction for future research.

Ray (2006) reviewed the literature on play therapy outcomes, and found that historical research, meta-analyses, and several exemplary individual studies yielded support for this

treatment mode. This review suggested that research over the past 60 years provided evidence of play therapy having a "large beneficial treatment effect over comparison or non-treatment groups" (p. 153). More specifically that, "play therapy has been demonstrated to improve the self-concepts of children, decrease anxious behaviors, lessen externalizing and internalizing problem behaviors, and increase social adjustment" (p.152).

In 2010, Baggerly, Ray, and Bratton published a review of more recent play therapy research (2000-2009). Studies were included if they clearly labeled the treatment as "play therapy," were published in a peer-reviewed journal or book, considered the intervention child-focused (rather than parent-focused or family-focused), and utilized aspects of an experimental design. Twenty-five studies were reviewed and categorized into three labels based on the level of rigor in the research design. There were 13 Experimental studies; those that included random assignment, comparison to a control or treatment group, clear methodology and treatment descriptions, and consideration given to validity threats. There were four Quasi-experimental studies; those that did not use random assignment but were otherwise similar to Experimental studies. There were eight Evidentiary studies; those that used clear methodology and pre- and post-assessment measures, but did not use a comparison or control group. All but one of the studies (including 12 of the most rigorous or "experimental") resulted in the positive effects of play therapy. Positive effects of play therapy were seen across various outcome measures and across various populations.

Studies with outcome measures of externalizing behavior included four that were considered Experimental, three Quasi-experimental, and three Evidentiary (Baggerly et al., 2010). One Experimental study focusing on externalizing behavior found that children with special education labels who received six sessions of weekly 30-minute individual Child

Centered Play Therapy showed decreased problem behavior and fewer social problems compared to a no-treatment control group (Fall, Navelski, & Welch, 2002). The second Experimental study focusing on externalizing behavior assigned Hispanic children who were identified as having behavior problems to 15 individual sessions of weekly 30-minute intervention that was either Child Centered Play Therapy or a guidance curriculum intervention (Garza & Bratton, 2005). Results indicated decreases in externalizing behavioral problems for those who received play therapy. The third Experimental study focusing on externalizing behavior found that children with behavioral and learning problems who received 12 sessions of weekly 60-minute humanistically-based group play therapy, showed a moderate effect (though not statistically significant) for decreased externalizing behaviors (Packman & Bratton, 2003). The fourth Experimental study focusing on externalizing behavior found that children with behavioral problems who received 10 weekly 45-minutes sessions of group sand tray therapy, showed decreased externalizing behaviors (Wang Flahive & Ray, 2007). The Quasi-experimental studies showed decreases in aggressive behaviors for those who received Child Centered Play Therapy over a no-treatment control group (Ray, Blanco, Sullivan, & Holliman, 2009), decreases in externalizing problems (including aggressive behavior) for those who received either individual Child Centered Play Therapy or an evidence-based group guidance curriculum (Schumann, 2010), and decreases in externalizing problems (including aggressive behavior) for those who lived in domestic violence shelters and received either intensive individual play therapy or sibling group play therapy (Tyndall-Lind, Landreth, & Giordano, 2001). The Evidentiary studies further provided support for play therapy as a useful tool in addressing externalizing problems.

Studies with outcome measures of internalizing behavior included three that were considered Experimental, one Quasi-experimental, and one Evidentiary (Baggerly et al., 2010). The first Experimental study focusing on internalizing behavior assigned Hispanic children who were identified as having behavior problems to 15 individual sessions of weekly 30-minute intervention that was either Child Centered Play Therapy or a guidance curriculum intervention (Garza & Bratton, 2005). Results indicated moderate improvements in internalizing behavioral problems for those who received play therapy. The second Experimental study focusing on internalizing behavior found that children with behavioral and learning problems who received 12 sessions of weekly 60-minute humanistically-based group play therapy showed improved internalizing problems with a large effect size (Packman & Bratton, 2003). The third Experimental study focusing on internalizing behavior found that children with behavioral problems who received 10 weekly 45-minutes sessions of group sand tray therapy showed improved internalizing behaviors (Wang Flahive & Ray, 2007). The Quasi-experimental study showed improvements in internalizing behavior problems (including anxiety, depression, and self-esteem) for those who lived in domestic violence shelters and received either intensive individual play therapy or sibling group play therapy (Tyndall-Lind, Landreth, & Giordano, 2001). The Evidentiary study further provided support for play therapy as a useful tool in addressing internalizing problems with children who are homeless (Baggerly & Jenkins, 2009).

Additional studies focused on specific outcome measures within internalizing behavior including anxiety, depression, self-concept and self-esteem (Baggerly et al., 2010). An Experimental study focusing on anxiety assigned children who were diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) to 16 individual sessions of 30-minute intervention over eight weeks that was either Child Centered Play Therapy or a reading mentoring active control

group (Ray, Schottelkorb, & Tsai, 2007). Results indicated improvements for both groups in symptoms of ADHD and anxiety, but children in the play therapy group demonstrated more improvement over those in the reading mentoring group in symptoms of anxiety/withdrawal. A second Experimental study focusing on anxiety found that, following an earthquake, Taiwanese children at high risk for maladjustment who received ten forty-minute group sessions of Child Centered Play Therapy over four weeks, demonstrated a decrease in anxiety and suicide risk (Shen, 2002). An Evidentiary study showed improvement in self-concept and self-esteem related to depression and anxiety for children living in a homeless shelter who received nine to twelve 30-minute Child Centered Play Therapy sessions (Baggerly, 2004). Another Evidentiary study showed decreases in trauma symptom severity, anxiety, and depression for children who disclosed sexual abuse and received weekly individual 50-minute play therapy sessions over six months (Reyes & Asbrand, 2005).

One study focused on moral reasoning (Baggerly et al., 2010). An Experimental study assigned at-risk children to 10 group sessions of weekly 50-minute intervention that was either talk therapy or activity therapy (Paone, Packman, Maddux, & Rothman, 2008). Results indicated superior moral reasoning for the children in the activity therapy condition over those in the talk therapy condition.

Studies with outcome measures of child-parent relationships and child-teacher relationships included two that were considered Experimental, one Quasi-experimental, and three Evidentiary (Baggerly et al., 2010). The first Experimental study focusing on relationships assigned children who were identified as experiencing emotional and behavioral difficulties to one of three treatment conditions: play therapy only, play therapy and person-centered teacher consultation, or person-centered teacher consultation only (Ray, 2007). Treatment lasted eight

weeks, with play therapy occurring twice a week for 30 minutes and consultation occurring once a week for 10 minutes. Results indicated decreases in teacher-child relationship stress with large treatment effect sizes for all three treatment groups. The second Experimental study focusing on relationships, assigned children who were identified as experiencing emotional and behavioral difficulties to 16 30-minute sessions of individual Child Centered Play Therapy that was either short-term (over eight weeks) or long-term (over 16 weeks) (Ray, Henson, Schottelkorb, Brown, & Muro, 2008). While both treatment groups improved in teacher-student relationship stress, larger effect sizes were seen for the short-term intensive group. The Quasi-experimental study focusing on relationships assigned Taiwanese children to one of three treatment conditions: Gestalt-play group counseling (10 40-minute sessions over five weeks), cognitive-verbal group counseling (10 40-minute sessions over five weeks), or a no-treatment control group (Shen, 2007). Results indicated that both treatment groups improved in overall behavioral and emotional strengths. The play therapy group demonstrated improvement in family involvement, while the cognitive-verbal group demonstrated improvement in affective strength. The Evidentiary studies further provided support for Child Centered Play Therapy as a useful tool in addressing parent-child relationship stress (Dougherty & Ray, 2007; Ray, 2008), and teacher-child relationship stress (Muro, Ray, Schottelkorb, Smith, & Blanco, 2006).

Studies focusing on children with sexual behavior problems or who were suspected to be victims of sexual abuse included one that was considered Experimental and one that was considered Evidentiary (Baggerly et al., 2010). The Experimental study assigned children identified as having sexual behavior problems to either a cognitive-behavioral treatment condition or a play therapy treatment condition (Carpentier, Silovsky, & Chaffin, 2006). Follow up results from ten years later indicated that children who received the cognitive-behavioral

treatment committed fewer sex offenses, than did those who received the play therapy treatment. The Evidentiary study found that children referred for possible sexual abuse demonstrated an increased sense of competency following seven to 13 sessions of Child Centered Play Therapy (Scott, Burlingame, Starling, Porter, & Lilly, 2003).

Three Experimental studies focused on coping with disabilities and academic skill deficits (Baggerly et al., 2010). The first study assigned children who qualified for speech therapy to either regularly scheduled speech therapy sessions or group play therapy along with regularly scheduled speech therapy sessions (Danger & Landreth, 2005). Results indicated that children who received group play therapy in addition to speech therapy showed increased receptive and expressive language skills. The second study found that children diagnosed with insulin-dependent diabetes mellitus who received 12 sessions of Child Centered Play Therapy during a three week camp improved in diabetes adaptation over a no-intervention control group (Jones & Landreth, 2002). The third study found that children considered academically at risk who received 16 30-minute sessions of Child Centered Play Therapy over eight weeks improved in academic achievement over children in a control group (Blanco, 2010).

In summary, Baggerly et al. (2010) provided a review of recent literature that demonstrated the positive effects of play therapy. Outcome measures with positive results included externalizing behavior, internalizing behavior, aggression, anxiety, depression, self-concept and self-esteem, social behavior, moral reasoning, parent-child and teacher-child relationships, adjustment to trauma and coping, language skills, and academic achievement. One area in which play therapy was not effective, compared to Cognitive Behavioral Therapy, was as a prevention activity for future sexual offenses. This review suggested that the play therapy approach most frequently researched was considered child-centered, and aligned with the

philosophies of Axline and Landreth. This review also suggested a recent trend toward the use of outcome measures that focus more on disruptive and externalizing behaviors, and less on self-concept and social behavior. Researchers observed that this "trend coincides with the rise of behaviorism in the schools and the focus on external achievement-related status in American culture" and argued that this focus in play therapy research is an attempt to stay relevant in the minds of parents and authorities (p. 29). Researchers concluded that changes in play therapy research methodology over the last ten years have resulted in strong evidence to support its use among a variety of populations and presenting problems.

Application of Play Therapy to School Problems

Though traditionally used in clinical settings, there have been recent efforts to incorporate the use of play therapy into school settings (Landreth, 1991). With the value of play therapy recognized in the literature, it seems logical to extend its use to school practitioners, who have the most access to a wide array of children. Play therapy offers the school practitioner a developmentally appropriate alternative to more traditional methods of service delivery. Where language barriers or resistance may hinder traditional methods, play therapy allows for the necessary relationship variables to develop in a context in which the children are more comfortable expressing themselves.

Research investigating the effectiveness of play therapy in schools has yielded some positive results. Johnson, McLeod, and Fall (1997) provided nondirective, child-centered play therapy to six male students, ages five to nine. All students were classified with some form of disability based on results of standardized intelligence testing or physician diagnosis. Labels included attention-deficit/hyperactivity disorder, mentally disabled, autistic, cerebral palsy, obsessive-compulsive disorder, and communication deficits. Students were given six weekly 30-

minute sessions of play therapy. Therapy sessions were transcribed and analyzed to evaluate changes in play with regard to expression of feelings and expression of control. Results indicated that, with one exception, all students expressed both feelings and control through language and actions in play therapy sessions. The intervention was successful in that it facilitated the expression of emotions and increased the ability to cope. While the acceptance provided through nondirective child-centered play therapy was considered to allow for the expression of feelings, the encouragement of initiative during therapy was judged to facilitate self-control over students' behaviors and emotions. Further success was indicated by teachers, who reported generalization of results as evidenced by improvements in classroom behaviors.

Post (1999) evaluated the impact of child-centered play therapy on at-risk students in grades four, five, and six. She was specifically interested in changes in self-esteem, locus of control, and anxiety over the course of six months. While all students in the study (n=168) were considered at-risk due to characteristics of their school population, only those referred for counseling comprised the experimental group, which received the treatment. The other group of students served as the control group, and received no treatment. Results indicated that, while students in the experimental group maintained their level of self-esteem, those in the control group showed a significant decrease in self-esteem over the course of the school year. Similarly, while students in the experimental group maintained their locus of control for academic achievement, those in the control group showed a significant decrease in locus of control (moving toward external). Thus, although participating in child-centered play therapy did not enhance self-esteem or locus of control, it may have prevented a decline in those areas for at risk children. No significant results regarding anxiety were found.

Recognizing the power of parent involvement, Filial Therapy has shown some success in addressing the secondary, emotional problems that arise in relation to learning problems. Louise Guerney (1979) explained the issues of dependence/independence, self-control, and judgment/evaluation that are particular to children with learning problems. The accepting atmosphere of play therapy provided by the child's parent in Filial Therapy allows him to work through these issues and find success. The parent-therapist can relax and enjoy the child in the non-evaluative role, and may generalize their acceptance and empathy to the real world. Parents may also become more comfortable allowing the child to take more responsibility for self-control outside of the playroom. Guerney suggested that children treated in this model increase in ability to concentrate, attempt new material, and handle frustration. They may even show academic gains in some instances. Through therapy, children with disabilities show growth in positive feelings, independence, and self-control "as predictably as children whose problems are purely emotional and interpersonal in origin" (p. 244). Thus, whether children's social/emotional concerns are a primary or secondary school-related issue, their needs can be met through this approach.

As previously discussed, Baggerly et al. (2010) reviewed studies focused on coping with disabilities and academic skill deficits. Results of one study showed that when group play therapy was added to speech therapy, children showed increased receptive and expressive skills (Danger & Landreth, 2005). Results of a second study found that when children who were diagnosed with insulin-dependent diabetes mellitus received play therapy, they improved in diabetes adaptation (Jones & Landreth, 2002). Results of a third study found that children who were considered academically at risk and received play therapy, improved in academic achievement (Blanco, 2010).

Use of Play Therapy by School Practitioners and its Relationship to Training

To investigate the use of play therapy by school practitioners, Taggart and Cerio (1996) surveyed 159 members of the National Association of School Psychologists (NASP). Results revealed that 27% of school psychologists report some use of play therapy in their practice. There was an overrepresentation of play therapy use in the Northeast, likely due to a higher number of available training programs in the area. Various factors promoted the use of play therapy by school psychologists. Training was one of the most important factors related to use of play therapy, $\chi^2(1) = 17.57$, $p < .001$. Both pre-service and in-service training were found to positively correlate with therapeutic self-efficacy and positive outcome expectations, which positively correlated with use. Thus, it seems that those who receive higher quality training in play therapy feel more confident in their ability to use it effectively, and, therefore, are more likely to use it. The authors concluded that "self-efficacy serves as an intervening variable between training and use" (p. 14). Recency of training further increased use of play therapy. Additionally, school psychologists were more likely to use play therapy in their practice if they worked in rural or suburban settings, which may lack community resources. Other factors that promoted the use of play therapy included: support (of staff and parents), time afforded within their schedule, and adequate facilities and equipment. The study was limited by its sole reliance on self-report data from practitioners, which may have resulted in under-reporting due to lack of general acceptance of play therapy in the field. The study also did not survey practitioners, other than school psychologists, and only focused on those that were members of NASP. Another limitation of the study was the lack of extensive research on reliability and validity of the scale that was developed specifically to measure self-efficacy for this study, the Play Therapy Self-Efficacy Scale (PTSES).

More recently, Ray, Armstrong, Warren, and Balkin (2005), conducted a survey of the use of play therapy by 381 elementary school counselors who were members of the American School Counseling Association (ASCA). Results revealed that the majority of these counselors (62%) reported using play therapy between zero and three hours per week; 19 percent reported using play therapy four to six hours per week; and the remaining 21 percent of respondents reported using play therapy seven or more hours per week. Similar to the findings of Taggart and Cerio (1996), Ray et al. found that the level of training in play therapy was the only factor significantly related to its use in elementary schools, $\chi^2 = 11.56$, $p < .001$. The amount of training received also had a positive effect on the perception of play therapy as effective. Thus, it may not just be a matter of acquiring play therapy skills, but also developing an understanding of and belief in the process, which encourages one to use the skills. The vast majority of school counselors reported beliefs about children that are consistent with child-centered play therapy. Belief in play as the natural language of children was related to use of play therapy. School counselors reported lack of time for counseling students and lack of training to be the main barriers to their use of play therapy. The study was limited by its sole reliance on self-report data from practitioners. It also did not distinguish between those that do not use play therapy at all from those that use it one to 3 hours per week. The study also did not survey practitioners, other than school counselors, and only focused on those that were members of ASCA.

Play Therapy Training

In light of the literature citing the impact of training on the use of play therapy, it appears that investigating more specifically the amount and type of training provided to school-based practitioners would be of great value to the field. School psychologists (members of NASP) were surveyed about their training in play therapy (Taggart & Cerio, 1996) with only 19% of

respondents reporting that they received pre-service training (i.e., coursework) in play therapy. Of those that received pre-service training in play therapy, 70% reported that the training was required, while 30% reported that the training was optional. In-service training (i.e., workshops) was reported by 33% of the respondents, and this consisted mostly of workshops. The primary orientations of play therapy training were behavioral (39%), developmental (24%), psychodynamic (16%), humanistic (10%), and systems (3%). More specific information on the type and amount of play therapy training was not provided. The study was limited in that it only focused on members of NASP.

Elementary school counselors (members of ASCA) were also surveyed about their training in play therapy (Ray, Armstrong, Warren, Balkin, 2005). Approximately 21 percent of respondents indicated that they had taken one university-level course and 12 percent reported having taken two or more university level courses in play therapy, while 67 percent indicated that they had not taken a play therapy course, and more than 53 percent reported no formal training in play therapy. No information was reported on the orientation or type of play therapy training provided. This study was limited in that it only focused on members of ASCA.

Cerio, Taggart, and Costa (1999) conducted a national survey of school counselor training programs. Of the 117 (out of 435) school counseling programs that responded, large colleges and those from urban settings were over-represented. While a little over half of the 117 programs surveyed (55%) reported providing some form of training in play therapy, only 3% required a course in play therapy, 9% offered an elective course in play therapy, and 21% offered play therapy training as *part* of a required course. Of those that indicated that play therapy training was part of another course, the majority (66%) indicated that the percentage of the course devoted to play therapy was less than or equal to 25% of the entire course. Only 19% of

the programs indicated that 25% to 50% of the course was devoted to play therapy. Even fewer (14%) indicated that 50% or more of the course was devoted to play therapy. In considering application of skills, only 15% of training programs reported the availability of a play therapy practicum experience, while even fewer required it. Of those that did offer a practicum experience, most offered less than twenty hours of play therapy experience. While many school counseling programs (40%) did not indicate any specific barriers to offering play therapy courses, others mentioned philosophical/research issues (28%), lack of faculty expertise (14%), and limited funding (10%). With regard to the content of play therapy training offered, 43% of the 117 school counseling programs indicated providing a general overview. A very small percentage of programs indicated providing training in specific approaches; seven percent offered training in child-centered play therapy and one percent offered training in developmental play therapy. The researchers concluded that, "much of what programs label as "training" in play therapy consists of minimal exposure to general information about this approach" (p. 60). Despite the obvious lack of sufficient training offered, when surveyed about their beliefs regarding the effectiveness of play therapy and its use in school settings, representatives from school counseling training programs were fairly positive. Results indicated that trainers believe that play therapy is therapeutically useful, that courses in play therapy belong in school counseling training programs, and that schools are appropriate settings in which to use play therapy. This research was limited in its use of statistical procedures to examine data. It was also limited to school counselor training programs.

Cerio, Taggart, and Costa (1997) conducted a national survey of school psychology training programs. Of the 54 (out of 200) school psychology programs that responded, large colleges and those from urban settings were over-represented. A little less than half of the

programs surveyed (43%) reported providing some form of training in play therapy. Of those that reported providing training in play therapy, 11% required a course in play therapy, 9% offered an elective course in play therapy, and 15% offered play therapy training as *part* of a required course. Of those that indicated that play therapy training was part of another course, the majority (75%) indicated that the percentage of the course devoted to play therapy was less than or equal to 25% of the entire course. Only 25% of programs indicated that 25% to 50% of a course was devoted to play therapy. None indicated that 50% or more of the course was devoted to play therapy. In considering application of skills, only 20% of training programs reported the availability of a play therapy practicum experience. Of those that did offer a practicum experience, most offered less than ten hours of play therapy experience. Within the general practicum experiences offered through training programs, 13% reported that a play therapy experience was required, while 11% indicated that it was optional. The remaining majority of programs indicated that a play therapy experience was not an option within their practica. While many school psychology programs (32%) did not indicate any specific barriers to offering play therapy courses, others mentioned philosophical/research based reservations (25%), lack of faculty expertise (15%), and limited funding (8%). With regard to the content of play therapy training offered, 15% of the 54 school psychology programs indicated providing a general overview. A small percentage of programs offered training in various specific approaches (6% Child-Centered, 4% Psychodynamic, 6% Cognitive-Behavioral). The remaining programs reported using other approaches (6%) or combinations of approaches (11%). Compared to their school counseling counterparts, when surveyed about their beliefs regarding the effectiveness of play therapy and its use in school settings school psychology trainers were less positive. Results indicated that, although trainers believed that children can resolve unpleasant feelings through

play and that play therapy helps children relax so that they will talk more in counseling, only about 50% agreed (and about 20% disagree) that play therapy is therapeutic and that it works. While 59% agreed that play therapy courses belong in a school psychology program, only 32% agreed that schools are ideal settings in which to use play therapy. This research was limited in its use of statistical procedures to examine data. It was also limited to school psychology training programs.

Ryan, Gomory, and Lacasse (2002) surveyed members of Association for Play Therapy (APT) (n=891). Participants were mostly female (90%), trained at the master's degree level (77%), and had spent an average of two years in the mental health field. They came from three main academic disciplines, counseling (39%), social work (30%), and psychology (21%). Although they were all assumed to be play therapists, based on their membership status, they specifically identified themselves primarily as: counselors (35%), social workers (19%), play therapists (13%), therapists (12%), and psychologists (11%). They most often reported working in private practice settings (34%), and this was especially true for psychologists. Play therapists who were counselors were overrepresented in school settings, while those who were social workers were overrepresented in private/non-profit settings. The majority of play therapists (60%) reported providing ten hours or less of general therapy services per week, with counselors and social workers providing more than others, F (3, 825) = 3.498, p <.015 With regard to training, 41 percent of play therapists received coursework in play therapy. More counselors, than social workers, received exposure to play therapy in their coursework, F (3, 872) = 7.85, p <.001. Thirty-eight percent of play therapists had practicum experiences in play therapy during their pre-service training. The total percent of play therapists who received pre-service play therapy exposure in the form of coursework and/or practicum was 54 percent. Play therapists

reported receiving play therapy training in several approaches with child-centered (56%) and cognitive-behavioral (42%) being most prevalent. With regard to post-service training, respondents varied widely in the number of play therapy workshop hours attended, based on membership status. Most play therapists (76%) reported receiving play therapy supervision of one hour per week in individual sessions (78%) and/or group sessions (54%). Of those who were supervised, most reported receiving supervision from a Registered Play Therapy-Supervisor (61%), in alignment with APT recommendation. The presenting problems addressed in play therapy included: family issues (89%), child behavioral problems (85%), grief issues (57%), and violence/victim services (55%). Since this study focused on members of APT, it provided a sample of practitioners committed to providing play therapy. However, the sample seemed to be limited to those with little experience in the field and little time spent providing general therapy services (with no mention of the time spent providing play therapy services). The study also failed to collect information on the variability within the amount of pre-service play therapy training provided (i.e., part of one course versus two courses).

Lambert, LeBlanc, Mullen, Ray, Baggerly, White, and Kaplan (2007) conducted a study of play therapists (n=978) who were members of Association for Play Therapy (APT) (56%), members of American Counseling Association (ACA) (12%), or members of both associations (22%). Participants were mostly female (92%), trained at the master's degree level (80%), worked in a private practice or mental health setting, and had spent an average of 10 years in the mental health field. They identified themselves as professional counselors (45%), social workers (20.5%), school counselors (9.8%), marriage family therapists (7.2%), and psychologists (5.95%). With regard to training, play therapists indicated that, on average, they took 1.5 graduate level courses in play therapy. Members of APT were reported to have engaged in a

significantly greater amount of continuing education (M=121 CEUs), compared to members of ACA (M=18 CEUs), $U = 6899$, $p < 0.001$. Members of APT were also reported to have received more play therapy supervision (M=123 hours), compared to members of ACA (M=65 hours), $\chi^2 = 29.67$, $p < 0.001$. The majority of play therapists indicated their primary theoretical orientation to be child-centered (67%), followed by cognitive behavioral (9%) and Adlerian (7%). Since this study also focused on members of APT, it provided a sample of practitioners who are committed to providing play therapy. Soliciting play therapists who were ACA members broadened the sample beyond APT members, but resulted in an underrepresentation of other mental health professionals.

Recommended Training Guidelines for Play Therapists

It is important to establish what constitutes "adequate" training in play therapy. To judge this, there needs to be a standard against which programs may be compared. Landreth (1991), a respected authority in the field, recommends guidelines for training in play therapy. He suggests that play therapists should have a "master's degree in an area of the helping professions," and knowledge of relevant content areas (i.e., child development, counseling/psychotherapy, group counseling). As part of their development, they should undergo personal counseling in efforts to examine themselves over time. To develop a specialized knowledge base, practitioners should attain the equivalent of 45 clock hours of instruction in play therapy. In acquiring a practical application of knowledge/skills, they should participate in observation and case analysis of typical and maladjusted children. They should also observe, discuss, and critique sessions of experienced play therapists. Finally, they should gain experience in the practice of play therapy while supervised by a professional skilled in play therapy (p. 105-106).

The Association for Play Therapy (APT) has also created guidelines for training by establishing criteria for earning the Registered Play Therapist™ credential (2006). These criteria state that applicants must: 1) hold a current mental health license or certification for clinical practice; 2) have a masters or doctoral degree in a mental health specialty; 3) have completed core graduate course work in several areas (i.e., ethics, child development, personality, psychotherapy, child/adolescent psychopathology); and 4) have participated in at least 150 hours of specific instruction in play therapy, 50 of which may be non-contact hours. The play therapy instruction must include four content areas: history (four to five hours recommended), theories (40-50 hours recommended), techniques/methods (40-50 hours recommended), and applications to special settings or populations (40-50 hours recommended). Applicants must also accrue 2,000 hours of general supervised clinical experience, with no more than 1,000 these hours completed pre-master's degree. In addition, applicants must have completed 500 hours of supervised play therapy experience, which includes 50 hours of play therapy supervision. After becoming Registered Play Therapists, individuals must participate in continuing education in order to renew their credentials every three years consisting of 36 hours over three years. At least 18 of these hours must be in the area of play therapy, half of which may be non-contact hours.

Play Therapy as an Effective Intervention that has been Under-represented

Previous research has provided evidence that play therapy is an effective intervention with children, and a developmentally appropriate alternative to traditional talking therapy. Meta-analyses of studies conducted prior to 2000 demonstrated that play therapy is effective in addressing issues of both internalizing and externalizing behavior, with a large beneficial treatment effect over comparison or non-treatment groups (LeBlanc & Ritchie, 2001; Ray et al.,

2001). Play therapy was shown to be effective in addressing issues of social adjustment, aggression, behavioral disruptions, self-concept, anxiety and fear, depression, personality, family functioning and relationships, and developmental-adaptive behavior. The effectiveness of play therapy was increased by involving parents in the treatment, and by providing the optimal number of sessions (30-45). Research that was conducted between 2000 and 2009 contributed improved methodologies and further strengthened the support for play therapy as an effective intervention. Play therapy was shown to be effective in addressing issues of both internalizing and externalizing behavior, including aggression, anxiety, depression, self-concept and self-esteem, social behavior, moral reasoning, parent-child and teacher-child relationships, adjustment to trauma and coping, language skills, and academic achievement. The most frequently researched play therapy approach was child-centered.

Research has shown that the use of play therapy greatly depends on whether or not a mental health professional has received training in its use. In 1996, nineteen percent of school psychologists reported pre-service training in play therapy, and 27 percent reported using play therapy in their practice (Taggart & Cerio). They reported that training in play therapy is related to feelings of self-efficacy and, thus, results in using play therapy. In 2005, 33 percent of elementary school counselors reported having taken at least one course in play therapy, and 62 percent reported using play therapy zero to three hours per week, while 40 percent reported using play therapy more than four hours per week (Ray et al.). They reported that training in play therapy is related to belief in play therapy as effective, and also results in the use of play therapy. It seems that play therapy is underutilized as a treatment due to a lack of training.

Though the majority of graduate level training programs in mental health fields have provided general training, experience, and supervision in counseling approaches, there has been

a lack of focus on specific training in play therapy. In 1999, 55 percent of school counselor trainers reported providing some form of training in play therapy, but only three percent required a course in play therapy (Cerio et al.). In 1997, 43 percent of school psychology trainers reported providing some form of training in play therapy, but only 11 percent required a course in play therapy (Cerio et al.). Research in play therapy suggests that the instruction provided has not approached the recommended 45-150 hours of play therapy instruction. Few school counseling and school psychology programs offered play therapy training in a specific approach, instead favoring a general overview or minimal exposure to several play therapy approaches. Only 15 to 20 percent of programs reported the availability of practicum experiences in play therapy. Barriers included philosophical issues, lack of research in the field, lack of faculty with expertise, and limited funding. School counseling trainers generally expressed positive views about play therapy, but only about half of the school psychology trainers believed play therapy to be an effective intervention.

Surveys of play therapists (Lambert et al., 2007; Ryan et al., 2002) revealed that they are generally female, master's level practitioners who work in private practice settings. They are generally from counseling backgrounds, followed by social work backgrounds. Only slightly more than half have pre-service training in play therapy (one and a half courses on average), with less having pre-service practicum experience in play therapy. They favor child-centered play therapy, followed by cognitive-behavioral play therapy.

Although the past research on play therapy training has been useful in suggesting a history of insufficient training, some questions remain unanswered. Without a clear report on the number of hours of play therapy instruction and the number of hours of supervised play therapy experience, research cannot determine if play therapy training meets the recommended

guidelines established by Landreth and APT. In discussing the underrepresentation of play therapy training among graduate programs, it is useful to consider attitudes about play therapy. While information on attitudes about play therapy have been gathered in the past, it has not been determined if attitudes about play therapy correlate with offering training in the area.

With the exception of the LeBlanc et al. (2007) study, previous surveys of graduate training programs have focused mainly on the mental health disciplines of school counseling and school psychology, but have neglected to include social work training programs. LeBlanc et al. suggested that social workers were second to counselors in providing play therapy services. Though they work with individuals across the lifespan, social workers often specialize in working with children and are employed by schools. Including information regarding their training in play therapy is important. Comparing the play therapy training offered by school counseling, school psychology, and social work programs would be most informative in assessing the current status of play therapy training among graduate programs.

Since it has been several years since the state of training in play therapy has been assessed, it is possible that there have been some changes and, hopefully, some improvement in training practices. Perhaps recent research that has provided evidence for play therapy as an effective intervention with children has encouraged graduate programs to provide training in the area. It is clear that the use of play therapy greatly depends on obtained training. Thus, it is worthwhile to investigate the current level of training. If high-quality training is not provided, we cannot expect play therapy to be used widely, not to mention, effectively. Without play therapy as a modality for counseling children, practitioners may be limited to traditional "talking" approaches when attempting to engage children in therapy.

The purpose of this study is to investigate the current state of play therapy training offered to counselors, school psychologists, and social workers at the graduate school level. In surveying training institutions designed to prepare practitioners for work with youth, a cross-disciplinary perspective will be of value. Comparisons will be made among school psychology, social work, and school counseling disciplines. Findings will be compared to those from previous studies on training, to determine if changes have occurred over time.

Chapter Two: Method

Research Questions

The research questions addressed in this study include:

- How do graduate trainers view play therapy?
- Is there a relationship between attitudes about play therapy and offering play therapy training?
- Are there differences in play therapy training between school psychology, school counseling, and social work graduate programs?
- What is the current status of graduate training in play therapy across disciplines?
- Does the current training in play therapy match the guidelines set by Garry Landreth and the Association for Play Therapy (APT)?
- Is there a difference between current and previous play therapy training?

Participants

Participants were faculty or administrators of graduate training programs representing three disciplines that provide counseling services to children: counselors, school psychologists, and social workers. Nearly 70% of survey respondents self-identified as program directors or chairpersons. The remainder of respondents identified as faculty who teach play therapy (19%), faculty who do not teach play therapy (17%), deans (4%), and those who held other faculty or administrative positions (5%). Respondents were 48% male and 52% female. The mean age of respondents was 54, with the mean number of years in the field being 25.

The sample included 26 school psychology trainers, 28 social work trainers, and 29 school counseling trainers. The responding programs offered the following degrees: M.A. or M.Ed. (47%), M.A./C.A.S. (7%), Ed.S. (18%), M.S.W. (34%), Ph.D. (19%), Psy.D. (4%), Ed.D. (1%), and other master's level degrees (4%). Regarding geographical location within the U.S.A., programs represented were most often from the Midwest region (34%), followed by the

Northeast (19%), Mid-Atlantic (11%), Southeast (17%), Mountain/Southwest (7%), and West (12%). Regarding setting, the programs represented were most often located in urban settings (45%), with the remaining programs located in suburban (20.5%) and rural (24%) settings. The majority of programs were connected to public institutions (65%), with a much smaller percentage connected to private institutions (28%). Most of the programs were identified as being housed within a comprehensive university (47%); some within a small university (24%); and just a few within a college (2%). It should be noted that a substantial percentage of the sample (27%) left this item unanswered. Most programs were associated with large institutions where enrollment ranged from 10,001 to 20,000 (36%), or over 20,000 (24%). Smaller institutions represented the remainder of the sample, with enrollment described as: 5,001 to 10,000 (21%); 2,000 to 5,000 (15%); and under 2,000 (5%).

Instruments

A survey was constructed to assess views and practices of graduate trainers. The survey was partially based on those used in previous studies (Cerio, Taggart, & Costa, 1997; Cerio, Taggart, & Costa, 1999) (Appendix A). The first section of the survey collected demographic information about trainers, their institutions, and their programs. The second section of the survey elicited information on the trainers' views of play therapy. The third section assessed play therapy training provided, encompassing both instruction and practicum experience. This section addressed whether or not programs provided play therapy training, and the type and amount of play therapy training that was provided. It also solicited information regarding the level of expertise of the instructor who provided play therapy training.

Procedure

Lists of graduate training programs within the U.S.A. were obtained from the National Association of School Psychologists (NASP) (154 programs), the Council on Social Work Education (CSWE) (205 programs), and the American School Counselor Association (ASCA) (469 programs). A random sample of 100 programs per discipline was selected, for a total of 300 programs.

The survey was mailed to graduate program directors in December of 2007. As an incentive, the first 30 trainers to respond were mailed a copy of, Play Therapy: A Do-It-Yourself Guide for Practitioners. Seventy-eight surveys were initially completed and returned. Nine were unable to be delivered due to incorrect contact information, and were resent. Second requests for survey completion were sent to all non-responders in March of 2008. Final survey collection was completed in April of 2008, with a total of 84 surveys returned, resulting in a 28% response rate. One social work program was omitted due to likely misinterpretation of the Likert scale ratings, lowering the total number of completed surveys to 83.

Chapter Three: Results

Current Attitudes about Play Therapy

Results of play therapy rating scale. Graduate school trainers were asked to rate the following items regarding their attitudes toward play therapy:

- Play is the natural medium of expression for children.
- Children are able to resolve unpleasant feelings through play.
- Children are able to resolve internal conflicts through play.
- I think play therapy works.
- Play therapy, in and of itself, is therapeutic.

Items were rated on a Likert scale, ranging from 1 (*strongly disagree)* to 5 (*strongly agree).* Based on these five items, an average attitude score was calculated to provide an overall measure of attitude toward play therapy. Responses are summarized in Tables 1 through 4.

Table 1

Attitude of Graduate Trainers Regarding Play and Play Therapy, indicated by Item Response Percentages and Mean

Item	n	Strongly Disagreed (rating=1)	Disagreed (rating=2)	Neutral (rating=3)	Agreed (rating=4)	Strongly Agreed (rating=5)	M
Natural medium of expression.	82	0%	0%	3.7%	26.8%	69.5%	4.66
Resolve unpleasant feelings.	83	1.2%	1.2%	10.8%	38.6%	48.2%	4.31
Resolve internal conflicts.	83	1.2%	3.6%	14.5%	34.9%	45.8%	4.20
Play therapy works.	83	0%	2.4%	13.3%	34.9%	49.4%	4.31
Play therapy is therapeutic.	83	0%	3.6%	19.3%	30.1%	47.0%	4.20
Play therapy attitude average	83						4.34

Table 2

Attitude of School Psychology Graduate Trainers Regarding Play and Play Therapy, indicated by Item Response Percentages and Mean

Item	n	Strongly Disagreed (rating=1)	Disagreed (rating=2)	Neutral (rating=3)	Agreed (rating=4)	Strongly Agreed (rating=5)	M
Natural medium of expression.	26	0%	0%	3.8%	42.3%	53.8%	4.50
Resolve unpleasant feelings.	26	3.8%	3.8%	19.2%	42.3%	30.8%	3.92
Resolve internal conflicts.	26	3.8%	11.5%	23.1%	30.8%	30.8%	3.73
Play therapy works.	26	0%	3.8%	30.8%	30.8%	34.6%	3.96
Play therapy is therapeutic.	26	0%	7.7%	30.8%	30.8%	30.8%	3.85
Play therapy attitude average	26						3.99

Table 3

Attitude of Social Work Graduate Trainers Regarding Play and Play Therapy, indicated by Item Response Percentages and Mean

Item	n	Strongly Disagreed (rating=1)	Disagreed (rating=2)	Neutral (rating=3)	Agreed (rating=4)	Strongly Agreed (rating=5)	M
Natural medium of expression.	28	0%	0%	7.1%	21.4%	71.4%	4.64
Resolve unpleasant feelings.	28	0%	0%	10.7%	32.1%	57.1%	4.46
Resolve internal conflicts.	28	0%	0%	17.9%	28.6%	53.6%	4.36
Play therapy works.	28	0%	3.6%	10.7%	39.3%	46.4%	4.29
Play therapy is therapeutic.	28	0%	3.6%	21.4%	28.6%	46.4%	4.18
Play therapy attitude average	28						4.39

Table 4

Attitude of School Counseling Graduate Trainers Regarding Play and Play Therapy, indicated by Item Response Percentages and Mean

Item	n	Strongly Disagreed (rating=1)	Disagreed (rating=2)	Neutral (rating=3)	Agreed (rating=4)	Strongly Agreed (rating=5)	M
Natural medium of expression.	28	0%	0%	0%	17.9%	82.1%	4.82
Resolve unpleasant feelings.	29	0%	0%	3.4%	41.4%	55.2%	4.52
Resolve internal conflicts.	29	0%	0%	3.4%	44.8%	51.7%	4.48
Play therapy works.	29	0%	0%	0%	34.5%	65.5%	4.66
Play therapy is therapeutic.	29	0%	0%	6.9%	31.0%	62.1%	4.55
Play therapy attitude average	29						4.61

As shown in Table 1, graduate trainers reported that, overall, they view play and play therapy as positive for children. There was overwhelming support for the belief that play is the natural medium of expression for children, with over 95% of respondents in agreement. Over 80% agreed that children are able to resolve unpleasant feelings and internal conflicts through play. Over 75% agreed that play therapy works and that play therapy, in and of itself, is therapeutic.

When comparing the three types of programs, there was a significant difference in attitude about play therapy. Descriptive statistics shown in Table 2 through 4 indicate that school counseling trainers rated play therapy most positively, followed by social work trainers, and then school psychology trainers. An ANOVA revealed that there is a significant difference among the average attitude scores about play therapy among the three program types, $F(2,79) = 5.822$, $p = .004$. Post Hoc analyses (Tukey HSD) revealed that the counselor trainers have a significantly more positive attitude about play therapy than school psychology trainers do ($p=.003$).

Each of the five questions that assessed play therapy attitude were analyzed for comparisons among program types. Universal support of one question was revealed, in that over 90% of graduate trainers from each of the three programs agreed that children express themselves through play. However, in analyzing the four questions that assess attitudes about the therapeutic value of play, less agreement was suggested among the three professions. A consistent pattern emerged in that school counseling trainers rated play and play therapy most positively, followed by social work trainers, and then school psychology trainers. When asked about the efficacy of play therapy, 100% of school counselor trainers agreed that play therapy works, while 86% of social work trainers and 65% of school psychology trainers agreed that play

therapy works. It should be noted that, of the remaining social work and school psychology trainers, the majority remained neutral regarding the efficacy of play therapy, with less than four percent indicating that play therapy does not work.

Opinion regarding play therapy courses as part of graduate programs. Graduate trainers were also asked whether play therapy training courses belong in each of the three types of programs. Overall, 87% of trainers indicated that play therapy training courses belong in school counseling programs while 74% of trainers indicated that play therapy training courses belong in social work programs, and 68% of trainers indicated that play therapy training courses belong in school psychology programs. Differences in opinions were revealed between the trainers based on program type. The school psychology trainers were least likely to indicate that play therapy courses belong in school psychology programs with only 48% agreement, while the majority of social work trainers (85%) and school counseling trainers (74%) agreed that play therapy courses belong in school psychology programs. School psychology trainers were also least likely to indicate that play therapy courses belong in social work programs with only 52% agreement, while an overwhelming majority of social work trainers (85%) and school counseling trainers (80%) agreed that play therapy courses belong in social work programs. The majority of trainers from each of the three programs, school psychology (81%), social work (85%), and school counseling (93%) agreed that play therapy courses belong in school counseling programs. Comments made by school psychology trainers helped to clarify their differences in opinion from the other two groups of trainers. The main reason school psychology trainers expressed the opinion that courses in play therapy do not belong in their programs had to do with lack of time within the curriculum. They often recommended play therapy training as an elective or part of another course instead of a full required course. They also reported that play therapy is not

within the typical role of a school psychologist and it is not an evidence-based intervention for the problems that school psychologists typically address. The main reason school psychology trainers expressed the opinion that courses in play therapy do not belong in social work programs had to do with social work programs lacking clinical training. They also reported that an approach like play therapy is not central to the role of a social worker. School psychology trainers were in support of play therapy courses belonging in school counselor programs because they view the main role of the school counselor to be working with young children to enhance their social-emotional well-being.

Reported barriers to play therapy training. A review of the reported barriers to play therapy training further illuminated factors related to attitudes and logistics impacting play therapy training. Results can be viewed in Table 5. Only 25% of trainers indicated that there were no barriers to offering play therapy training. The greatest barrier to play therapy training was reported to be lack of faculty with play therapy expertise (34%), with the second leading barrier involving a lack of time within the curriculum (24%). Other barriers included: funding (17%), research-based reservations about the approach (13%), philosophical reservations about the approach (8%), lack of student interest (7%), and inter-departmental disagreement or turf issues (4%). Trainers who indicated barriers that did not clearly fall into one of these categories (13%) commented on issues involving limited course openings, small program size, use of adjunct faculty, lack of required training, lack of clinical focus, and ignorance. Similarities and differences in barriers were revealed by the type of graduate program. Similar percentages of each program indicated no barriers. The three programs were similar in reporting lack of faculty expertise to be a major barrier. Lack of time with the curriculum was also a leading barrier for each of the three programs. In addition to lack of faculty with play therapy expertise and lack of

time within the curriculum, school psychology trainers indicated two other major barriers involving research-based reservations (39%) and philosophical reservations (19%). By comparison, school counseling trainers and social work trainers indicated very minimal barriers in these two areas. Of the three groups, the social work trainers were more likely to indicate funding (25%) and lack of student interest (14%) to be barriers.

Table 5

Barriers to Play Therapy Training by Program Type

Barriers	School Psychology	Social Work	School Counseling	Total
None	19.2%	25.0%	31.0%	25.3%
Lack of funding	7.7%	25.0%	17.2%	16.9%
No faculty with PT expertise	38.5%	35.7%	27.6%	33.7%
Lack of student interest	0%	14.3%	6.9%	7.2%
Inter-dept. disagreement/turf issues	3.8%	7.1%	0%	3.6%
Philosophical reservations	19.2%	3.6%	3.4%	8.4%
Research-based reservations	38.5%	3.6%	0%	13.3%
Lack of time within curriculum[a]	34.6%	17.9%	20.7%	24.1%
Other	19.2%	10.7%	10.3%	13.3%

Note. PT = Play Therapy.
[a]This barrier was added upon analysis due to a high number of written responses reflecting this concept.

Program characteristics. In considering attitudes about play therapy training, other contributing factors were examined. The type of settings in which program graduates find

employment was examined. Overall, an average of 61% of program graduates were reported to work in public or private schools, 39% in out-patient clinics or agencies, 13% in residential treatment centers or facilities, and 7% in colleges or universities. In reviewing differences across program types, the majority of school psychology graduates (88%) and school counseling graduates (58%) were reported to work in schools, and the majority of social work graduates were reported to work in clinics or agencies (64%). The populations with which graduates generally work was also examined. Overall, an average of 38% were reported to work with adults, 9% with college age individuals, 22% with high school age, 18% with middle school age, 29% with elementary school age, and 10% with preschool age individuals. In looking at differences across program types, the majority of school psychology graduates (52%) were reported to work with elementary age individuals, while the majority of social work graduates (53%) and school counseling graduates (39%) were reported to work with adults. With play therapy being a developmentally appropriate mode of treatment for young children, programs in which a high percentage of graduates work with preschool age and elementary age individuals may be most relevant respondents. School psychology trainers indicated that an average of 63% of their graduates work with preschool or elementary age individuals, while social work trainers indicated that only 23% of their gradates work with this population and school counseling trainers indicated that only 27% of their graduates work with this population.

Relationship between Trainer Attitude and Play Therapy Training

Play therapy offerings related to trainer attitude. Trainers who expressed more positive attitudes about play therapy were generally more likely to offer play therapy training. There was a moderate positive correlation between trainers' average attitude about play therapy and whether they offered play therapy training to their students, either within their program or

through another program at their institution, $r = .40$, $p < .001$. Trainers who expressed more positive attitudes about play therapy were also more likely to offer play therapy training within their own program, rather than through another program at their institution. There was a moderate positive correlation between trainers' average attitude about play therapy and whether they offered play therapy training within their own program, $r = .54$, $p < .001$. Trainers who expressed more positive attitudes about play therapy were also more likely to offer a practicum in play therapy. There was a moderate positive correlation between trainers' average attitude about play therapy and whether they offered a practicum experience in play therapy, $r = .31$, $p = .024$. No further analyses were significant, indicating that trainer attitudes about play therapy were not related to the number of courses offered, the percentage of a course devoted to play therapy, or the likelihood of offering play therapy through another department on campus.

Table 6

Play Therapy Training Offered by Program Type

Offerings	School Psychology n=26	Social Work n=28	School Counseling n=29	Total n=83
Respondents for offering PTT	**n=26**	**n=28**	**n=29**	**n=83**
No PTT offered	34.6%	39.3%	17.2%	30.1%
Some PTT offered	65.4%	60.7%	82.8%	69.8%
PTT in own program	50.0%	46.4%	79.3%	59.0%
PTT in another program	30.8%	32.1%	6.9%	22.9%
PTT in both[a]	15.4%	17.9%	3.4%	12.0%
Respondents for Type of Course	**n=15**	**n=15**	**n=22**	**n=52**
Required Course	6.7%	6.7%	18.2%	11.5%
Elective Course	40.0%	33.3%	31.8%	34.6%
Part of a Required Course	53.3%	20.0%	50.0%	42.3%
Part of an Elective Course	0%	40.0%	0%	11.5%
Respondents for offering PPT	**n=16**	**n=15**	**n=22**	**n=53**
No Practicum in PT	43.8%	46.7%	63.6%	52.8%
Practicum in PT	56.3%	53.3%	36.4%	47.2%
Respondents for Type of PPT	**n=9**	**n=7**	**n=8**	**n=24**
PPT Required if Assigned	11.1%	28.6%	0%	12.5%
PPT Optional	66.7%	71.4%	87.5%	75.0%
PPT Required	22.2%	0%	12.5%	12.5%

Note. PTT = Play Therapy Training; PT = Play Therapy; PPT = Practicum in Play Therapy. Percentages are based on the number of respondents to each survey item.

[a]Indicates the percentage that provided PTT both in their own program and in another program at their institution; explains the overlap between *PTT in own program* and *PTT in another program* which results in the sum of the two being greater than the percentage of *Some PTT offered.*

Comparisons of play therapy offerings among graduate training programs related to attitude. The school counseling trainers expressed the most positive attitude about play therapy. Naturally then, the school counseling trainers outnumbered trainers in the other professions in offering play therapy training. As shown in Table 6, school counseling trainers reported offering play therapy training most often. Over 80% of the school counseling programs participating in this study offered play therapy training to their students, either within the program or through another program at their institution. Comparatively, only 65% of school psychology programs and 61% of social work programs offered play therapy training to their students, either within their program or through another program at their institution. Differences among the three program types were not, however, significant, $\chi^2(2) = 3.652$, $p = .161$. Thus, statistically, program type is unrelated to offering play therapy training, when *offering play therapy training* is defined as offering it within one's own program or through another program at the institution.

Further examination of the data on programs that offered play therapy training within their own program revealed a more pronounced pattern. Almost 80% of school counseling trainers reported offering play therapy training within their own program, while only 50% of school psychology trainers and 46% of social work trainers offered play therapy training within their own program. Although the differences among groups were significant in this case, $\chi^2(2) = 7.647$, $p = .022$, the post hoc analysis (standard residuals) did not yield a significant difference between expected and observed counts for any of the three groups. A trend was identified in that the Standard Residuals for the counseling trainers approached the critical value of 1.96. Specifically, the standard residual of counseling trainers who responded that they provide play therapy training in their program trended toward being high (1.4) and the standard residual of

counseling trainers who responded that they do not provide play therapy training in their program trended toward being low (-1.7). In looking at the type of course offerings in play therapy, school counseling trainers, again, led the three groups. Eighteen percent of school counseling programs offered play therapy as a required course, compared to 7% of school psychology trainers and 7% of social work trainers.

Exceptions to the relationship between attitude and training. There were some exceptions to the strong relationship between trainer attitude about play therapy and offering play therapy training. In the case of the school counseling trainers, their positive attitude about play therapy seemed to correlate with quantifiable play therapy course offerings, but this was not the case for the social work trainers. Even though social work trainers had the second most positive attitude about play therapy of the three groups, they did not seem to rank second in offering play therapy. Specifically, social work trainers were most likely to offer play therapy training as an elective course or part of an elective course, while both school counseling trainers and school psychology trainers most frequently required play therapy training as part of a required course. Also contradicting the hypothesis that attitude relates to training, school counseling programs led in offering play therapy training, but were least likely to offer a practicum experience in play therapy. Of the programs that offered play therapy training, more than half of school psychology and social work programs offered a practicum experience in play therapy, but only 36% of school counseling programs offered such a practicum. However the differences among groups regarding a practicum were not significant, $\chi^2(2) = 1.789$, $p = .409$. Of the programs that offered a practicum experience in play therapy, the practicum was most often optional. The practicum was required in 22% of school psychology programs, 13% of school

counseling programs, and no social work programs. However, over 25% of social work programs required a play therapy practicum if a play therapy case was assigned.

Current Play Therapy Training in Relation to Guidelines

Play therapy offerings. While some interesting between-group results have been discussed, looking at the sample of graduate trainers as a whole offered a broader perspective of play therapy training at the graduate level. As seen in Table 6, when responses were combined for graduate trainers in the areas of school psychology, school counseling, and social work, nearly 70% of trainers reported that they offer some sort of play therapy training to their students, either in their own program or through another department on campus. The majority of trainers offered play therapy training through their own program, while a small percentage offered it through another program at their institution. Of those who offered play therapy training, it was most often provided as part of a required course or through an elective course. When play therapy training was provided as part of a required course, on average, 24% of the course was dedicated to play therapy. When play therapy training was provided through separate, elective course(s), most trainers offered one course, but some offered two or more courses. Only 12% of play therapy trainers provided instruction through a separate required course.

Play therapy instruction measured in contact hours. Table 7 focuses on the trainers for whom the total number of contact hours of play therapy instruction could be calculated. The last column of data describes total responses from all three groups of graduate trainers combined. Overall, the graduate trainers reported an average of 42 total contact hours of play therapy instruction over the course of their programs. However, there was low response to this survey item and a good deal of variability within the sample which can be further examined in the table.

Due to the impact of outliers on the means, the medians may be considered most representative of the results. Overall, the graduate trainers reported a median of 29 total contact hours of play therapy instruction over the course of their programs, suggesting that half of all programs are providing less than 30 hours of play therapy instruction.

Table 7

Overall Contact Hours of Play Therapy Instruction by Program Type

PTT Hours	School Psychology n=7	Social Work n=8	School Counseling n=12	Total n=27
Mean	54.50	28.81	42.74	41.66
SD	77.53	15.99	39.45	47.01
Minimum	4.00	11.00	0.40	0.40
Maximum	222.50	53.00	115.00	222.50
Median	15.00	27.00	29.50	29.00
Mode	4.00[a]	15.00	100.00	15.00

Note. PTT = Play Therapy Training. Garry Landreth recommends 45 clock hours of play therapy instruction. In order to earn the Registered Play Therapist credential, APT requires 150 hours of play therapy instruction, 50 of which may be non-contact hours.
[a] = multiple modes exist. The smallest value is shown.

Comparisons of contact hours between programs. Table 7 also displays the total contact hours of play therapy instruction by type of graduate program. A comparison of the means suggests that the school psychology (M=55) and school counseling (M=43) programs provided more hours of instruction in play therapy than did the social work (M=29) programs. However, there was great variability within the responses for both the school psychology and the school counseling groups. Reported contact hours for school psychology programs ranged from four to 223. Reported contact hours for school counseling programs ranged from less than 1 to 115. With the means for those two groups influenced by outliers, the medians are considered

most representative of the results. A comparison of medians suggests different results, particularly that the school psychology programs (Mdn=15) provided fewer hours of instruction in play therapy than did the school counseling (Mdn=30) and social work (Mdn=27) programs.

Play therapy instruction compared to Landreth's recommendation. As a guideline for play therapy training, Garry Landreth (1991) recommended that practitioners accrue the equivalent of 45 clock hours of instruction in play therapy (p.105-106). A review of frequency data revealed that of those that provide play therapy training, only 30% reported providing at least 45 hours of play therapy instruction, while the majority (70%) of programs provided less than 45 hours of play therapy instruction. A comparison of the three program types revealed that 25% of social work and school counseling trainers and 43% of school psychology trainers reported providing at least 45 hours of play therapy instruction. For each program type, the majority of trainers reported providing less than the number of instructional hours recommended by Landreth. In general, it seems that graduate programs are not offering the number of hours of play therapy instruction recommended by Landreth.

Play therapy instruction compared to APT's requirements. In order to earn the Registered Play Therapist credential, APT requires 150 overall hours of specific instruction in play therapy, 50 of which may be non-contact hours (APT, 2006). A review of frequency data revealed that only 4% of trainers reported providing at least 150 hours of play therapy instruction and only 15% reported providing at least 100 hours of play therapy instruction. The majority of trainers (85%) provided less than 100 hours of play therapy instruction. A comparison of the three program types revealed that 14% of school psychology trainers and 25% of school counseling trainers reported providing at least 100 hours of play therapy instruction. No social work trainers reported providing 100 or more hours of play therapy instruction. For each

program type, the majority of trainers reported providing less than the number of instructional hours recommended by APT. In general, it seems that graduate programs are not offering the number of hours of play therapy instruction recommended by APT.

Table 8

Hours of Play Therapy Training by Content Area and Program Type

PTT Content Areas	School Psychology n=7-10		Social Work n=8-10		School Counseling n=13-14		Total n=7-12	
	M	Mdn	M	Mdn	M	Mdn	M	Mdn
History	5.92	2.00	2.38	2.00	4.89	3.00	4.43	2.00
Theories	17.30	3.00	5.10	4.50	8.04	5.25	9.90	4.25
Techniques/Methods	22.70	9.00	12.05	8.00	18.85	12.00	17.96	10.00
Special Settings/Populations	10.25	4.50	5.78	3.00	10.47	5.50	9.05	5.00

Note. PTT = Play Therapy Training. APT requires 4 hours in the area of History, 40 hours in the area of Theories, 40 hours in the area of Techniques and Methods, and 40 hours in the area of Applications to Special Settings and Populations.

APT further specifies the amount of instruction required in each of the four content areas of play therapy training: history, theories, techniques and methods, and applications to special settings or populations. A comparison of instructional hours in each of the content areas can be seen in Table 8. APT requires a minimum of four contact hours in the component of history. Trainers that offered play therapy reported a mean of 4.43 and a median of 2.00 contact hours of instruction in the history of play therapy over the course of their program. A review of frequency data revealed that only 29% of trainers reported providing at least 4 hours of play therapy instruction in history, while the majority (71%) of trainers provided less than 4 hours of play therapy instruction in this area.

APT requires a minimum of 40 contact hours in the theories component. Trainers that offered play therapy reported a mean of 9.90 and a median of 4.25 contact hours of instruction in the theories of play therapy over the course of their program. A review of frequency data revealed that only 6% of trainers reported providing at least 40 hours of play therapy instruction in theories, while the majority (94%) of trainers provided less than 40 hours of play therapy instruction in this area.

APT requires a minimum of 40 contact hours in the techniques and methods component. Trainers whose programs offered play therapy training reported a mean of 17.96 and a median of 10.00 contact hours of instruction in techniques and methods of play therapy over the course of their program. A review of frequency data revealed that only 9% of trainers reported providing at least 40 hours of play therapy instruction in techniques and methods, while the majority (91%) of trainers provided less than 40 hours of play therapy instruction in this area.

APT requires a minimum of 40 contact hours in the component of applications to special settings or populations. Trainers that offered play therapy reported a mean of 9.05 and a median of 5.00 contact hours of instruction in applications of play therapy to special settings or populations over the course of their program. A review of frequency data revealed that only 6% of trainers reported providing at least 40 hours of play therapy instruction in applications to special settings and populations, while the majority (94%) of trainers provided less than 40 hours of play therapy instruction in this area.

Also displayed in Table 8 is a comparison of instruction in the four play therapy content areas for each of the three types of graduate programs. All three groups of graduate trainers reported spending the least amount of time training in the area of history, though this is within APT expectations. All programs also spent less time training in the areas of theories and

applications to special settings or populations, though APT recommended much more training in those areas. All three groups seemed to emphasize training in the area of techniques and methods, although only a small percentage of school psychology (20%) and school counseling (8%) programs provided the 40 hours recommended by APT as a minimum in this area. No social work programs provided the 40 recommended hours in this area.

Play therapy practicum compared to APT requirements. As displayed in Table 6, of the programs that offer play therapy training, about half offer a practicum experience in play therapy. Most often the play therapy practicum is optional, by student choice. Only 13% of those that offer a practicum in play therapy, require it as part of their program. In order to earn the Registered Play Therapist credential, APT requires 500 hours of supervised play therapy experience, which includes 50 hours of play therapy supervision (APT, 2006). Trainers that offer a play therapy practicum reported an average of 68.91 hours of play therapy practicum experience (Mdn=60.00), including supervision, with hours ranging from nine to 140. Trainers that offer a play therapy practicum reported an average of 16.91 hours of play therapy supervision (Mdn=15.00), with hours ranging from three to 30. Although the amount of experience and supervision varied greatly among the few trainers who reported hours related to play therapy practica, none of the trainers reported offering the required number of practicum or supervision hours.

Current Play Therapy Approach

Respondents who provided play therapy training selected one of six categories that they judged to best describe their primary approach to play therapy training. A selection of *other* was also available. Table 9 reflects the primary play therapy approaches reported by graduate trainers. Of those who offered play therapy training, nearly 65% provided general overviews of

several play therapy approaches, 31% provided an approach that was considered non-directive, child-centered, or relationship therapies, and 2% provided an approach that was considered psychodynamic. No respondents indicated that their primary approach was behavioral, cognitive-behavioral, developmental, Theraplay®, or filial.

In looking at the play therapy approaches by program type, differences among the groups are suggested. Over 70% of the social work and school counseling programs provided general overviews of several play therapy approaches, while about 20% of these programs provided training in approaches that were considered non-directive, child-centered, or relationship therapies. Sixty percent of school psychology programs favored the non-directive, child-centered or relationship therapies approaches, while the remaining 40% provided general overviews of several play therapy approaches. A small percentage of school counseling trainers provided instruction in an approach that is considered psychodynamic. A small percentage of social work trainers indicated that their primary approach was unknown.

Table 9

Primary Play Therapy Training Approach by Program Type

PTT Approach	School Psychology n=15	Social Work n=14	School Counseling n=22	Total n=51
General Overview	40%	71.4%	77.3%	64.7%
Non-directive, Child-Centered	60%	21.4%	18.2%	31.4%
Psychodynamic	0%	0%	4.5%	2.0%
Behavioral, Cognitive-Behavioral	0%	0%	0%	0%
Developmental, Theraplay®	0%	0%	0%	0%
Filial	0%	0%	0%	0%
Other	0%	7.1%	0%	2%

Note. PTT = Play Therapy Training. The respondent who selected the *Other* category indicated that the specific play therapy approach was "unknown".

Differences in Play Therapy Training Compared to Previous Research

Comparisons were made between the current (2007) sample of school psychology trainers and those from a study conducted in 1997 (Cerio et al., 1997). Comparisons were also made between the current (2007) sample of school counseling trainers and those from a study conducted in 1999 (Cerio et al., 1999). Results are displayed in Table 10. It is important to note that since percentages in previous studies were based on the total sample size, percentages from the current study (2007) were calculated in that way for the purposes of comparison.

Table 10

Play Therapy Training Offered by Two Program Types across Several Years

Offerings	School Psychology 1997 n=54	School Psychology 2007 n=26	School Counseling 1999 n=117	School Counseling 2007 n=29
No PTT offered	54%	35%	39%	17%
Some PTT offered	43%	65%	55%	83%
NR regarding offering PTT	3%	0%	7%	0%
Required Course	11%	4%	3%	14%
Elective Course	9%	23%	9%	24%
Part of a Required Course	15%	31%	21%	38%
Other	---	0%	6%	0%
Practicum in PT offered	20%	35%	15%	28%

Note. PTT = Play Therapy Training; All percentages are based on the total number of participants in each of the four samples.

School psychology program comparisons. In 1997 school psychology trainers (n=54) were surveyed, and 43% reported offering some sort of play therapy training (Cerio et al., 1997). In 2007 school psychology trainers (n=26) were surveyed, and 65% reported offering some sort of play therapy training. The difference in frequency of play therapy training for school psychology programs was tested using chi-square. The results revealed a trend suggesting that the frequency of offering play therapy training increased between 1997 and 2007, $\chi^2(1) = 3.16$, $p < .10$.

Respondents also provided information about the type of play therapy instruction provided. Of the 1997 school psychology trainers, 11% required a course in play therapy, 9% offered an elective course in play therapy, and 15% offered play therapy training as part of a

required course. Of the 2007 school psychology trainers, 4% required a course in play therapy, 23% offered an elective course in play therapy, and 31% offered play therapy training as part of a required course. It seems that although more school psychology programs may be offering play therapy training now than in 1997, the training provided is less likely to be in the form of a required course devoted to play therapy. In looking at the play therapy approach that is offered in school psychology programs, it seems that a nondirective or child-centered approach became more prevalent by 2007.

Twenty percent of the 1997 school psychology trainers reported providing a practicum in play therapy, compared to 35% of the 2007 respondents.

School counseling program comparisons. In 1999 school counseling trainers (n=117) were surveyed, and 55% reported offering some sort of play therapy training (Cerio et al., 1999). In 2007 school counseling trainers (n=29) were surveyed, and 83% of them reported offering some sort of play therapy training. The difference in frequency of play therapy training for school counseling programs was tested using chi-square. Results were significant, indicating that the frequency of offering play therapy training among school counseling trainers increased between 1999 and 2007, $\chi^2(1) = 5.72$, $p < .05$.

Respondents also provided information about the type of play therapy instruction provided. Of the 1999 school counseling trainers, 3% required a course in play therapy, 9% offered an elective course in play therapy, and 21% offered play therapy training as part of a required course. Of the 2007 school counseling trainers, 14% required a course in play therapy, 24% offered an elective course in play therapy, and 38% offered play therapy as part of a required course. It seems that, as the percentage of school counseling programs that offer play therapy training has increased, the percentage that offer required courses devoted to play therapy

has also increased. In looking at the play therapy approach that school counseling students are trained in, it seems that providing a general overview of several approaches has remained most prevalent over time.

Fifteen percent of the 1999 school counseling trainers reported providing a practicum in play therapy, while 28% of the 2007 respondents reported providing a practicum in play therapy.

Chapter Four: Discussion

The Current State of Play Therapy Training

Across school psychology, social work, and school counseling graduate programs, the majority of graduate trainers reported offering training in play therapy to their students. This training usually occurred within their own programs, rather than through other programs at their institution. This finding was especially true for the school counseling trainers, who, of the three training groups, were the most likely to offer play therapy training within their own program. Play therapy training was usually provided as an elective course, or part of a required course. Few programs offered a separate required course devoted to play therapy. Half of all programs provided less than 30 hours of play therapy instruction. The majority of these hours were focused on instruction in the area of techniques and methods. Regarding play therapy approach, most trainers provided either a general overview of several play therapy approaches or taught an approach that was considered non-directive, child-centered, or relationship therapies. A comparison of programs revealed that the majority of social work and school counseling programs provided general overviews, while the majority of school psychology programs provided an approach that was considered non-directive, child-centered, or relationship therapies. Of those that offered play therapy training, about half offered a practicum experience in play therapy. The practicum experience was most often optional, by student choice.

The majority of trainers reported that their programs offer some amount of play therapy training to their students, either within the program or through another program at the institution. However, the majority of programs do not appear to be offering the number of instructional hours recommended by Landreth or APT. In addition, they do not offer the number of practicum and supervision hours required. It seems clear that if graduate students desire to obtain training

in play therapy that meets the standards of Landreth or APT, they will likely have to seek additional training and practicum experiences in play therapy outside of their graduate programs.

Trainer Attitudes

Graduate trainers indicated that, overall, they generally view play therapy as positive. Among the three groups of trainers, counselor trainers expressed the most positive attitudes about play therapy while school psychology trainers expressed the least positive attitudes. The school psychology trainers were least likely to report that play therapy courses belong in school psychology programs, mainly due to lack of time within the curriculum. The school psychology trainers were also least likely to report that play therapy courses belong in social work programs, mainly due to lack of clinical focus. However, social work and school counseling trainers agreed that play therapy belongs in school psychology programs and social work programs. The majority of trainers from each of the three programs agreed that play therapy belongs in school counseling programs.

The differences in attitudes may be due to several factors. Characteristics of the program may affect how relevant play therapy is to the work of a particular professional group. In reviewing differences across program types, the majority of school psychology and school counseling graduates were reported to work in schools, and the majority of social work graduates were reported to work in clinics or agencies. There were also differences in the age groups served by the different professions. The majority of school psychology graduates were reported to work with elementary age individuals, while the majority of social work graduates and school counseling graduates were reported to work with adults. Since play therapy is a developmentally appropriate mode of treatment for young children, programs in which a high percentage of graduates work with pre-school and elementary-age individuals may be most relevant

respondents. More school psychology trainers indicated that their graduates work with pre-school or elementary age individuals, while fewer social work and school counseling trainers indicated that their graduates work with this population.

It is interesting that the school psychology trainers, who are most likely to prepare practitioners to work with an elementary school population, expressed the least positive attitude about play therapy, a mode of treatment that is considered developmentally appropriate for this population. It is likely that because this population makes up a large percentage of their client base, they feel a responsibility to be more discriminating in evaluating modes of treatment that are suggested for young children. They may instead lean toward behavioral interventions because of greater familiarity with the research in this area. School psychology trainers may also prefer behavioral interventions that appear to more quickly affect externalizing behavior, and that are useful in the more indirect role of the school psychologist in teacher consultation. Additionally, with high demands for time within the school psychology curriculum in preparing students to work with this population in a variety of capacities, strong justification is needed for training outside of areas specifically required for certification. Thus, lack of familiarity with recent research in the field of play therapy may have a greater impact on the attitude of school psychology trainers because they have already-established philosophies and methods for training practitioners to intervene with children.

It is also interesting that the school counseling trainers, who reported that they generally prepare practitioners to work with adolescents or adults, expressed the most positive attitude about play therapy. School counseling programs tend to focus training on counseling approaches that are appropriate across the lifespan. School counseling training may also be provided as a "track" in a general counseling master's program, thus emphasizing skills for working with

adolescents and adults. Since providing services to elementary students is not a major focus of school counseling training, trainers may tend to be more open-minded and generous in their attitude about treatments for young children. With lower vested interest in the population, they are willing to expose their students to various approaches for working with young children, regardless of their familiarity with the research on these approaches. Also, counseling programs generally view the primary goal of their graduates to be enhancing the social-emotional well-being of their clients. Even though they prepare their graduates to provide services across the lifespan, their goal is very much in line with the goal of play therapy, which would lead to an enhanced attitude about play therapy.

The play therapy approach that is taught in programs may also be a factor in influencing attitudes regarding play therapy. Most school counseling and social work programs relied primarily upon a general overview of several play therapy approaches. The majority of school psychology programs favored the non-directive, child-centered or relationship therapies approach. While all three groups expressed a generally positive attitude regarding play therapy, it seemed that the school psychology trainers, who favor a child-centered approach, did not endorse play therapy as strongly as those that favored a more general overview of play therapy. When average attitude ratings were compared for those that offered a child-centered approach to those that offered a general overview of play therapy, regardless of program type, differences in attitudes were not suggested.

Thus, there is likely a third variable that accounts for the difference among programs in attitude and in a preferred play therapy approach. Due to the nature of the role of the school psychologist, trainers from those programs are most likely to focus on data-based decision making and implementing a protocol with fidelity. Also, in recent years, legislation has pushed

for accountability and evidence-based intervention in working with school children. School psychology trainers have risen as leaders in this regard. It makes sense that the school psychology trainers were most likely to select a specific play therapy approach to teach, rather than exposing their students to a variety of play therapy approaches. It also makes sense that they selected the non-directive approach which has the largest research base. However, when compared to other intervention approaches with which they are familiar (i.e., behavioral), the research on play therapy is not as extensive. School psychology trainers listed research-based reservations as one of their top barriers to offering play therapy training. The relatively limited research on play therapy likely influences their attitude about the approach. It is also likely that a program that commits to a specific play therapy approach feels a higher responsibility to insure its treatment value. A program that merely exposes students to an overview of several play therapy approaches may not see a need to fully explore the research base.

Barriers to play therapy training reflect attitudes about the approach, as well as, logistical issues. The greatest barrier to play therapy training was reported to be lack of faculty with play therapy expertise. The second greatest barrier to play therapy training was reported to be lack of time within the curriculum. It seemed that school psychology trainers were more affected by limited time within the curriculum, than were social work or school counseling trainers. This is likely due to the increasing requirements for program approval by NASP. NASP introduced 11 Domains of School Psychology Training and Practice in 2000, and by 2010 they had organized 10 domains of practice into a Model for Comprehensive and Integrated School Psychological Services (NASP, 2010). With the comprehensive role of the school psychologist incorporating various areas of competency (e.g., assessment, academic and behavioral interventions, consultation, prevention), only one aspect of the model focuses on mental health services to

develop social and life skills, which would include all counseling-based service delivery approaches. With the high demand for other areas of competency, there is limited room in the curriculum for counseling-based training, let alone a specific approach such as play therapy. In addition to the two main barriers of faculty and time, school psychology trainers indicated a third main barrier involving research-based reservations. A very small percentage of social work programs and no school counseling programs indicated research-based reservations. Possible reasons for this finding were discussed earlier in this section.

It is not surprising that trainers who have more positive attitudes about play therapy are generally more likely to offer play therapy training. They are also more likely to offer play therapy training within their own program, and to offer a practicum in play therapy. School counseling trainers have the most positive attitudes about play therapy and are most likely to offer play therapy training within their own program. However, they were least likely to offer a practicum experience in play therapy. This could be due to the fact that most programs emphasize preparation for working in middle school and high school settings, where most of the counseling positions are, and thus place trainees in practicum and field experiences in these types of settings in which play therapy would not be used. Only counseling graduate students who select an early childhood or elementary track within their programs would likely receive practicum experiences in play therapy. In addition, trainers may view the practicum as a general experience in which a trainee may use play therapy occasionally, but not consider it a “play therapy practicum” experience. Thus, they may under-report these types of practicum hours. Future research could explore this discrepancy within school counselor training.

Changes from Previous Research

Comparing the findings of this survey to the previous survey of school psychology programs (Cerio et al., 1997), current school psychology trainers showed a trend toward somewhat higher frequency of offering some form of play therapy training. However, the percentage of school psychology programs offering a required course in play therapy has decreased, while the percentage of school psychology programs offering a practicum in play therapy has increased. Although it seems that play therapy training has become more frequent in school psychology programs, it is not a major focus of the training. This is likely due to two factors, one being the previously discussed research-based and philosophical reservations regarding the approach, and the second being the previously discussed increasing requirements for program approval by NASP.

Comparing the findings of this survey to the previous survey of school counseling programs (Cerio et al., 1999), the current school counseling trainers showed a significantly higher frequency of play therapy training. The percentage of school counseling programs requiring a course in play therapy has increased, as has the percentage offering a practicum experience in play therapy. Some notable growth in play therapy training has occurred among school counseling program, reflecting the focus on provision of direct counseling services as the primary role of counselors. As the research in play therapy has grown, counseling trainers have become even more open to the approach. Though they report that their graduates most often provide services to adolescents and adults, their broader role focuses on counseling services across the lifespan, which would include reaching young children.

There was no available survey of play therapy training within social work programs with which to compare the current findings. However, when play therapists were surveyed, social

workers were second to counselors in providing play therapy (Ryan et al., 2002; Lambert et al., 2007). Thus, it is important to include the social work discipline in research about play therapy training and practices. The current study is the first to survey social work training programs about the training they provide in play therapy, and will serve as a baseline comparison for future studies.

Limitations

Several limitations of this study impact its utility. A primary limitation is the sample size. While the overall number of respondents was satisfactory in making general conclusions, once divided into program type, each group had less than thirty respondents. When considering only those that actually provide training in play therapy, the number decreased even more. In order to answer questions regarding what type of play therapy training was provided, approximately 18 respondents were relied upon for each of the three program types, while only 8 respondents from each profession provided information about play therapy practicum experiences. The variability in responses among a small number of respondents made it difficult to draw conclusions about the sample. In some cases, a comparison of means or percentages among program types was difficult due to low numbers of responses. The small sample size may have prevented differences among groups from reaching statistical significance.

The overall response rate for the survey was under 30%. This raised questions about possible differences between trainers who returned the survey and those who did not. Though efforts were made to distribute the survey to a random selection of graduate programs, trainers may have self-selected in responding to the survey, thus interfering with the attempt at random selection. Factors related to a program's decision to return the survey may have introduced bias into the results. It is likely that trainers from programs that did not offer play therapy training

were less likely to return the survey, having less of a vested interest in the topic. This would produce an overrepresentation of play therapy training based on survey results. It is also likely that trainers from programs that held strong views regarding training priorities were more likely to complete the survey, resulting in polarized responses. However, all of these factors related to self-selection bias would have also been present in the previous studies (Cerio et al., 1997; Cerio et al. 1999). Thus, comparisons between previous studies and the current study can be made with relative confidence.

The surveys of school counseling programs were distributed to counseling programs that are listed by ASCA, suggesting that they focus on school counseling. However, the respondents may have answered questions based on the perspective of their general counseling program, rather than a school counseling program. This would result in less specificity and consistency among respondents.

Another issue was limited access to the raw data from previous research for comparison. Consideration was given to using a parametric statistical analysis to compare the proportion of those offering play therapy training in the past to the proportion of those offering play therapy training currently. However, due to lack of information on variance and small and/or different sample sizes, this could not be done with confidence. A nonparametric chi-square was selected instead and computed for the main variable in which raw scores could be calculated. For all other variables, comparisons between previous studies and the current study were limited to a qualitative report on percentages.

Also, there was no previous study available for comparison of play therapy training in social work programs. While trends in play therapy training can be suggested for school

psychology and school counseling programs, no such trends can be suggested for social work programs.

The survey design may also have deterred some programs from completing it fully. The survey consisted of four pages of questions, which may have seemed time consuming. Stop points were inserted following key questions to omit needless responses. However, several respondents (two to three per program) stopped at stop points when they shouldn't have. They either misinterpreted the stop points or decided to stop answering questions at that point. It is possible that respondents decided to stop answering questions because they lacked the knowledge of their program's play therapy training that was needed to respond to subsequent questions. There also seemed to be some confusion regarding survey question number six, which asked whether play therapy courses belong in each of the three types of graduate programs. Regardless of their program type, respondents were expected to provide their opinion regarding play therapy training as part of each of the three program types. Several respondents only provided their opinion regarding play therapy training belonging in their program type.

The position of the professional completing the survey may have impacted results as well. The survey was sent to directors or chairpersons of the graduate programs, but may have been passed on to faculty members to complete. It is likely that program directors completed surveys with objectivity, but less specific knowledge of play therapy training. Faculty who provided play therapy training likely completed surveys with a favorable bias and a high level of knowledge of play therapy training. Some restrictions to ensure consistency in the position of the professional completing the survey would have been useful.

When asking about barriers to play therapy training, respondents were asked to select any that applied to their program from a list of seven. An *other* category was provided with a space

for comments. Several respondents wrote in a barrier that was not listed involving *lack of time within their curriculum.* Though an additional variable was added to reflect these responses, had this barrier been predicted and incorporated into the list initially, more respondents may have selected it.

Implications for Future Research

Several aspects of play therapy training should be explored further. The differences in attitude about play therapy and the play therapy approach that was taught, by type of graduate training program were discussed. It was found that school psychology trainers, who expressed the least favorable attitude about play therapy, were most likely to select a non-directive approach to play therapy training, rather than provide a general overview of several play therapy approaches. It was suggested that the importance of research-based practices mediated the selection of an approach and the attitude about it. However, certain follow-up questions would help to clarify the results. Future research should further explore factors that impact the selection of a play therapy approach, including how familiar trainers are with the research in the field.

It would also be valuable to expand the research on the effectiveness of play therapy. Focusing research on specific play therapy approaches and specific client populations would be of interest. Also, further exploring the effects of group play therapy and shorter-term play therapy would be valuable.

An unexpected finding was that the school counselor trainers, who expressed the most favorable attitude about play therapy and were most likely to provide play therapy training within their own program, were least likely to provide a practicum experience in play therapy. Additional research on the availability and focus of school counseling practica would put this finding into perspective. It would also be interesting to survey current graduates from these

programs to assess their use of play therapy in their positions, and also their perceptions of their training to prepare them for this work.

Implications for Training

Graduate programs today are training practitioners to address a wide range of needs. School psychology trainers prepare graduates to work with a school-age population providing academic and social-emotional intervention. Social work trainers prepare graduates to work with all ages providing social-emotional intervention as well as linkage with community resources. School counseling trainers prepare graduates to work with school-age and adult populations, providing social-emotional intervention as well as career planning. Graduate trainers need to determine to what extent their graduates will work with children in a direct-service capacity to address social-emotional needs. To meet these needs, graduates need to be well-trained in a treatment modality specific to children. Play therapy is a modality that reaches children, but it is not being fully utilized.

With regard to the amount of training, Landreth (1991) recommends 45 clock hours of instruction in play therapy and APT requires 100 contact hours of instruction in play therapy. Graduate trainers do not appear to be providing training that satisfies Landreth's recommendation or APT's requirement. To meet APT's requirements, most programs would need to more than double their hours of play therapy instruction. More specifically, they would need to increase their training in the content areas of: history, theories, techniques and methods, and applications to special settings and populations. In addition to play therapy instruction, APT requires 500 hours of supervised play therapy experience (including 50 hours of supervision). This would be the equivalent of a three month long, full-time practicum, and a significant increase in hours from the experience that is generally offered during graduate training. Given

the high demands on time within graduate training curriculums, it may not be realistic for trainers to increase the amount of play therapy training so significantly. Even if graduate trainers choose to do this, they will likely need to link interested students with summer or post-graduate opportunities for accruing hours toward earning the Registered Play Therapist credential through APT.

Of the three disciplines, it seems that school counseling training programs that focus on early childhood issues would be in the best position to increase the amount of play therapy training. They have a positive attitude about play therapy and may be able to overcome their barriers. It may also be relevant for social work programs to increase play therapy training, especially those that focus on early childhood or family work. In increasing their play therapy training, both disciplines should focus on training in a child-centered approach to increase therapist effectiveness. School psychology training programs are least likely to increase their play therapy training due to both time constraints and reservations about the approach. However, if school psychology trainers familiarize themselves with the play therapy research and consider its implications, they may come to view it as a valuable treatment modality. Since school psychologists are most likely to work with children and are skilled at implementing an intervention with fidelity to the model, play therapy would be an ideal social-emotional intervention for them to use.

Regardless of their mental health discipline, graduate trainers need justification to advocate for inclusion of play therapy within their tightly packed curriculums. The available research on the effectiveness of play therapy should be used to provide a compelling rationale for trainers to provide the level of play therapy training required. Efforts should be made to draw direct connections between play therapy outcomes and priorities of the graduate program. If

play therapy is shown to be effective with problems that practitioners typically address, trainers may come to view it as more central to the role of their professions. For example, the potential impact that remediating early social-emotional concerns in elementary school has on preventing behavioral and academic needs in later years could be highlighted. Expanding the research on the effectiveness of play therapy in this regard is recommended.

Research should focus on comparing specific play therapy approaches to other counseling approaches and behavioral interventions in working with particular populations. It should also further explore the effectiveness of shorter-term play therapy and group play therapy to appeal to those concerned with time constraints of the job. To make the research more visible, it should be submitted for publication in broad-reaching counseling, social work, and psychology journals, rather than primarily in books and journals dedicated to play therapy. The play therapy research should also be submitted for presentations at conferences of the national associations.

Once committed to providing sufficient training in play therapy, trainers also need to recruit competent play therapy instructors. APT should facilitate access to instructors by providing graduate programs with a list of individuals qualified to provide play therapy training. In a time when the focus is on evidence-based practices and accountability, clear justification and access to resources are needed to advocate for proper training in a specific treatment modality.

Summary and Conclusions

The purpose of this study was to investigate current play therapy training practices of school psychology, school counseling, and social work graduate programs. The results suggest that over the past 15 years, there is a growing group of trainers in all three of these professions who see some benefit in exposing graduate students to play therapy as a tool for working with

children. However, format and amount of training that is offered is not adequate for realistically preparing trainees to become competent in the use of play therapy. If trainers in these professions truly want to prepare their students to provide services to the broad range of potential clients they will encounter, then they should consider including more substantial training and field experiences in play therapy. After all, as they have overwhelmingly agreed, play is the natural medium of expression of children.

References

Allen, F. (1942). *Psychotherapy with children.* New York; Norton.

Association for Play Therapy (2006). *Guide: RPT/S credentialing program.* Retrieved November 7, 2006, from http://www.a4pt.org/download.cfm?ID=12426.

Axline, V. M. (1947). *Play therapy.* New York: Ballantine Books.

Baggerly, J. N., Ray, D. C., & Bratton, S. C. (Eds.) (2010). *Child-centered play therapy research: The evidence base for effective practice.* Hoboken, New Jersey: John Wiley & Sons, Inc.

Bratton, S. C., & Ray, D. C. (2000). What the research shows about play therapy. *International Journal of Play Therapy, 9,* 47-88.

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

Cerio, J. (2000). *Play therapy: A do-it-yourself guide for practitioners.* Alfred, New York: Alfred University Press.

Cerio, J., Taggart, M. T., & Costa. L. (1997, November). *Play therapy training practices for school psychologists.* Paper presented at the annual convention of New York Association of School Psychologists, White Plains, New York.

Cerio, J., Taggart, T, & Costa, L. (1999). Play therapy training practices for school counselors: Results of a national survey. *The Journal for the Professional Counselor, 14*(1), 57-67.

Freud, A. (1946). *The psychoanalytic treatment of children.* London, England: Imago.

Freud, S. (1909/1955). *The case of "Little Hans" and the "Rat Man".* London, England: Hogarth Press.

Ginott, H. (1961). *Group psychotherapy with children: The theory and practice of play therapy.* New York: McGraw-Hill.

Guerney, B. G., Jr. (1964). Filial therapy: Description and rationale. *Journal of Consulting Psychology, 28*(4), 303-310.

Guerney, L. (1979). Play therapy with learning disabled children. *Journal of Clinical Child Psychology, 9,* 242-244.

Guerney, L. (1997). Filial therapy. In K. J. O'Connor & L. M. Braverman (Eds.), *Play therapy theory and practice: A comparative presentation* (pp. 131-159). New York: John Wiley & Sons, Inc.

Hug-Hellmuth, H. (1921). On the technique of child analysis. *International Journal of Psychoanlaysis, 2,* 287.

Jernberg, A. M., & Booth, P. B. (2001). *Theraplay: Helping parents and children build better relationships through attachment-based play, 2nd ed.* San Francisco, CA: Jossey-Bass.

Johnson, L., McLeod, E. H., & Fall, M. (1997). Play therapy with labeled children in the schools. *Professional School Counseling, 1*(1), 31-35.

Klein, M. (1955). The psychoanalytic play technique. *American Journal of Orthopsychiatry, 25,* 223-237.

Knell, S. M. (1997). Cognitive-behavioral play therapy. In K. J. O'Connor & L. M. Braverman (Eds.), *Play therapy theory and practice: A comparative presentation* (pp. 79-99). New York: John Wiley & Sons, Inc.

Kottman, T. (1997). Adlerian play therapy. In K. J. O'Connor & L. M. Braverman (Eds.), *Play therapy theory and practice: A comparative presentation* (pp. 310-340). New York: John Wiley & Sons, Inc.

Lambert, S. F., LeBlanc, M., Mullen, J. A., Ray, D., Baggerly, J., White, J., & Kaplan, D. (2007). Learning more about those who play in session: The national play therapy in counseling practices project (phase 1). *Journal of Counseling and Development, 85,* 42-46.

Landreth, G. L. (1991). *Play therapy: The art of the relationship.* Bristol, Pennsylvania: Accelerated Development.

LeBlanc, M., & Ritchie, M. (2001). A meta-analysis of play therapy outcomes. *Counseling Psychology Quarterly, 14*(2), 149-163.

Moustakas, C. (1955). Emotional adjustment and the play therapy process. *Journal of Genetic Psychology, 86,* 79-99.

National Association of School Psychologists (2010). *Model for Comprehensive and Integrated School Psychological Services, NASP Practice Model Overview.* [Brochure]. Bethesda, MD: Author. This brochure is based on the NASP 2010 standards.

Pehrsson, D. E., & Aguilera, M. E. (2007). *Play therapy: Overview and implications for counselors.* Alexandria, VA: American Counseling Association.

Post, P. (1999). Impact of child-centered play therapy on self-esteem, locus of control, and anxiety of at-risk 4th, 5th, and 6th grade students. *International Journal of Play Therapy, 8*(2), 1-18.

Ray, D. C. (2006). Evidence-based play therapy. In C. E. Schaefer & H. G. Kaduson (Eds.), *Contemporary play therapy: Theory, research, and practice* (pp. 136-157). New York, NY: Guilford Publications.

Ray D. C., Armstrong, S. A., Warren, E. S., & Balkin, R. S. (2005). Play therapy practices among elementary school counselors. *Professional School Counseling, 8*(4), 360-365.

Ray, D. C., Bratton, S. C., Rhine, T., & Jones, L. (2001). The effectiveness of play therapy: Responding to the critics. *International Journal of Play Therapy, 10*(1), 85-108.

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

Ryan, S. D., Gomory, T., & Lacasse, J. R. (2002). Who are we? Examining the results of the Association for Play Therapy membership survey. *International Journal of Play Therapy, 11*, 11-41.

Shaeffer, C. E., & Reid, S. E. (1986). *Game play: Therapeutic use of childhood games.* New York: John Wiley & Sons, Inc.

Taft, J. (1933). *The dynamics of therapy in a controlled relationship.* New York: Macmillan.

Taggart, T. & Cerio, J. (1996). School psychologists and play therapy: Results of a national survey. Unpublished manuscript, Department of School Psychology, Alfred University, Alfred, NY.

Appendix A:

Play Therapy Training Survey

Directions: Please respond to the items below.

Information About Respondent

Age: _____ Sex: _____ Years in the Field: _____

Position of Person Responding (check any that apply):
___ Program Director or Department Chair
___ Instructor of play therapy courses
___ Faculty member who does not teach play therapy
___ Dean of _____
___ Other: _____

General Information About Program

1) Indicate the degree(s), number of credits hours required, and number of contact hours required in practicum and/or internship:

Degree	# Credit Hrs.	Practicum Contact Hrs.	Internship Contact Hrs.
__M.A./M.Ed	_____	_____	_____
__M.A./C.A.S.	_____	_____	_____
__Ed.S.	_____	_____	_____
__M.S.W.	_____	_____	_____
__Ph.D.	_____	_____	_____
__Psy.D.	_____	_____	_____
__Ed.D.	_____	_____	_____
__D.S.W.	_____	_____	_____
__Other_____	_____	_____	_____

2) Number of students enrolled in program
Full-time: Master's_____ Doctoral_____
Part-time: Master's_____ Doctoral_____

3) Setting
State: _____
Location: _____ Urban _____ Suburban _____Rural
Type of College/University (Check one in each column.)
_____ Public _____ College
_____ Private _____ Small University (4 colleges or less)
_____ Comprehensive University (more than 4 colleges/schools)

Enrollment of College/University
_____ Under 2,000 _____ 10,001-20,000
_____ 2,000-5,000 _____ Greater than 20,000
_____ 5,001-10,000

4) In general, in what types of settings, and with what types of populations do your program graduates work?
Please indicate the approximate percentage of graduates in each category below.

Setting	Population
_____% Public or Private School	_____% Pre-school age
_____% Out-patient Clinic or Agency	_____% Elementary age
_____% Residential Treatment	_____% Middle School age
_____% College/University	_____% High School age
	_____% College age
	_____% Adult

Attitudes Regarding Play Therapy

5) To share your general attitudes toward play therapy, please complete the items below. Use the following ratings:
1=Strongly Disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree

A) Play is the natural medium of expression for children. **1 2 3 4 5**

B) Children are able to resolve unpleasant feelings through play. **1 2 3 4 5**

C) Children are able to resolve internal conflicts through play. **1 2 3 4 5**

D) I think play therapy works. **1 2 3 4 5**

E) Play therapy, in and of itself, is therapeutic. **1 2 3 4 5**

6) Do you think courses in play therapy belong in the following training programs?

School Psychology: _____Yes _____No
Why or why not?

School Counseling: _____Yes _____No
Why or why not?

Social Work: _____Yes _____No
Why or why not?

7) What barriers to offering play therapy training exist in your program or at your institution? (check all that apply)

_____None.
_____ Lack of funding.
_____ No faculty with play therapy expertise.
_____ Lack of student interest.
_____ Inter-departmental disagreement/turf issues.
_____ Philosophical reservations about the approach.
_____ Research-based reservations about the approach.
_____ Other: _____
Comments:

8) Do you provide play therapy instruction in your program?

_____Yes
_____ No

9) Are courses in play therapy available to your students through other departments on campus?

_____ Yes. What department(s)?_____
_____ No

If you responded **"yes" to item #8 or item #9, please complete items 10-14 to further describe the training in play therapy.*
If you responded **"no" to both item #8 and item #9, please stop here.*

Play Therapy Training Provided

10) Please indicate the primary approach to play therapy that is provided. (check one)

_____ General overview of several play therapy approaches.
_____ Non-directive, child-centered, relationship therapies.
_____ Psychodynamic, psychoanalytic, object relations therapies.
_____ Behavioral, cognitive-behavioral approaches.
_____ Developmental, Theraplay®.
_____ Filial approaches.
_____ Other: _____

11) How is this instruction provided:

_____ Separate required course(s) devoted to play therapy. How many?_____
_____ Separate elective course(s) devoted to play therapy. How many?_____
_____ Part of a required course. What percentage of course is dedicated to play therapy?_____
_____ Part of an elective course. What percentage of course is dedicated to play therapy?_____
_____ Other: _____

12) Please estimate the number of contact hours provided in each of the following components of play therapy training?

_____History _____Techniques and Methods
_____Theories _____Applications to Special Settings or Populations

13) What is the level of expertise of the instructor who provides play therapy training? (respond to all that apply)

A) Training in Play Therapy:

_____ Course(s) _____ Readings
_____ Workshop(s) _____ Mentoring
_____ Experience _____ Completely self-taught

B) Practice in Play Therapy:

Check one: ___Current ___Past___None
Average number of clients per week _____ Number of years in practice ____

14) Is a practicum experience in play therapy offered?

_____ yes _____ no

If you responded **"yes" to item #14, please complete items 15-20, to further describe the play therapy practicum.*
If you responded **"no" to item #14, please stop here.*

Play Therapy Practicum

15) Is the practicum experience in play therapy:
_____ Required
_____ Optional, by student choice
_____ Required only if assigned a play therapy case

16) Where does this practicum take place?
_____ Program-run Clinic
_____ Community Clinic or Non-Profit Agency
_____ Hospital or Residential Setting
_____ School
_____ Other:_____

17) How much supervised play therapy experience is provided through the practicum?
_____ hours over _____ weeks.

18) How much play therapy supervision is provided through the practicum?
_____ minutes per week.

19) What is the level of expertise of the practicum supervisor? (provide responses to all that apply)

A) Training in Play Therapy:

_____ Course(s)	_____ Readings
_____ Workshop(s)	_____ Mentoring
_____ Experience	_____ Completely self-taught

B) Practice in Play Therapy:
Check one: ___Current ___Past ___None

Average number of clients per week ___ Number of years in practice _____

20) What type of play therapy supervision is provided? (check all that apply)

_____ Individual
_____ Group
_____ Direct/Live (one-way mirror or remote video or audio)
_____ Indirect Audiovisual (video or audio tape)
_____ Indirect Descriptive (oral descriptions or case notes)

Thank you very much for your participation!

Appendix B: Letter to Trainers

Christina Bechle Pascarella
31 Homer St.
Rochester, NY 14610

December X, 2007

Director of XXX Program
XXX University
Street
City, State, Zip

Dear XXXX:

I am writing to ask for your response to the enclosed survey, which is an important component of my dissertation. The purpose of the study is to investigate the type of play therapy training offered at the graduate level. Various institutions across the country have been randomly selected to participate in this study. The results obtained will provide valuable, comprehensive information on the current status of play therapy training and factors related to its availability. With this knowledge, we will be able to track trends in the field and address barriers.

It would be greatly appreciated if you would respond to the following questions about your XXX program. While I understand how difficult it is to find time to respond to such surveys, it would be most helpful to me if your response was returned within two weeks. As an incentive, I will mail to the first 30 responders a copy of, Play Therapy: A Do-It-Yourself Guide for Practitioners, written by Jay Cerio, Ph.D. Please accept in advance my sincere and immeasurable gratitude.

If you have any questions please contact any of the individuals below:

Christina B. Pascarella
Principal Researcher
CLB3@alfred.edu

John D. Cerio
Faculty Sponsor
Alfred University
Saxon Dr.
Alfred, NY 14802
607-871-2757
fcerio@alfred.edu

Dr. Jana Atlas, Chair
Human Subjects Committee
Alfred University
Saxon Dr.
Alfred, NY 14802

Sincerely,

Christina B. Pascarella, M.A./C.A.S.

Biographical Data

Christina Bechle Pascarella completed her undergraduate work at the State University of New York at Fredonia, where she graduated with a Bachelor of Arts in Psychology and Sociology in 1996. Following completion of her undergraduate degree, she pursued her graduate work at Alfred University, where she earned her Master of Arts in School Psychology in 1998 and her Certificate of Advanced Study in 2000. She furthered her graduate work through Alfred University, earning her Doctorate of Psychology in School Psychology in 2012. She has worked as a school psychologist for the past 12 years in upstate New York. Her professional affiliations include membership in National Association of School Psychologists and Association for Play Therapy.