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Factors Associated with Play Therapists' Use of Family-Systems Play Therapy Interventions

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Dedication

I dedicate this dissertation to my daughter, Kate. You inspire me to be a better version of myself every day. I hope that I can do the same for you one day.

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Without the patience, support, and love of my family, my professional goals would be impossible. I hope to express gratitude for the love I have been shown during the last three years. My success belongs to all of us.

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Abstract

Four hundred fifty-six (456) members of the Association for Play Therapy responded to the researcher-developed survey, the *Play Therapists' Decision-Making Inventory-Revised* (*PTDI-R*). The instrument assessed play therapists' perceptions of the role of attachment in the treatment process, the frequency with which play therapists feel competent to use family-systems play therapy, and the frequency with which they utilize these interventions. Items from the *PTDI-R* were analyzed using a principal component analysis to assess the underlying structure of six items that addressed participants' frequency of use of FSPTI relative to their understanding of the attachment relationship. This factor accounted for 45% of the variance between the 6 survey items. These items from the *PTDI-R* were combined into one variable for use in the analysis of the remaining research questions. Using this enhanced dependent variable representing frequency of use of FSPTI by play therapists, three multiple regression models were built. Of these, the third model had the most power, explaining 65% of the variance in the dependent variable. When examining the relationships between play therapists' demographic variables, beliefs about attachment, and play therapy practice patterns, significant relationships were identified among all but one set of variables. The results of this study supported the need for required play therapy education that applies family systems approaches to address attachment dysfunction in the caregiver-child relationship. Findings resulted in training and education recommendations to play therapists, counselor education programs, and the play therapy credentialing body.

Key words: attachment theory, play therapy, family-systems, play therapists, caregiver

Chapter One

INTRODUCTION

Play is present in all children from all cultures and is the method through which children best communicate, as opposed to verbal means of self-expression that arise from more developed cognitive processes (Drewes, 2006; Landreth, 2002). Through capturing the natural powers of play, play therapists are able to connect with their child clients through play therapy interventions. According to the Association for Play Therapy (APT; 2012a), play therapy is "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (para. 5). Bratton, Ray, Rhine, and Jones (2005) found that play therapy is an effective treatment modality resulting in large treatment effects for clinicians who utilize a child-centered approach and a medium effect for other theoretical orientations. Additionally, play therapy conducted by a caregiver seems to be more impactful than play therapy conducted by play therapists. Bratton, Ray, Rhine, and Jones (2005) also concluded that treatment outcomes from a filial therapy intervention, or play therapy conducted by a parent, were significantly greater than outcomes from play therapy conducted by a mental health professional.

Bratton, Ray, Rhine, and Jones's (2005) findings support a supposition that play therapists should be prepared to engage the family in ways that will assist with the child's treatment. Caregivers should be involved in treatment when possible because external factors, including the caregiver-child attachment relationship, affect the functioning of child clients. Ryan and Bratton (2008) indicated, "Attachment theory and research is a well-established framework for understanding children's normal and atypical social/emotional development. It is used

extensively by clinicians to design interventions, understand interactions, and assess clinical progress" (p. 28). Attachment is a bond between a caregiver and a child that is formed through the child's consistent interactions with the caregiver(s). Infants learn through these interactions whether they can depend on the caregiver(s) to meet their physical and emotional needs. Consistent, caring responses from caregivers to infants' can produce a secure attachment, whereas inconsistent, punishing responses can build a dysfunctional bond. The presence of an insecure attachment style or disorganized attachment style is considered dysfunctional in the attachment relationship. The current study uses the term dysfunctional attachment to capture all types of attachment other than secure attachment. Labeling this group of attachment styles as dysfunctional conveys an idea that the attachment style children are currently working with is not allowing them to function at an optimum level. Additionally, using a broader term like dysfunctional attachment allows for clinicians who are assessing attachment relationships between a child and caregiver to indicate a breakdown in the relationship without conducting a formal assessment to specifically identify the insecure attachment type.

Insecure attachment is prevalent in as many as 30% of infants, as evidenced in a meta-analysis conducted by van IJzendoorn, Goldberg, Kroonenberg, and Frenkl (1992). Attachment relationships transmit intergenerationally from caregiver to child to grandchild. Because insecure attachment connects to relational and developmental dysfunction, recognition and reparation of an insecure attachment bond is paramount to long-term system change within the family (Prior & Glaser, 2006). However, only scant research exists to suggest that play therapists are considering children's styles of attachment to their primary caregivers before providing services and, if they do consider it, how prepared they are to implement the appropriate intervention.

If play therapists are initiating services with children without incorporating the attachment of the parent-child into their treatment plans, child clients may not be receiving the most beneficial services. Assessing for attachment styles between children and their identified primary and secondary caregivers could greatly assist professionals in understanding the needs of the child before initiating therapeutic services (Martin, 2005). After such an assessment, utilization of a play therapy intervention tied to the concepts of attachment theory could be effective in remediating a dysfunctional relational bond. Four such play therapy interventions, including Filial Therapy, Child-Parent Relationship Therapy, Theraplay, and Parent-Child Interaction Therapy, will be examined in the proposed study. Play therapy interventions for the family are not included in the required training to become a registered play therapist/ supervisor (Association for Play Therapy, 2012b). Additionally, it appears that play therapy education is largely unavailable in graduate programs that train a sub-population of students who will likely work with children who are effected by attachment dysfunction and who are appropriate candidates for play therapy services (Association for Play Therapy, 2012d; Council for Accreditation of Counseling and Related Educational Programs, 2012). It seems reasonable to conclude that, if play therapists were required to obtain training in family-systems play therapy interventions, they would better understand the power of parent-child bonds and would be better equipped to respond to dysfunctional attachment relationships and provide more effective interventions. Additionally, appropriate interventions could decrease the likelihood of a dysfunctional attachment relationship transmitting to the next generation. It is hoped that the findings of this study will increase awareness of play therapists' attitudes towards attachment relationships and their readiness, based on their training in family-systems play therapy

interventions, to respond to an dysfunctional attachment between child clients and their caregivers.

Conceptual Framework

Attachment theory serves as the conceptual framework for this study. Abundant research supports the effects of the attachment bond on social, cognitive, and developmental functioning. The attachment bond is evident in the first year of life and aids in the development of cognitive patterns that persist throughout the lifespan. The availability and responsiveness of the caregiver(s) translates into an Internal Working Model (IWM) for the infant, which the infant uses to navigate future relationship behaviors. The IWM is a mental representation of self and how others see self. For instance, if mothers respond in a predictable, caring way to infants' cries for comfort, infants learn that their needs are important. By contrast, infants whose cries are met with anger could develop the idea that expressing needs brings punishment. The former infants would likely develop a secure attachment style, whereas the latter are likely to become insecurely attached.

The healthier the attachment relationship, the more likely the child will feel safe to explore the surrounding environment with little anxiety, knowing that the caregiver is available if safety becomes a concern. A weak attachment relationship, or dysfunctional attachment, between a caregiver and a child connects to areas of dysfunction elsewhere in the child's life, such as social and cognitive difficulties. A stable IWM provides the child comfort outside the presence of the attachment figure (Sroufe, 1988). This model is the child's internalization of the perceived importance others place on remaining available to the child and the child's self-worth due to the caregiver's readiness to respond. It is malleable throughout a child's life and application occurs to all relationships during the lifetime (Sroufe, 1988). The IWM translates to romantic partners

and transmits intergenerationally to offspring. A mother who experienced insecure attachment as a child is likely to treat her child in such a way as to foster insecure attachment.

Bowlby saw attachment as an ongoing system of interaction (Bowlby, 1958; Bowlby, 1969/1982). The process of attachment is an evolutionary, instinctive trait that is necessary for the survival of a species (Bowlby & Ainsworth, 1991). The foundation of the theory is that infants are born with the instinct to attach to a caregiver in order to keep safe during times of distress, which in turn promotes extended life of the infant and greater likelihood of future procreation. In fact, Cassidy (2008) reported that Bowlby thought infants instinctually developed the attachment behavioral system. Originally, Bowlby (1958) proposed a theory that identified attachment behaviors of "sucking, clinging, crying, following, and smiling" (p. 351) as the ingredients for the attachment relationship bond. Eventually, Bowlby acknowledged a network of systems, including the attachment, exploratory, affiliative, and fear systems, which utilize attachment behaviors within a goal-corrected framework with the ultimate objective of leading the infant closer to the attachment figure when needed in order to promote safety (Bowlby, 1969/1982; Zeanah & Boris, 2000). Cassidy (2008) summarized Bowlby's theory that the attachment system becomes active based on the child's environment and internal conditions; any activation of the attachment system has the set-goal of reducing distance from the caregiver and terminates only when the desired amount of nearness to the figure occurs. For instance, the infant may be unsettled due to fatigue and unable to regulate internally. The infant will use attachment behaviors, such as crying or crawling, until the attachment figure responds to the signals, reduces the distance, and gives comfort. When the attachment figure repeatedly fails to respond to these signals, the infant learns that crying or crawling do not produce reliable results and begins the

process of detachment. Over time, the detachment begins to integrate into the IWM and an insecure attachment forms.

Bowlby's conceptualization of attachment, with its modifications over several decades, provides the conceptual basis for the proposed study. The majority of Bowlby's assumptions have withstood the test of time; evidence for his theories has emerged due to a plethora of supporting research in the field of human development. Divergent theories of attachment have not proven as reliable in research studies. Although many other theories on the development of the bond between a caregiver and child are present in the literature, the abundance of empirical evidence supporting Bowlby's theories provides a strong base to support the current study.

Significance of the Study

Attachment is one ingredient that contributes to the complicated formula of family dynamics. One way for mental health clinicians to determine the direction they will take in providing treatment to children who are externalizing or internalizing problems and thereby contributing to familial disharmony, is to evaluate the attachment strength between the child and primary caregiver(s). The purposes of this quantitative study were to determine the extent to which play therapists integrate into treatment planning their knowledge of the attachment style between the child and caregiver and to examine the preparedness of play therapists to respond to dysfunctional attachment relationships using family-system play therapy interventions for attachment deregulation. Haslam and Harris (2011) recommended that future play therapy research examine the "practice patterns of play therapists working with families and what factors influence these behaviors" (p. 64). This recommendation provided support for the study.

The results of this study support the need for required play therapy education that applies family systems approaches to address attachment dysfunction in the caregiver-child relationship.

The findings also indicated that play therapists need to seek additional or more advanced education and training in play therapy in order to meet the needs of the clients they are serving. Currently, it is unclear whether play therapists are competent in interventions used to remediate dysfunctional attachment and whether they design appropriate treatment plans for these clients. Findings resulted in training and education recommendations to counselor education programs and the play therapy credentialing body.

Method

The members of the Association for Play Therapy (APT) were the population of interest. Currently, APT membership is 5,207 individuals (C. Guerrero, personal communication, March 27, 2012), which includes 915 Registered Play Therapists and 992 Registered Play Therapist-Supervisors (APT, 2012c). All members who have supplied an email address to the Association for Play Therapy were invited to participate in the study. The purposes of this quantitative study were to determine the extent to which play therapists are prepared to respond to dysfunctional attachment relationships using family-system play therapy interventions for attachment deregulation. A quantitative method was chosen to gain an understanding of the practices and beliefs of members of a large organization by generalizing results from the sample to the larger population of members in APT.

Play Therapists' Decision-Making Inventory-R (*PTDI-R*), which was created by me for the purposes of this study, was used for data collection. The *PTDI- R* was used to assess play therapists' perceptions of the role of attachment in the treatment process, the frequency with which play therapists feel competent to use family-systems play therapy, and the frequency with which they utilized these interventions. Information on the demographic characteristics of sex, age, ethnicity/race, professional license(s), play therapy certification status, play therapy

theoretical orientation, and years of play therapy experience was solicited to describe the sample. The *PTDI-R* was distributed electronically.

I conducted a pilot study in March 2012 to test the initial construction of the *Play Therapists' Decision-Making Inventory.* First, an expert panel reviewed the survey and suggested modifications. Then, 125 members of the Louisiana Association for Play Therapy received the survey. A total of 29 of the 30 survey responses were considered appropriate for analysis. The respondents largely consisted of Caucasian females whose mean age was 39.5 and who had a mean of 8 years of experience in play therapy, and held certification as a licensed professional counselor and/or a registered play therapist- supervisor (see Appendix A). The emerging trend in the descriptive statistics (see Appendix A) suggested that surveyed play therapists are aware of the importance of attachment and that they are utilizing assessment procedures to better understand this relationship. However, the majority of surveyed play therapists were not extensively trained in family-systems play therapy approaches.

Research Questions

The study sought to understand the extent to which play therapists were prepared to respond with effective therapeutic interventions to dysfunctional attachment between a child and caregiver. Play therapists' frequency of usage of family-systems play therapy interventions was the dependent variable, whereas the independent variables were perceived importance of the attachment relationship between a child and caregiver, play therapists' perceived level of competence in family-systems play therapy interventions, play therapists' demographic variables (age, sex, ethnicity, and race), play therapists' theoretical orientation, play therapists' years of experience in play therapy, and play therapists' credentials. The following were the specific research questions:

1. What variables contributed to play therapists' frequency of usage of family-systems play therapy interventions?
2. Was there a relationship in the perceived importance of the attachment relationship and play therapists' perceived level of competence in family-systems play therapy interventions among play therapists?
3. Was there a relationship between perceived importance of the attachment relationship and frequency of usage of family-systems play therapy interventions?
4. Was there a relationship between play therapists' perceived level of competence in family-systems play therapy interventions and frequently of usage of family-systems play therapy interventions to respond to dysfunctional attachment?
5. Was there a relationship between play therapists' perceived level of competence in family-systems play therapy interventions and their perception of adequacy of training in family-systems play therapy interventions?
6. Was there a relationship between play therapists' theoretical orientation and frequency of usage of family-systems play therapy interventions?
7. Was there a relationship between play therapists' years of experience and frequency of usage of family-systems play therapy interventions?
8. Was there a relationship between play therapists' credentialing as an RPT and frequency of usage of family-systems play therapy interventions to respond to dysfunctional attachment?
9. Was there a relationship between play therapists' credentialing as an RPT-S and frequency of usage of family-systems play therapy interventions to respond to dysfunctional attachment?

10. What factors contributed to perceived importance that play therapists' of the influence of attachment between a client (child) and primary caregiver?

Limitations of the Study

Confidence in the results of the study are based in the assumption that the *PTDI-R* is valid and accurately measured play therapists' perceptions of the importance of assessing for attachment and their readiness to utilize appropriate therapeutic interventions to remediate a dysfunctional attachment between a child and caregiver. After initially designing the *PTDI-R* instrument, I conducted a pilot study of the instrument with a sample of members from the Louisiana Association for Play Therapy. An expert panel also reviewed the instrument. Despite these precautions, the *PTDI-R* may have lacked reliability in reporting play therapists' beliefs and practice patterns in treatment planning.

Additionally, use of an online survey might have resulted in a reduction of responses and selection bias (Granello, 2007). To the extent that the sample is representative, the results of this study are generalizable to mental health professionals trained in play therapy who are members of APT. The results are not generalizable to mental health professionals who are not APT members. Finally, all play therapists may not be current members of APT; thus, the results are not generalizable to play therapists who are not APT members.

Members of the population may have been reluctant or unable to participate in the survey due to difficulty of use and lack of access to technology (Granello, 2007). Additionally, lack of interest in use of FSPTI may have resulted in participants discontinuing the survey or failing to initiate response altogether. Whereas the technology inherent in an Internet survey may have discouraged participation for some members of the population, other members may have not have been aware of the email containing information about the survey. An inability to

outmaneuver the participants' email spam filter may have led to members of the population overlooking or not receiving the participation inquiry (Granello, 2007).

Finally, I assumed that all participants submitting surveys were honest in their responses to the survey items and that these respondents were representative of all APT members. To reduce the likelihood that participants would provide dishonest responses, I included a detailed introductory letter to participants. Additionally, I controlled for multiple submissions through an option in the Qualtrics ™ software, which prevented ballot stuffing. Although respondents may have been able to complete the survey multiple times using different computers, it is unlikely participants were motivated to do so because there were no incentives (Siah, 2005).

Delimitations of the Study

The participants in this study were delimited to members of the Association for Play Therapy. Play therapists' perceptions of the attachment relationship as an external factor in treatment planning was asked, but other external factors were not considered. Evaluation of play therapists' perceptions of the role of attachment assessment in the treatment process occurred through open-ended, fixed-choice responses, and Likert scale questions. Only those questions deemed appropriate by the expert panel and supported by the results of the pilot study were included in the instrument. The results of this study can be generalized to mental health professionals trained in play therapy who are members of APT. The results are not generalizable to mental health professionals who are not APT members.

Assumptions of the Study

I assumed that the *PTDI-R* was valid and accurately measured play therapists' perceptions of the importance of assessing for attachment and their readiness to utilize appropriate therapeutic interventions to remediate a dysfunctional attachment between a child

and caregiver. Second, I assumed that participants who completed the survey had basic training and knowledge about play therapy and attachment relationships. Third, I assumed that all play therapists participating in the research conduct an intake procedure upon initiating services with a client. Fourth, I assumed that members currently participating in a graduate program have the freedom in their clinical practice to engage the families of their clients. Finally, I assumed that all participants submitting surveys were honest in their responses to the survey items and that these respondents were representative of all APT members.

Terminology

Attachment Relationship- Ainsworth defined this as "a relationship in which the attachment component is central" (as cited by Cassidy, 2008, p. 18). The relationship can occur between the child and multitudes of caregivers in the child's system.

Attachment Theory- An evolutionary theory of survival where infants learn a concept of "self" as result of the attachment figures responsiveness to their attachment behaviors (Bowlby, 1969/1982). The resulting attachment relationship serves as a reference for all future relationships (Bowlby, 1969/1982).

Child-Parent Relationship Therapy- An intervention requiring 10 sessions grounded in "enhancing and strengthening the parent-child relationship" (Landreth & Bratton, 2006, p. 15)

Dysfunctional attachment- The presence of an insecure attachment style or disorganized attachment style is considered dysfunctional in the attachment relationship.

Disorganized Infant Attachment Classification- Used when infants respond to caregivers inconsistent with avoidant, ambivalent, or secure behaviors. These infants typically exhibit contradictory behaviors, such as distressed signals and movement away from caregiver, as if they are unable to organize their responses to caregivers (Lyons-Ruth & Jacobvitz, 2008).

Filial Therapy- A "psychoeducational intervention" (VanFleet, 2011a, p.154) developed by the Guerney's, based in family therapy, and utilizing play where parents are trained in nondirective play therapy to improve family relationships (VanFleet, 2011a).

Insecure: Ambivalent/ Anxious Infant Attachment Classification- Typically, the ambivalent infant sends mixed messages to mother. The messages often appear to have an angry undertone, where the infant is simultaneously wanting the mother's contact or attention and rejecting of her (Ainsworth, Blehar, Waters, & Wall, 1978).

Insecure: Avoidant Infant Attachment Classification- Usually, the avoidant infant is indifferent to its mother's presence, treating her in the same way as it would treat a stranger upon separation and reunion (Ainsworth et al., 1978).

Parent-Child Interaction therapy- The foundation for the treatment is the belief that a healthy attachment is necessary for behavioral change to occur within the context of the parent-child relationship. Furthermore, through a combination of behavioral techniques, play therapy techniques, family systems, and the social learning theory, parent-child interaction therapy teaches parental skills in the context of a healthy child-caregiver relationship (Drewes, 2006; Herschell, Calzada, Eyberg, & McNeil, 2002)

Play Therapy- "The systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (Association for Play Therapy, 2012a)

Primary Caregiver- Bowlby also called it "mother-figure" (Bowlby, 1958, p. 370), defined as the person to whom the child is most attached within the hierarchical order of attachment relationships (Cassidy, 2008).

Secure Attachment Relationship – According to Bowlby (1951), "the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment" (p. 11).

Secure Infant Attachment Classification- The secure infant becomes distressed in the mother's absence, seeks contact or interaction with her upon return, and is comfortable upon making contact with mother (Ainsworth et al., 1978).

Theraplay- Therapy modeled after a healthy parent-child relationship, in which the therapist concentrates on providing the child "Structure, Challenge, Intrusion, and Nurture" (Jernburg, 1984, p. 40).

Chapter Two

REVIEW OF THE LITERATURE

A review of the seminal and current literature relevant to the proposed study occurs in this chapter. This chapter begins with a reiteration of the purpose and significance of the study. Then, play therapy is discussed in the following sections: an overview of play therapy, training in play therapy, and family-systems play therapy interventions. Next, attachment theory is reviewed, including the background of attachment theory and developments in attachment theory. Finally, the link between attachment and play therapy is described.

Purpose and Significance

Attachment contributes to the complicated formula of family dynamics. One way for mental health clinicians to determine the direction they will take in providing treatment to children who are contributing to familial disharmony is through evaluation of the attachment strength between the child and primary caregiver(s). The purposes of this quantitative study were to determine the extent to which play therapists integrate into treatment planning their knowledge of the attachment style between the child and caregiver, and to examine the preparedness of play therapists to respond to dysfunctional attachment relationships using family-system play therapy interventions for attachment deregulation. Haslam and Harris (2011) have recommended that play therapy research examine the "practice patterns of play therapists working with families and what factors influence these behaviors" (p. 64).

It was anticipated that the results of this study might support the need for required play therapy education that applies family systems approaches to address attachment dysfunction in the caregiver-child relationship. It was anticipated that the findings might also indicate that play therapists need to seek additional or more advanced education and training in play therapy in

order to meet the needs of the clients they serve. Based on the literature review, it was unclear whether play therapists are competent in interventions used to remediate dysfunctional attachment and whether they design appropriate treatment plans for clients with dysfunctional attachment to their caregiver(s). Findings resulted in training and education recommendations to counselor education programs and the play therapy credentialing body.

Play Therapy

Play is present in all children from all cultures and is the method through which children best communicate, as opposed to verbal means of self-expression based on higher-cognitive processes (Drewes, 2006; Landreth, 2002). The study of play therapy as a viable treatment option for children has persisted over the last 60 years (Porter, Hernandez-Reif, & Jessee, 2009). During this period, several disciplines in play therapy have emerged, as well as play therapy interventions used to remediate the dysfunctional child-parent relationship.

Models of Play Therapy

According to the Association for Play Therapy (APT; 2012a), play therapy is "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (para. 5). Originally, play therapy was developed by therapists who adhered to the psychoanalytic model, including Sigmund Freud, Anna Freud, and Melanie Klein (Porter et al., 2009), and was used as an alternative to free association (Bratton, Ray, Edwards, & Landreth, 2009). Since the inception of play therapy, multiple theoretical orientations have developed; these include child-centered, Jungian, Adlerian, cognitive-behavioral, ecosystemic, psychodynamic, object relations, gestalt, and prescriptive play therapy.

In 1947, Virginia Axline introduced child-centered play therapy, which incorporated the theories of Carl Rogers (Bratton et al., 2009). When specified by respondents in various studies, a child-centered theoretical orientation has emerged as the most practiced approach in play therapy (Lambert et al., 2007; Phillips & Landreth, 1995), as well as the theory in which most play therapists receive training (Ryan, Gomery, & Lacasse, 2002). Axline believed that all children have the inner resources to resolve their problems; in play therapy, this occurs within the context of certain conditions in the therapeutic relationship. Change within the child occurs due to the conditions of the relationship with the therapist. Through the therapist's ability to demonstrate "being real," "warm caring and acceptance," and "sensitive understanding" (Landreth, 2002, p. 70), children can experience true acceptance and understanding in the therapeutic relationship and are able to accept the self as a result. Once self-acceptance occurs, children begin to believe that they are competent, worthy human beings and that they have the resources necessary to achieve (Landreth, 2002).

Children are the directors of a child-centered play therapy session and play therapists must work from an attitude that conveys, "I am here"; "I hear you"; "I care"; and "I understand" (Landreth, 2002, p. 205-206). These messages communicate importance of the child and attention to the child; additionally, Bratton et al. (2009) pointed to Axline's principles of play therapy, which are the foundation for the child-centered play therapist's attitudes. These principles indicate that it is essential for a therapist to:

> (a) develop a warm, friendly relationship with the child; (b) accept the child exactly as he is; (c) facilitate an atmosphere of permissiveness so that the child is free to express self; (d) recognize and reflect the child's feelings in order to help him gain insight into his behavior; (e) honor the child's inherent capacity to solve his own problems; (f) allow the

> child to direct the therapy; (g) understand that therapy is a gradual process and should not be hurried; and (h) establish only the limits necessary to ground the child in the world of reality and make the child aware of his responsibility within the therapeutic relationship. (Bratton et al., 2009, p. 271)

Nonverbal and verbal interactions communicate the principles of child-centered play therapy to the child. Play therapists base their responses on the children's difficulties and their emotional and cognitive development (Bratton et al., 2009).

Child-centered play therapy, in addition to being the most commonly practiced form of play therapy, also appears to result in strong treatment outcomes. Bratton, Ray, Rhine, and Jones (2005) conducted a meta-analytic study on 93 published studies between 1953 and 2000 on play therapy treatment efficacy. The researchers examined 11 variables across the 93 studies. The findings indicated that play therapy is an effective treatment modality, resulting in large treatment effects for clinicians who utilize a child-centered approach and a medium effect for other theoretical orientations. The authors cautioned readers not to assume that child-centered play therapy is a more valuable modality. They highlighted the elevated number of child-centered studies as compared to other play therapy approaches, the tendency for authors of the included studies to vaguely discuss the theoretical orientation of their study, and the differences in application of techniques between therapists within the same orientation.

Play Therapists and Play Therapy Practices

Phillips and Landreth (1995) conducted a study to characterize the population of play therapists. They surveyed 1,166 members of the Association for Play Therapy and the Child Clinical Psychology division of the American Psychological Association. Results indicated that the majority of the respondents were female (78%), between 31 and 50 years of age, had

completed a masters degree program, and worked as a counselor or therapist in a private practice using a combination of theoretical viewpoints. When specifying a theoretical orientation, male play therapists were more likely than women to practice from a cognitive-behavioral perspective, whereas female play therapists were more likely to practice child-centered play therapy. Most play therapists surveyed provided individual play therapy, with a small number providing group and/or family play therapy. Counselors, psychologists, child-centered play therapists, play therapists practicing from other theoretical orientations in play therapy, and therapists newer to the field were all more likely to see only the child in their play therapy sessions (Phillips & Landreth, 1995).

In a follow up analysis of data from the same survey instrument, Phillips and Landreth (1998) closely examined the trends of play therapy practice and the clients who received the services. Play therapists responding to the survey indicated that the majority of their clients were 6-8 years old, and that age and presenting issue most often determined clinicians' recommendation for play therapy intervention. Presenting issues considered by the respondents to be effectively addressed through the use of play therapy included abuse, depression, externalizing behaviors, and academic issues. Additionally, the respondents indicated that play therapy worked when parents were included in the treatment process and the therapeutic rapport between the child and therapist was solid (Phillips & Landreth, 1998).

Lambert et al. (2007) published an updated survey of 978 play therapists that indicated similar results to those of Phillips and Landreth (1995). They reported that responding play therapists were White (85%), female (92%), with an average age of 44 years, had a master's degree (80%), and worked in their own counseling practice. The most noticeable difference in their demographic findings was that the two most commonly reported professional identities

were counselors (45%) and social workers (20.5%) and that play therapists were largely practicing from a child-centered (66.6%) approach to play therapy.

Play Therapy Credentialing

The Association for Play Therapy's (2009) recommendations for best practices in play therapy state:

> Play therapists recognize that children often have family members and other significant adults that have influence in the child's psychosocial growth and development, and strive to gain understanding of the roles and involvement of these other individuals so that they may provide positive therapeutic support where appropriate. (p. 7)

This recommendation supports a supposition that play therapists should be prepared to engage the family in the ways that will assist with the child's treatment. Bratton, Ray, Rhine, and Jones (2005) concluded that treatment outcomes from a filial therapy intervention, or play therapy conducted by a parent, were significantly greater than outcomes from play therapy conducted by a mental health professional. Despite these conclusions, however, a registered play therapist is not required to obtain specific training or education in family play therapy interventions (Association for Play Therapy, 2012b). This could potentially leave play therapists unprepared to address family dysfunction, and a lack of preparedness could lead to less effective treatment outcomes.

LeBlanc and Ritchie (2001), in their meta-analytic review, reported positive treatment outcomes from parental intervention with the child. When parents acted as treatment providers for their children, therapeutic outcomes improved greatly when compared to other play therapy treatments. It is important to note that a trained mental health professional supports education and supervision of the parents in this type of therapy. Lambert et al. (2007), in their survey of

play therapists, reported that 24.7% of play therapists engaged in filial therapy and 26.8% engaged in family play therapy. This relatively small percentage of play therapists who actually practice family-systems play therapy leads to questions regarding the preparedness and competence of play therapists to initiate these services. Furthermore, play therapists might be unsure as to when family-systems treatment is appropriate and might lack the knowledge to make this decision. Lack of training guidelines by APT, despite the association's recommendations to include the family, may add to uncertainties about engaging caregivers in treatment.

Registered Play Therapist

The Association for Play Therapy (APT) began a credentialing program in 1993 for mental health professionals to become registered play therapists (RPT) as a way to recognize and promote additional education, experience, and supervision specifically in play therapy (Association for Play Therapy, n.d.). To apply for this adjunctive credential, the mental health professional must hold a current state license or certification in a mental health field and a master's degree or higher mental health degree with specific course work in a variety of counseling-related topics (Association for Play Therapy, 2012b). Additionally, APT requires that clinicians who apply for the RPT credential must have at least 2 years and 2,000 hours of clinical experience under a qualified supervisor, to include at least 500 hours specifically in play therapy overseen during 50 hours of supervision. Finally, APT (2012b) requires certain training in play therapy before applying for RPT credentials. Play therapy training must total 150 clock-hours of instruction in the areas of play therapy history, theories, techniques or methods, and applications. To become RPTs, clinicians must obtain supervision under a clinician with experience in play therapy; supervision under a registered play therapist- supervisor (RPT-S) is preferred. The

credentialing process for RPT-S requires an additional 3 years and 3,000 hours of clinical experience, with 500 of those being in play therapy, and 24 additional hours of training in supervision obtained by clinicians who are eligible under their license to supervise other clinicians (Association for Play Therapy, 2012b). Under these stipulations, mental health clinicians could receive their RPT or RPT-S credential without ever having participated in family-systems play therapy training or educational workshops.

Training in Play Therapy

Play therapy interventions for the family are not included in the required training to become a registered play therapist/ supervisor (Association for Play Therapy, 2012b), nor are play therapists in training receiving education in these play-based interventions in their graduate training programs in counseling (Phillips & Landreth, 1995). APT (2012d) lists 183 universities that offer at least one graduate-level course in play therapy and the Council for Accreditation of Counseling and Related Educational Programs (2012) recognizes 600 graduate level university programs in various disciplines of mental health counseling. Thus, it appears that a substantial majority of programs offers no play therapy course work, and play therapists may not be receiving the education they need in order to provide family services. Play therapy education is largely unavailable as part of graduate programs that train a sub-population of students who will likely work with children who are affected by attachment dysfunction and who may be appropriate for play therapy services. As required by the RPT certification guidelines developed by APT, training specifically in the field of play therapy is essential to skill development, play therapy knowledge, and clinician competence.

Kao and Landreth (1997) measured the effects of a graduate-level course in child-centered play therapy on beginning play therapists' attitude, knowledge, dominance, and

intellectual efficiency using the Play Therapy Attitude-Knowledge Skills Survey and the California Psychological Inventory. Kao and Landreth (1997) reported several findings; most pertinent to this study was a significant increase in play therapy knowledge and confidence in application of play therapy skills at the end of the semester when compared to the beginning of the semester.

Homeyer and Rae (1998) examined the impact of length of a child-centered play therapy course through comparison of pre- and post-test scores on the Play Therapy Attitude-Knowledge Skills Survey on trainees' play therapy knowledge, confidence, and attitude towards work with children. Sub-groups of the sample of 29 play therapy trainees were exposed to a three-week course, a five-week course, or a fifteen-week course. Results indicated no significant differences among the three treatment groups in student development. Additionally, all course lengths, except the five-week course, resulted in significant growth in play therapy knowledge, confidence, and attitude towards work with children. The five-week group did not experience significant change in their attitude towards work with children; however, their baseline scores were higher than the other groups' baseline and their scores did increase at the time of the post-test (Homeyer & Rae, 1998). The results of this study suggested that training in play therapy, regardless of its length, results in improvement in clinician knowledge, confidence, and attitude towards children.

VanderGast, Post, and Kascsak-Miller (2010) presented a model utilized within a graduate-level class to educate students in the practice of Child-Parent Relationship Therapy (CPRT). The researchers focused on supplementing a ten-week graduate course modeled after actual CPRT sessions with practical cultural experience with parents from a low SES preschool.

VanderGast et al. (2010) reported that feedback from students in the course indicated positive professional growth in multiple areas.

Although training seems to increase play therapists' skills and knowledge, play therapists must participate in these educational sessions to reap the benefits. Fall, Drew, Chute, and More (2007) surveyed members of APT who held an RPT-S credential and reported that about 70% of respondents participated in graduate-level play therapy training, and about 46% had completed three or more graduate level play therapy courses. Fall et al. (2007) reported on the most trained and experienced population of play therapist, the RPT-S, and the focus of their course work was not indicated. Lambert et al. (2007) reported on a broader range of experience and training when they surveyed 978 play therapists. These participants reported an average of 1.5 graduate-level courses in play therapy, and play therapists who were members of APT obtained an average of 121.02 play therapy continuing education units. In addition to graduate-level training in play therapy, 77% of 1,159 members of APT and American Psychological Association reported participation in play therapy workshops (Phillips & Landreth, 1995). Ryan, Gomory, and Lacasse (2002) survey 891 members of APT on their demographics, training, and practices. The authors concluded that 53.5% had experienced some sort of exposure to play therapy before completing their graduate school course work; however, only 14.7% indicated that these experiences were grounded in Filial Therapy.

Research on the effectiveness and gains from graduate school course work in play therapy indicates that course work is a successful method for improvement of play therapists' skills and confidence in play therapy. Additionally, research indicates that training or education in play therapy contributes to a mental health professional's capability to effectively, appropriately, and confidently intervene with the client. Furthermore, play therapists believe that

play therapy works when parents are involved in the process, and they consider a strong therapeutic alliance with the child to be essential (Phillips & Landreth, 1995). In fact, Ryan, Gomory, and Lacasse (2002) found that in their sample of APT members, 88.5% believed that "family issues" (p. 25) were the most prevalent presenting issue in their practices. If play therapists cannot implement family-systems interventions due to lack of training, the gains from play therapy services could be limited of family-systems problems are most commonly encountered in treatment. Additionally, a lack in this training leaves clinicians vulnerable to unethically practicing outside their areas of competence or being inadequately prepared to offer clients the most effective services.

If play therapists believe that families are important to the treatment process, then logically it would follow that preparedness in engaging families in treatment would be a necessity. Haslam and Harris (2011) investigated play therapists' attitudes about the integration of family therapy with play therapy. Participants were 295 members of the Association for Play Therapy. Descriptive results from the survey indicated that the majority of play therapists who participated believed environmental issues in the home are affecting children who come for play therapy services and that involvement of parents in the treatment process is effective and imperative (Haslam & Harris, 2011). It seems that play therapists were eager to engage the family, as indicated by their interest level in family play therapy work (83.7%), but that play therapists may lack adequate skills to involve the family, as indicated by their low levels of great comfort (25.8%) and competence (23.5%) in family engagement when compared to great comfort (82.6%) and competence (69.9%) in individual play therapy work. Additionally, most respondents (75.4%) believed that their graduate training in family play therapy did not fully prepare them to engage families (Haslam & Harris, 2011), leading the researchers to conclude

that the level of competence indicated by the surveyed clinicians must result from other forms of training in their post-graduate education. Whereas 44.3% of the respondents indicated being "very comfortable" in play therapy with parent-child pairs, and 36.8% indicated they felt "very competent," these percentages were much lower than their comfort and competence in conducting individual play therapy sessions (82.6% and 69.9%, respectively) (Haslam & Harris, 2011).

Although Haslam and Harris (2011) investigated the beliefs and perceived competence of play therapists to engage in family play therapy, they did not investigate play therapists' application of family-systems play therapy as a response to family dysfunction. In addition, Haslam and Harris (2011) asked only about "play therapy with most/all family members" (p. 59); they did not focus on specific family-systems play therapy interventions, such as Child-Parent Relationship Therapy. As clarified by one of the authors, within their study "family therapy" was defined as "the whole family in a play therapy intervention" (D. Haslam, personal communication, July 7, 2012). The present study seeks to build on and add to the findings of Haslam and Harris (2011) by investigating play therapists' perceived competence in attachment-focused, family-systems interventions, and frequency of implementing these interventions. Additionally, the present study will investigate whether the presence of attachment dysfunction relates to play therapists' initiation of a family-focused intervention, as recommended by Haslam and Harris (2011).

Family-systems Play Therapy Interventions

Many interventions for parents or caregivers and children have been described in the literature on play therapy. However, the interventions pertinent to the present study are narrowly focused. Play therapy interventions that involve participation of children and their caregivers

and address reparation of the attachment bond between children and caregivers are discussed in this section. These interventions include Filial Therapy, Child-Parent Relationship Therapy, Theraplay, and Parent-Child Interaction Therapy.

Filial Therapy

Bernard and Louise Guerney originally developed Filial Therapy (FT) around 1960 as a psychoeducational model, which assumes that familial issues occur primarily due to a lack of knowledge (VanFleet, 2011a). The overarching goal of Filial Therapy is "to help families become stronger, achieving more satisfying relationships built on love, understanding, trust, security, loyalty, belonging, compassion, companionship, and enjoyment" (VanFleet, 2011a, p.156) in, on average, 10-20 caregiver group sessions. Filial Therapy combines theories of psychodynamic, humanistic, behavioral, interpersonal, cognitive, developmental/attachment, and family systems into a program to teach caregivers a new way of relating, accepting, and supporting their children during non-directive play sessions and, eventually, everyday life (VanFleet, 2011a; 2011b).

Specifically, when addressing concerns of attachment, VanFleet (2011b) stated, "FT empowers all family members in such a way that they can shift to healthier attachment styles and ways of relating" (p. 18). The Guerney model of Filial Therapy has six themes, which must be present during intervention in order to accurately identify a caregiver-led intervention as Filial Therapy. First, the relationship between family members is the client, whereas traditional therapy identifies the individual as the client (VanFleet, 2011c). Filial Therapists believe that environmental and relationship patterns affect an individual's functioning; therefore, treatment of the relationship will help resolve some of these issues. Second, therapists teach caregivers to

meet their child's needs with empathy and acceptance by demonstrating those attitudes when addressing parental concerns.

Third, Filial Therapy encourages participation from all family members, to include both parents, whenever possible. Fourth, the therapist imparts Filial Therapy skills through "explanation, demonstration, skills practice, and individualised feedback" to the caregivers (VanFleet, 2011c, p. 9). Fifth, during training, caregivers conduct play sessions with their children under supervision of the filial therapist during practice sessions one through four or six (VanFleet, 2011c). Past this point, caregivers conduct play sessions at home and the therapist reviews sessions through verbal report or video footage to support caregiver development in use of Filial Therapy skills. Caregivers are encouraged to use the skills only in the play sessions until they achieve competence, as generalization of the skills too quickly might lead to caregiver discouragement and disengagement from the process (VanFleet, 2011c). Finally, therapists manage the training sessions and supervision, but work collaboratively with the caregiver to gather information and provide suggestions for improved skill implementation. According to VanFleet (2011a), caregivers are taught skills in "structuring," "empathetic listening," "child-centered imaginary play" (p. 158), "limit setting" (p. 159), and identification of play themes.

To be able to teach parents or caregivers these skills, the therapist must have a solid knowledge base in utilization of these techniques. As Landreth (2002) suggested, lack of training for a filial therapist could lead to an inadequate ability to model play therapy techniques, insensitivity to the education-therapy balance required for a training group, and an unruly group when attempting to manage group discussions so each parent feels heard. VanFleet (2011b) recommended that clinicians obtain training and supervision to maintain the integrity of the treatment model and be adequately prepared to co-lead Filial Therapy sessions.

As a result of the empirical evidence that followed the development of the Filial Therapy model, several variations of the original treatment model were developed. Often, literature refers to play therapy sessions conducted by a caregiver, instead of a clinician, as filial therapy. However, Filial Therapy is a standardized treatment protocol and is differentiated from general filial therapy by using capitalization, as requested by Louise Guerney (VanFleet, 2011b). Furthermore, it is important to make this distinction to maintain clarity and congruence for the reader when presenting research conducted on Filial Therapy versus less standardized and less well-defined filial therapy. Child-Parent Relationship Therapy (Landreth & Bratton, 2006) is presented separately, in the following section, to maintain a clear distinction between the two filial interventions.

Child- Parent Relationship Therapy

Child Parent Relationship Therapy (CPRT) is a child-centered filial therapy adaptation, which prescribes 10 skill-acquisition sessions for caregivers under the supervision of a trained play therapist (Bratton, Landreth, & Yin, 2010). Two-hour sessions focus on "enhancing and strengthening the parent-child relationship" (Landreth & Bratton, 2006, p. 15). The CPRT method differs from the original Filial Therapy model in the condensed timeframe and the identification of one child for the caregiver's practice sessions (Landreth & Bratton, 2006; Vanfleet, 2011a); however, the models are similar in many ways. While participating in workshops to acquire the child-centered play therapy skills and attitude under the supervision of a play therapist, the parent translates the knowledge into 30-minute play therapy sessions at home over the course of seven weeks. To train the parent, the play therapist must be knowledgeable about the treatment protocol and specifically trained to conduct supervision and provide education to caregivers using the CPRT manual (Bratton, Landreth, & Yin, 2010). The

CPRT manual is organized as ten weeks of the workshop, with weekly caregiver homework and required videotaping of home sessions.

As recommended, caregivers meet in a group format to promote the curative factors of the group therapy environment; however, play therapists may also educate individuals or parental partners in the curriculum (Landreth, 2002). CPRT is an effective way to build an alternate caregiver-child relationship, which refocuses on strengths and caregiver attunement. Building on the comprehensive meta-analysis conducted by Bratton et al. (2005), Bratton, Landreth, and Yin (2010) expanded the 2005 meta-analysis through examining CPRT sessions conducted only by teachers, parents, and "student mentors" (p. 270). An effect size of 1.25 was found for CPRT sessions conducted by paraprofessionals, whereas an effect size of 1.30 resulted when analyzing sessions conducted only by a parent. These effect sizes indicate that CPRT treatment conducted by a parent was more impactful than CPRT conducted by other caregivers. Additionally, Ray conducted a study on CPRT in which a group of 25 parent-child pairs, identified as having a propensity for attachment issues and an increased rate of parental emotional distress, completed CPRT treatment. After treatment, parents displayed a significant increase in acceptance and the children displayed better adjustment when compared to the 25 dyads who did not receive intervention (as cited by Landreth & Bratton, 2006).

Theraplay

Theraplay, developed by Ann Jernberg in 1967, is a therapeutic intervention developed from attachment theory and applied through four Theraplay interventions, typically over 12 sessions with Theraplay activities assigned as homework for the family (Jernberg, 1984; Munns, 2011). The child's needs dictate the appropriate Theraplay intervention and the therapist tailors these interventions to the child's developmental level. Furthermore, Theraplay is built on

findings in neurological science, in that it incorporates the effect of trauma on brain development (Munns, 2011). For instance, the therapist utilizes interventions which focus on communication of value to the child through attending to physical needs, such as touch and hunger, in an effort to heal trauma that delayed brain development in infancy. Ultimately, the goal of treatment is to rebuild the caregiver and child relationship into a healthy attachment through use of empathy, mutual attunement, and assisting the child with self-regulation (Munns, 2011).

Before treatment, a Theraplay therapist must assess the needs of the child and relational patterns in the family using an in-depth intake interview and the Marschak Interaction Method assessment (Jernberg, 1984; Munns, 2011). After assessment, the therapist selects from the four types of Theraplay interventions based on the needs of the child. Jernberg developed these interventions from observations of typical caregivers' interactions with their children and determined that most interactions involved behaviors of structuring, engaging, challenging, or nurturing (Munns, 2011). Using these four patterns, she designed ways of being with the child in therapy that mimicked normal caregiver-child interactions, so that children who had not received the correct balance of these interactions could experience how it feels to be cared for and that they deserved to be cared for. The therapist, according to Jernberg (1984), must be the leader in the session, and must emphasize the child's special features and abilities, show concern for the child's safety, gently respond to any discomforts, and use eye contact regularly.

Theraplay differs from other interventions discussed in that the focus is not entirely on the caregivers' administration of treatment, due to a focus on use of touch with the child to promote the healing process, and toys are not required for a therapy session (Munns, 2011). Initially, the therapist employs some or all of the Theraplay interventions in session while the caregivers observe with an "Interpreting Therapist" (Jernberg, 1984, p. 41), who points out the

child's adaptive and maladaptive response patterns, discusses parental concerns, provides support, and educates on the Theraplay philosophy and techniques. Usually, after the completion of half the prescribed sessions, the caregivers become involved in half of each remaining session (Jernberg, 1984). The last session is a party to signify the family's graduation from the program; four post-treatment checkups are scheduled over a year to monitor progress (Munns, 2011).

Parent-Child Interaction Therapy

Parent-Child Interaction Therapy, developed in the 1970s by Shelia Eyberg, was originally intended for children ages 2-7 as a manualized treatment for those with externalizing behaviors (Drewes, 2006). The foundation for the treatment is the belief that a healthy attachment is necessary for behavioral change to occur within the context of the parent-child relationship. Furthermore, through a combination of behavioral techniques, play therapy techniques, family systems, and the social learning theory, parent-child interaction therapy teaches parental skills in the context of a healthy child-caregiver relationship (Drewes, 2006; Herschell, Calzada, Eyberg, & McNeil, 2002). The treatment typically lasts 12-20 weeks, with 5-10 minute homework play sessions completed daily by the parent. Following completion of the program, parental skills are monitored through checkups (Drewes, 2006). Mental health providers and parents work in role-playing, skill-building sessions before implementation of the program. Once the counselor believes the parent is ready, the next phase of the treatment, with the child-directed portion of the program, begins.

The child-directed interaction portion of the treatment focuses on relationship-building skills through utilization of "praise, reflection, imitation, description, and enthusiasm" (Herschell et al., 2002, p. 10) or PRIDE statements in responses to the child's actions within the play sessions. To maintain adherence to the treatment protocol, the parent wears a bug-in-the-ear

device so the clinician can offer feedback and prompts for the parent in difficult moments. During these treatment sessions, the parent utilizes a child-centered play therapy approach in the play sessions by allowing the child to choose activities and refraining from judgmental statements and directives (Drewes, 2006; Herschell et al., 2002). Once the therapist determines the parent has mastered the PRIDE attributes, the parent-directed interaction sessions constitute the latter part of the parent-child interaction therapy treatment.

In the parent-directed interaction sessions, the therapist observes behind a one-way mirror while the parent utilizes behavioral techniques within the play session to encourage desirable behavior and discourage undesirable behavior. For instance, a child who ignores the parent's directions must participate in a time out procedure in the playroom for noncompliance. The parent specifically praises the child the next time he or she issues a directive and the child follows through with the directive (Herschell et al., 2002). The focus of the these sessions is on increasing the parent's consistency with the child, promotion of parental comfort with setting and enforcing limits, and education of parents on positive discipline techniques that do not harm the foundational attachment bond (Drewes, 2006). The treatment is determined to be successful when the therapist believes the parent has mastered the skills and the parent is satisfied with the results. Using parent-child interaction therapy as the main treatment is not appropriate in circumstances of "severe, untreated adult psychopathology; severe marital discord; children are outside the PCIT age range; severe ADHD without medication consultation and parents/caregiver who are known perpetrators of sexual abuse" (Drewes, 2006, p. 151).

Overview of Attachment

Attachment is a bond between a caregiver and a child that is formed through the child's consistent interactions with the caregiver(s) (Cassidy & Shaver, 2008). Infants learn through

these interactions whether they can depend on the caregiver(s) to meet their physical and emotional needs. This bond is evident in the first year of life and aids in the development of cognitive patterns that persist throughout the lifespan (Cassidy & Shaver, 2008). The availability and responsiveness of the caregiver(s) translates into an Internal Working Model (IWM) for the infant, which the infant uses to navigate future relationship behaviors. The IWM is a mental representation of self and how others see self (Cassidy & Shaver, 2008). For instance, if mothers respond in a predictable, caring way to infants' cries for comfort, infants learn that their needs are important. By contrast, infants whose cries are met with anger could develop the idea that expressing needs brings punishment. The former infants would likely develop a secure attachment style, whereas the latter are likely to form a dysfunctional attachment.

The healthier the attachment relationship, the more likely the child will feel safe to explore the surrounding environment with little anxiety, knowing that the caregiver is available if safety becomes a concern. A weak attachment relationship, or insecure attachment, between a caregiver and a child connects to areas of dysfunction elsewhere in the child's life, such as social and cognitive difficulties. Furthermore, beliefs integrate into the IWM as ideas about self and others, translate to romantic partners, and transmit intergenerationally to offspring (Cassidy & Shaver, 2008). For instance, a mother who experienced insecure attachment as a child is likely to treat her child in such a way as to foster insecure attachment.

It is important to evaluate for attachment related issues when treating children seeking counseling before formulating treatment plans. The pervasiveness of functional or dysfunctional relationship patterns emerging from the IWM makes understanding the attachment strength between a child and caregiver paramount for play therapists as they build treatment plans to encourage long-term, healthy change. However, the value of evaluating attachment is reduced

unless the play therapist has received training in effective interventions for treating a disharmonious caregiver-child bond. It is possible that, if play therapists were required to obtain training in family-systems play therapy interventions, they could respond more effectively to insecure attachment relationships. Research indicates that a majority of play therapists do not feel competent in the utilization of family-systems play therapy (Haslam & Harris, 2011) and no known research exists indicating whether play therapists are adequately prepared to intervene in dysfunctional attachment styles between child and caregivers.

Insecure attachment connects to relational and developmental dysfunction. Recognition and reparation of an insecure attachment bond is paramount to long-term system change (Prior & Glaser, 2006). If play therapists are initiating services with children without incorporating the parent-child attachment into their treatment plans, child clients may not be receiving the most beneficial services. As Martin (2005) concluded, assessing for attachment styles between children and their identified primary and secondary caregivers could greatly assist professionals in understanding the needs of the child before they initiate therapeutic services. Research points to mental health clinicians' tendency to conceptualize child client cases in an attachment framework (Ryan & Bratton, 2008). However, lack of education in the play therapy techniques that address the dysfunctional attachment bond may make the outcome of an assessment less valuable and force play therapists to refer the client to another service provider, thereby delaying treatment.

According to Bowlby (1958), four common theories of attachment exist, including Secondary Drive, Primary Object Sucking, Primary Object Clinging, and Primary Return-to-Womb Craving. Secondary Drive theory proposes that infants develop an attachment to their mothers because of physical need gratification unrelated to emotional satisfaction (Bowlby,

1958). The infant desires the mother because she is the source of food. Primary Object Sucking and Primary Object Clinging are similar to Secondary Drive in that needs are being met by the mother; however, the infant learns to value the mother as separate from her ability to provide food. Finally, the Primary Return-to-Womb Craving supposes that infants wish to return to the safety of the womb and seek the mother as a means to do this. Bowlby (1958) dismissed this last theory as impossible and unscientifically sound. In the following section, a presentation of the theories of John Bowlby and the contributions that subsequent attachment researchers made to the field are described.

John Bowlby

Bowlby saw attachment as an ongoing system of interaction, incorporating aspects of Primary Object Sucking and Clinging, which is pervasive throughout the life cycle (Bowlby, 1958; Bowlby, 1969/1982). The process of attachment is an evolutionary, instinctive trait that is necessary for the survival of a species (Bowlby & Ainsworth, 1991). The foundation of the theory is that infants are born with the instinct to attach to a caregiver in order to keep safe during times of distress, which in turn promotes extended life of the infant and greater likelihood of future procreation. Bowlby's theories emerged from Lorenz's ethological studies based in behavioral systems that demonstrated the propensity for young goslings to seek an attachment-figure immediately upon hatching (Bowlby, 1969/1982). In fact, Cassidy (2008) reported that Bowlby thought infants instinctually developed the attachment behavioral system.

Originally, Bowlby (1958) proposed a theory that identified attachment behaviors of "sucking, clinging, crying, following, and smiling" (p. 351) as the ingredients for the attachment relationship bond. Categorization of attachment behaviors occurs in three groups of "orientation, executive, and signaling" (Ainsworth, 1969, p. 1003). In 1962, Bowlby revised his original work

to encompass a control systems theory that acknowledged a network of systems, including the attachment, exploratory, affiliative, and fear systems (Bowlby, 1969/1982; Zeanah & Boris, 2000). These systems utilize attachment behaviors within a goal-corrected framework with the ultimate objective of leading the infant closer to the attachment figure when needed in order to promote safety (Bowlby, 1969/1982).

Behavioral systems function in two ways: fixed action pattern and set-goal or goal-corrected. Fixed action pattern systems are simple, but usually lead to chain reactions that build to a larger result. For example, infants engage in fixed action patterns when they smile at a caregiver to get the caregiver to come nearer. In contrast, goal-corrected systems compare the current situation with the desired situation and make adjustments to achieve the desired situation; goal corrected systems are integral to the process of conceptualizing the mechanisms of the caregiver-child relationship (Bowlby, 1969/1982). An example of an infant engaging in a goal corrected system occurs when an infant is in distress and increases proximity to its attachment figure in order to stay safe or be comforted.

Depending on the attachment figure's response, the infant may increase attachment behaviors or settle down due to goal satiation. Cassidy (2008) reported that Bowlby primarily focused on three interrelated behavioral systems: attachment, exploratory, and fear. A stable IWM provides the child comfort outside the presence of the attachment figure (Sroufe, 1988). This model is the child's internalization of the perceived importance others place on remaining available to the child and the child's self-worth due to the caregiver's readiness to respond. It is malleable throughout a child's life and application occurs to all relationships during the lifetime (Sroufe, 1988). The level of exploration of the environment is also dependent upon the child's view of the attachment figure as a "secure base" (Ainsworth, 1969, p. 1006).

Additionally, Cassidy (2008) summarized Bowlby's idea that the attachment system becomes active based on the child's environment and internal conditions; any activation of the attachment system has the set-goal of reducing distance from the caregiver and terminates only when the desired amount of nearness to the figure occurs. For instance, the infant may be unsettled due to fatigue and unable to regulate internally. The infant will use attachment behaviors, such as crying or crawling, until the attachment figure responds to the signals, reduces the distance, and gives comfort. When the attachment figure repeatedly fails to respond to these signals, the infant learns that crying or crawling do not produce reliable results and begins the process of detachment. Over time, the detachment begins to integrate into the IWM and an insecure attachment forms.

Bowlby (1969/1982) advanced his theory by identifying the attachment behavior system's four phases of development. These phases encompass the existence of attachment behaviors, defined by Bowlby (1969/1982) as "seeking and maintaining proximity to another individual" (p. 195). Within phase one of "orientation and signals with limited discrimination of figure" (Bowlby, 1969/1982, p. 266), the infant directs attachment behavior indiscriminately towards any individual who approaches; this usually persists until the twelfth week of life. Infants move into phase two, developing an attachment system, when they show increased response to one or more individuals as compared to other individuals. This phase of "orientation and signals directs towards one (or more) discriminated figure(s)" (Bowlby, 1969/1982, p. 266) begins around 12 weeks of age and persists until about 6 months of age.

Phase three of "maintenance of proximity to a discriminated figure by means of locomotion as well as signals" involves preference of and nearness to a certain figure, suspicion of unknown persons, and the emergence of secure-base and "goal-corrected" (Bowlby,

1969/1982, p. 267) behavior. This phase begins around 6 to 7 months and lasts until the third birthday. Finally, in the last, most advanced phase of "formation of a goal-corrected partnership" (Bowlby, 1969/1982, p. 266), children have developed awareness of their mother's set-goals and can alter their goals to correspond. Children are more aware of needs that exist outside of their own and can begin to work within a reciprocal relationship.

Bowlby's conceptualization of attachment, and its modifications over several decades, provides the conceptual basis for the current study. The majority of Bowlby's assumptions have withstood the test of time; evidence for his theories has emerged due to a plethora of supporting research in the field of human development. Divergent theories of attachment have not proven as reliable in research. Freud's hypotheses on the infant-mother bond are mostly untenable and incongruent with ethological research (Richters & Waters, 1991). Erikson took a risk in advancing Freud's secondary drive theory to incorporate more environmental effects on infant development, but still failed to develop a theory rich enough to account for the variations in infant behavior towards caregivers (Brandell, 2010). Finally, research has indicated that Mahler's theories of normal autism and normal symbiosis were inaccurate, which undermined her theory of infant development (cited by Brandell, 2010; Brisch, 1999/2002). Although many other theories on the development of the bond between a caregiver and child are present in the literature, the abundance of empirical evidence supporting Bowlby's theories provides a strong base to support the current study.

Developments in Attachment Theory

Attachment Styles.

Bowlby was able to expand his theory of attachment through his partnership with Mary Ainsworth. According to Bretherton (1992), Bowlby primarily developed the background of

attachment theory and Ainsworth found ways to test it, provide supporting documentation, and advance the theory. Ainsworth utilized Bowlby's identification of attachment behaviors to guide her observational research on attachment patterns and applied those observations experimentally in the development of the Strange Situation test (Ainsworth, 1969; Ainsworth & Bowlby, 1991). From the results of the Strange Situation test using a small sample of 23 white, middle-class infant-mother dyads, Ainsworth categorized infants' attachment patterns as secure, avoidant, and ambivalent (Ainsworth et al., 1978). Ainsworth, through her rigorous observations in Uganda and the Baltimore project, conceptualized the necessity of an attachment figure serving as a "secure base" (Ainsworth & Bowlby, 1991, p. 6), which enables infants to feel safe while exploring their environment.

In addition, she linked the strength of an infant's attachment to the rate and care with which the mother responded when the infant needed her (Ainsworth & Bowlby, 1991). The presence of these responses from the mother to the infant leads to the development of secure attachment between the mother-infant dyad. Other researchers thought that Ainsworth's three attachment relationship classifications did not reflect divergent attachment behaviors that were occurring outside of Ainsworth's sample; as a result, Main and Soloman (1990) re-evaluated the classification system by administering the Strange Situation procedure to a larger sample of participants from various backgrounds. In their analysis of results, Main and Soloman discovered behaviors that did not fit into any of Ainsworth's patterns of attachment. Consequently, they identified a fourth type of attachment organization, disorganized type (Main & Soloman, 1990). In their observations, they noted that disorganized infants appeared unable to organize a reaction to reuniting with their mother during the laboratory observation. Essentially, this type of attachment develops when the infant conceptualizes the caregiver as both scary and scared;

therefore, the infant needs to be comforted, but is afraid to seek comfort from the caregiver (Zilberstein & Messer, 2010).

The current study uses the term dysfunctional attachment to capture all types of attachment other than secure attachment. Terming this group of attachment as dysfunctional conveys an idea that the attachment style children are currently working with is not allowing them to function at an optimum level. Additionally, using the term dysfunctional attachment allows for clinicians who are assessing attachment relationships between a child and caregiver to indicate a breakdown in the relationship without conducting a formal assessment to specifically identify the insecure attachment type.

Connection of Attachment Style to Later Functioning

Once a classification system for infants' attachment was developed, researchers began to explore its translation to adult attachment styles and the relationship between a child's attachment and mother's recollections about childhood that could be connected to an attachment style. George, Kaplan, and Main (1985) developed the Adult Attachment Interview used by Main, Kaplan, and Cassidy (1985) in the identification of three adult attachment classifications. Main et al. (1985) found links between the adult's attachment classification, the value placed on attachment, and the infant's attachment classification in the Strange Situation procedure. Subsequently, a considerable amount of research emerged on the effects of attachment security on an infant's development; Sroufe's (1979) research helped connect relationship behavior and developmental abilities to security in the attachment relationship. Main, Kaplan, and Cassidy (1983) further identified links to infant performance and attachment security when her research supported the hypothesis that secure infants are more likely to explore their environment. Finally, Grossman and Grossman gathered longitudinal data in Germany and connected

childhood “attachment and exploratory experiences” (as cited by Grossman et al., 2005, p. 125) with caregivers throughout childhood to behavior exhibited in adult relationships.

Although the list of preceding studies is not close to exhaustive, significant studies in the history of research on Bowlby’s attachment theory have been discussed. This, and all other, attachment research is important to a clinician convinced of the long-reaching effects of attachment security throughout the lifecycle; the studies’ findings provide clinicians with methods of assessment, categorization, and intervention. The attachment classification systems give clinicians the ability to communicate in a common language concerning the patterns of behavior observed and the family dynamics at hand, as does the Diagnostic and Statistical Manual IV- text revised (DSM IV-TR). Additionally, identification of the client’s attachment style, which is possible through use of instruments such as the Strange Situation procedure and the Adult Attachment Interview, allows clinicians to understand contributing factors in the child or adult’s presenting disorder. The knowledge base obtained from attachment security assessment and classification affords clinicians with the ability to formulate interventions to improve the client’s relational bonds. Further, this vast amount of research has resulted in the formulation of clinical interventions for attachment disorders (see Benedict & Schofield, 2010; Brisch, 1999/2002; Levy & Orlans, 1998), supervision styles for counselors in training (see Fitch, Pistole, & Gunn, 2010), and a theoretical approach to counseling (see Skourteli & Lennie, 2011).

Attachment Theory and Cultural Diversity

Infants are born with the instinct to attach to a caregiver in order to keep safe during times of distress, which in turn promotes extended life of the infant and greater likelihood of future procreation. A review of attachment theory points to the propensity for identifying the

mother as “the” attachment figure. The view of the central male group pushes the idea of the woman as the caretaker for the children, thereby communicating the idea that she should be the central attachment figure. Grossman, Grossman, Kindler, & Zimmerman (2008) pointed out that women are the primary caretakers and that “fathers prefer to play with their infants” (p. 859).

Bowlby did not write about the father until 1982, when he indicated that mothers and fathers could serve the same purpose as attachment figures (Bretherton, 2010). Interestingly, he still qualified this statement by indicating that children first attach to mother and “a little later” to father (Bowlby, 1969/1982, p. 378). Research on the type and quality of attachment of a father versus that of a mother reflects the deeply rooted social message surrounding the roles of women and men in families. Although it may be true that fathers foster attachment differently than mothers, society’s messages to mothers promote the practice of responsive, nurturing behavior towards their children. Researchers have pointed to evidence that children may use fathers as a different type of secure base and that fathers may be more important in promoting growth through challenging play and responsiveness during play (Grossman et al., 2008). Ainsworth’s Strange Situation might not be an accurate measurement for the quality of an infant-father attachment (Grossman et al., 2008).

The prevalence of attachment behaviors, which are the basis for the Strange Situation’s results, might be culturally biased as well as gender-biased. Although Hilde and Stevenson-Hilde (1993) reported that mothers’ display of sensitivity might look different across cultures, researchers agree that “sensitive responsiveness” (p. 60) is necessary for a child to securely attach. The behaviors of attachment are present in all humans, but the desired occurrence of the behaviors could vary by culture. Clearly, culturally sensitive lenses are required for examination of attachment theory. The primary bias in attachment research revolves around gender roles and

cultural applicability, which attachment researchers are actively investigating. Clinicians must remain cognizant of the cultural context behind relationship dysfunctions as they relate to attachment in order to accurately assess and formulate a responsible treatment plan. Due to the survival-based need for attachment behaviors, the drive to attach is present across all cultures; however, the ways in which infants display attachment and the methods of attachment are different (van Ijzendoorn & Sagi-Schwartz, 2008). Brown, Rodgers, and Kapadia (2008) referenced Minuchin's consideration that independence of a child may be encouraged less in some families and more in others; additionally, attachment figures including extended family should be recognized.

Researchers have investigated non-Westernized, culturally desirable infant-caregiver relationships in Japan, Israel, and Germany (Brown et al., 2008). In a meta-analysis of 1,990 Strange Situation procedures conducted in 32 samples and gathered from eight countries, van Ijzendoorn and Kroonenberg (1988) examined "intracultural" and "cross-cultural" (p.148) differences in attachment classification. Using Ainsworth et al.'s (1978) conclusions that the United States had the following distribution of attachment patterns: 20% avoidant, 70% secure, and 10% resistant, they compared small samples to an amassed set of attachment distributions in order to determine the variations within a culture and between cultures. Van Ijzendoorn and Kroonenberg reported that classifications within a culture varied greatly; in fact, these differences had 1.5 times the variance of that between countries. Based on results from their meta-analysis, van Ijzendoorn and Kroonenberg (1988) recommended caution when generalizing attachment classifications from a sample to a country's population.

Whereas the need to attach is prevalent across all cultures due to its origin in evolutionary necessity, the ways in which infants attach appears to be different across cultures. The United

States is comprised of many different cultures, ethnicities, and races. Therefore, researchers and counselors would be mistaken in expecting attachment behaviors and maternal sensitivity to manifest identically when applied cross-culturally. Clinicians should utilize culturally sensitive interventions for attachment dysfunction; one such culturally responsive intervention is the modality of play therapy.

Attachment and Play Therapy

Identification of the strength of the attachment relationship and corresponding maternal and infant behaviors between a child and caregiver provides an avenue for clinical treatment planning. Attachment is connected to developmental outcomes and is prevalent across cultures, genders, and ages; therefore, attachment lends itself as a structure on which to base therapeutic interventions. Zilberstein and Messer (2010) indicated that evidenced based interventions for dysfunctions in attachment have not been identified; however, counselors can apply their knowledge of the adult or child's attachment patterns in selection of therapeutic interventions. One approach is for the parent to receive individual treatment, in addition to caregiver-child treatment, to promote further insight into the caregiver's relational behaviors and increase sensitive parenting behaviors (O'Connor & Zeanah, 2003). Ryan and Bratton (2008) indicated, "Attachment theory and research is a well-established framework for understanding children's normal and atypical social/emotional development. It is used extensively by clinicians to design interventions, understand interactions, and assess clinical progress" (p. 28).

The Tulane Infant Team illustrated the efficacy of treatment plans built on attachment assessments in their findings with foster parents, birth parents, and children (Berlin, Zeanah, & Lieberman, 2010). Using the results from the "Crowell procedure" and the Working Model of the Child Interview, interventions targeted the child/foster parent and child/birth parent dyads.

These interventions included Child-Parent Psychotherapy, Circle of Security, and Interaction Guidance (Berlin, Zeanah, & Lieberman, 2010). In addition to the interventions utilized by the Tulane Team (Berlin, Zeanah, & Lieberman, 2010), other treatments aimed at improvement of parent-child relational pattern, including variations of play therapy, have been identified as viable options (Benedict, 2006; Zilberstein & Messer, 2010).

The overarching goal of attachment-based treatments should be to develop the propensity of caregivers to make themselves available as secure bases and increase the likelihood that their children will respond to this safe haven (O'Connor & Zeanah, 2003). However, findings of a study by Cohen et al. (1999) indicated that a shift in attachment status does not necessarily equate with a change in maternal sensitivity. In their research comparing effects on attachment status of the filial therapy, play-based interventions Watch, Wait, and Wonder (WWW) and Parent-Infant Psychotherapy, the WWW intervention resulted in a greater shift to secure attachment, but did little to effect material sensitivity and responsiveness (Cohen et al., 1999).

Other researchers have pointed to the need to consider factors beyond parental sensitivity when selecting therapeutic interventions in response to an attachment dysfunction. They support this claim with evidence that sensitively responsive foster parents can live with foster children who do not reorient their attachment towards the available sensitive parenting (O'Connor & Zeanah, 2003). Conversely, De Wolff and van IJzendoorn (1997) found a connection between maternal sensitivity and attachment security in their meta-analysis, supporting the possibility that intervention for maternal sensitivity is associated with a strengthened attachment bond. Therefore, interventions aimed at the attachment relationship or maternal sensitivity could influence the attachment relationship. O'Connor and Zeanah (2003) made further recommendations about the treatment of individuals with attachment disturbances, which

included support groups for caregivers and an expansion of the treatments with many different methods of intervention. These interventions could incorporate "increasing parental sensitivity to promote attachment security, helping [the] child develop better social problem-solving abilities, enhancing children's emotional understanding, and improving peer relations" (O'Connor & Zeanah, 2003, p. 241).

The treatment variables proposed by O'Connor and Zeanah (2003) are present in various play therapy interventions. In fact, when parents conduct the play sessions after being trained by a play therapist in filial therapy techniques, treatment appears to be more effective when compared to play therapy conducted by a mental health professional, as evidenced by a meta-analysis conducted by Bratton, Ray, Rhine, and Jones (2005). In using play therapy to intervene with attachment dysfunction of aggressive and aggressed-upon children, Mills and Allan (1992) proposed consideration of the child's internal working model, ego defense mechanisms, and transference in the therapeutic relationship

> (a) to help the child bring early trauma experienced through maltreatment or breaks in attachment to the play experience (and ultimately into consciousness); and (b) to rework through the therapeutic relationship the child's maladaptive internal models of self and self in relationship to others. (p. 7)

A play therapist should be aware of the child's current attachment style before formulating a treatment plan (Martin, 2005). If play therapists decide that individual play therapy is more appropriate, they could consider Helen Benedict's (2006) form of play therapy called object-relations play therapy, which reflects the goals identified by Mills and Allan. In object-relations play therapy, the therapist works to become the secure base within the relationship, thereby promoting the ability of the child to "explore his or her own psychological world" (Benedict,

2006, p. 5). Through this exploration, the goal is to challenge and alter the child's working models, along with the patterns of attachment with others (Benedict, 2006). Although individual play therapy, like object relations play therapy, is supportive of the treatment process, treatment aimed to strengthen the parent-child bond is paramount when addressing familial dysfunction (Lieberman, 2003). Schaefer and Drewes (2011) cited research that supported positive outcomes on the attachment relationship between a parent and child when the treatment involved Theraplay, filial therapy, and parent-child interaction therapy. Based on the research supporting the efficacy of these treatment modalities for attachment dysfunction, implementation of these modalities may be appropriate when play therapists treatment plan for an insecurely attached child client.

Summary

Many researchers have spent their careers studying the validity of Bowlby's ideas. The dedication of these researchers has provided clinicians with a way to conceptualize childhood distress, understand familial relationships and relational patterns, trace developmental patterns, and select appropriate treatment interventions. In contrast to other studies on the attachment relationship and its place in clinical practice, I examined the prevalence of perceived competence of play therapists to intervene in a dysfunctional attachment relationship through utilization of family-systems play therapy interventions.

Although research supports the inclusion of parents in the play therapy process as it relates to treatment outcomes, as well as the connection of attachment between a caregiver and child to later functioning, the Association for Play Therapy does not specifically require education in family play therapy when obtaining credentialing as a registered play therapist. Though research has concluded that attachment patterns relate to developmental outcomes, loose

requirements on the educational training clinicians obtain before certification as an RPT or RPT-S suggests the possibility for inadequate preparedness to respond to an identified family-systems dysfunction. One way to determine the need for family-systems intervention is through the understanding of the attachment style between a child and caregiver. No studies were found on perceived competence in family-systems play therapy interventions and its connections to appropriately implementing interventions for a dysfunctional attachment between child clients and caregivers. This study sought to investigate the relationship of perceived competence in family-systems play therapy interventions with play therapists' preparedness in utilization of family-system play therapy with an attachment-perspective on family dysfunction.

Chapter Three

METHODOLOGY

The methodology for the study is presented in this chapter. The chapter includes subsections that elaborate on the purpose of the study, research questions, development of the survey instrument, participants, pilot study, methods for data collection and data analysis, and summary.

Purpose of the Study

The purposes of this quantitative study with a qualitative adjunct were to determine the extent to which play therapists integrate into treatment planning their knowledge of the attachment style between the child and caregiver and to examine the preparedness of play therapists to respond to dysfunctional attachment relationships using family-system play therapy interventions for attachment deregulation.

This study sought to understand the extent to which play therapists were prepared to respond with effective therapeutic interventions to dysfunctional attachment between a child and caregiver. Studies within the field of play therapy have produced evidence that some family-systems interventions have a relationship-enhancing effect (as cited by Schaefer & Drewes, 2011). These interventions include Filial Therapy, Child-Parent Relationship Therapy, Theraplay, and Parent-Child Interaction Therapy.

Participants

The members of the Association for Play Therapy (APT) were the population of interest. Currently, APT membership is 5,207 individuals (C. Guerrero, personal communication, March 27, 2012). These members include 915 Registered Play Therapists and 992 Registered Play Therapist-Supervisors (APT, 2012d). There are three statuses of membership: affiliate,

professional, and international. Membership status is based on the individual's location and educational or training level. Affiliates are members who are either full-time graduate students or non-mental health professionals interested in play therapy. Professional members specialize in mental health care and live within the United States. International members specialize in mental health care, but live outside the United States.

Of the 5,207 APT members, 5,139 had made their email address available to APT. The survey was distributed to 5,139 members; 513 surveys were returned. Due to incomplete or unusable responses, listwise deletions were used to reduce the sample to 456 members of APT. This represented a response rate of 8.9%. Participants were asked to provide demographic information to assess for the presence of a representative sample. Participants indicated their sex, age, and ethnicity (see Table 1). The average age of participants was 45. A large majority of the respondents were female (93.6%) compared to the percentage male participants (6.4%). Most participants self-identified as Caucasian (85.1%), and smaller percentages self-identified as African American (3.9%), Hispanic (3.1%), Other (3.1%), Bi-racial/ Multiracial (2.4%), Asian American (0.9%), Native American (0.9%), Middle Eastern (0.4%), or Pacific Islander (0.2%). Lambert et al. (2007) and Ryan et al. (2002) found similar distributions of age, sex, and ethnicity among their study participants. Because the majority of the sample self-identified as Caucasian, the ethnicity items were collapsed into two categories of Minority and Non-minority for analysis.

Table 1

Participants' Demographics by Frequency or Means, Standard Deviations, and Ranges (n=456)

Variable	*n*	%	*M*	*SD*	Range
Sex					
Female	427	93.6			
Male	29	6.4			
Total	456	100			
Age (in years)			44.72	12.42	23-78
Ethnicity					
African American	18	3.9			
Asian American	4	0.9			
Bi-Racial/Multi-racial	11	2.4			
Caucasian	388	85.1			
Hispanic	14	3.1			
Middle Eastern	2	0.4			
Native American	4	0.9			
Pacific Islander	1	0.2			
Other	14	3.1			

Participants reported on their professional characteristics by credentials, graduate school enrollment, and future plans to obtain RPT credentials (see Table 2). Over one-third (37.5%) of the respondents indicated they held the credential of Licensed Professional Counselor. Other credentials held included Licensed Clinical Social Worker (28.9%), Other Credential (23.5%), Registered Play Therapist (23%), Registered Play Therapist-Supervisor (20.4%), National Certified Counselor (14.5%), Licensed Marriage and Family Therapist (14%), Counselor Intern (6.1%), National Certified School Counselor (2.9%), Psychiatric Nurse (0.7%), and School Psychologist (0.4%). Respondents were asked to choose all credentials currently held. For ease of analysis, the number of credentials per person was calculated. Almost 50% of respondents held only one credential, whereas 33.7% of the sample held two credentials. Given that Registered Play Therapists and Registered Play Therapists- Supervisors must hold a state license to obtain the RPT credential, it appears that most respondents held only a state license or a state license and an RPT or RPT-S credential. With respect to educational attainment, most respondents indicated post-Master's degree (98.2%). With respect to plans for acquiring the

RPT credential, 40.1% of those who were not RPTs planned to acquire the credential after completing education and/or experience requirements.

Table 2

Participants' Professional Characteristics by Frequency (n=456)

Variable	*n*	%
Current Credentials*		
Counselor Intern	28	6.1
Licensed Clinical Social Worker	132	28.9
Licensed Marriage Family Therapist	64	14
Licensed Professional Counselor	171	37.5
National Certified Counselor	66	14.5
National Certified School Counselor	13	2.9
Psychiatric Nurse	3	0.7
Registered Play Therapist	105	23
Registered Play Therapist- Supervisor	93	20.4
School Psychologist	2	0.4
Other	107	23.5
Number of Credentials per Respondent*		
1	227	49.8
2	153	33.6
3	58	12.7
4	13	2.9
5	5	1.1
Master's Student		
Yes	8	1.8
No	448	98.2
Plans for RPT		
Will acquire	183	40.1
Will NOT acquire	59	12.9
Not applicable	214	46.9

*Participants were asked to choose all that applied to them; therefore, resulting frequencies are greater than the number of participants

Participants also reported on their practice patterns in their play therapy work (see Table 3). On average, participants had almost 12 years of experience in play therapy and most worked in private practice (45.8%) or in an agency setting (31.1%). Half (50.4%) of the respondents identified with a Child-Centered theoretical orientation in their use of play therapy. Theoretical orientations selected less frequently were Eclectic play therapy (13.4%), Cognitive-Behavioral play therapy (9.9%), and Prescriptive play therapy (7.2%). Because the majority of the sample

identified with Child-Centered play therapy, the theoretical orientations were collapsed into two categories of Child-Centered and Other for analysis. Respondents were asked to choose the age groups of clients they primarily serve and were allowed to select all that applied. The three most common age groups served were clients ages 6-10 (87.5%), 0-5 (39.9%), and 11-15 (27.6%). For ease of analysis, these three age categories were collapsed into one age category to include clients 0-15 years old; data from previous literature indicated that ages 3-14 were most common.

Table 3

Participants' Practice Patterns by Frequency or Means, Standard Deviations, and Ranges (n=456)

Variable	*n*	%	*M*	*SD*	Range
Years of Play Therapy Experience			11.85	7.94	2-33
Practice Setting					
Agency	142	31.1			
Home-based Services	24	5.3			
Hospital	9	2			
Private Practice	209	45.8			
School	55	12.1			
University	7	1.5			
Other	6	1.3			
Not Applicable	4	0.9			
Theoretical Orientation					
Adlerian	29	6.4			
Child-Centered	230	50.4			
Cognitive-Behavioral	45	9.9			
Eclectic	61	13.4			
Ecosystemic	1	0.2			
Gestalt	6	1.3			
Jungian	11	2.4			
Object Relations	5	1.1			
Prescriptive	33	7.2			
Psychodynamic	12	2.6			
Unsure	5	1.1			
Other	18	3.9			
Ages of Clients Served*					
0-5 years	182	39.9			
6-10 years	399	87.5			
11-15 years	126	27.6			
16-20 years	42	9.2			
21-25 years	14	3.1			
Other	10	2.2			

*Participants were asked to choose all that applied to them; therefore, resulting frequencies are greater than the number of participants

Internet-Based Surveys

The process of surveying in research studies has changed considerably over the last few decades. Some researchers have observed the benefits of utilizing the Internet to conduct research, whereas others have recognized limitations to this method. Several advantages to internet-based surveys include reduced cost, speedier submission of responses, and ease of data

input for analysis; however, limitations such as risk of compromised security, possible issues with ease of use and access to technology, and "sample selection bias and reduced response rates" (Granello, 2007, p. 70) should be considered when developing electronic survey methodology (as cited in Jansen, Corley, & Jansen, 2007)

Jansen, Corley, and Jansen (2007) identified three types of electronic surveys: point-of-contact, e-mail based, and web-based. According to their definition, web-based surveys or Internet-based surveys are "survey instruments that physically reside on a network server (connected to either an organization's intranet of the Internet), and that can be assessed only through a Web-browser" (as cited in Jansen et al., 2007, p. 2). This definition is consistent with the present study's survey methodology. Jansen, Corley, and Jansen (2007), in their review of the literature surrounding the use and best practices of Internet surveys, reported that quick turn-around time for administration and reduction of overhead were realistic expectations when choosing Internet-based research; however, the effects of the chosen distribution method on response rates were not conclusive. Buchanan and Hvizdak (2009) cited research that recommended inclusion of a detailed introductory letter to participants in order to increase participants' trust in the researcher. These details should include "an explanation of the purpose of the study, how a respondent is selected, how data will be used, and who will have access to it" (Buchanan & Hvizdak, 2009, p. 38). Additionally, maintaining integrity of the survey's validity becomes problematic when researchers alter the survey once data collection has begun (as cited in Jansen et al., 2007).

Granello (2007) actually indicated a lower response rate for Internet surveys when compared to paper varieties. In fact, Granello (2007) cited research findings pointing to a 10-20% reduction in response rates. Distributing the survey by email to a specific population with

an introductory letter from an esteemed individual in the field, and addressing the letter to individual participants, were suggested for improving the rate of response. Another important consideration is outmaneuvering the server's spam filter for individuals on the distribution list in order to direct the email where it will be seen. Hanscom, Lurie, Homa, and Weinstein (2002) studied the use of computer-based surveys compared to paper-based surveys administered to patients in spine care clinics. They concluded that computer-based surveys lead to more item completion and patients' increased utilization of fixed choices. Additionally, they found that they got more precise information if they reduced the number of open-ended questions. In part, the researchers attributed the completion rate to placing only one survey item at a time on the computer screen and requiring the patient to intentionally advance to the following survey item (Hanscom et al., 2002). However, Hanscom et al. (2002) also noted that, contrary to common recommendations, they neither required patients to answer each question nor re-introduced skipped items.

In the present study, I implemented the suggestion to include a detailed informed consent in the email soliciting for participation. One alteration in the present study's instrument was necessary after the study began; however, the integrity of the data was maintained because the addition of the response item made the survey more accurate. An effort was made to bypass spam filters by sending the electronic communication through an individually registered server; however, I found that sending the request for participation in this way led to an increase in human error. In the second request for participation, the participation request was distributed through Qualtrics ™. The suggestion to reduce the number of items presented to participants at one time was considered when constructing the survey in Qualtrics ™. The items per page were kept to a minimum. Finally, in the present study, participants were forced to answer each

question before proceeding to the next item. These strategies may have increased the number of completed surveys available for analysis upon conclusion of the data collection period.

Instrument Development

I was unable to find an existing instrument to examine play therapists' patterns of assessing for attachment between a child and caregiver and their preparedness to respond to the results of this assessment with family-systems play therapy interventions. Therefore, I developed the *Play Therapists' Decision-Making Inventory* (*PTDI*), and revised it to become the *Play Therapists' Decision-Making Inventory-Revised* (*PTDI-R)* based on results from my pilot study. The *Play Therapists' Decision-Making Inventory-Revised* (*PTDI-R*) examined the following: a) the relationship between the perceptions of competency play therapists have in a family-systems play therapy interventions and their perception of the importance of the attachment relationship; b) the relationship of the amount of play therapists' clinical experience to their utilization of family-systems play therapy interventions; c) the relationship of utilization of family-systems play therapy interventions and play therapists' perception of the importance of the attachment relationship; d) the frequency with which play therapists respond to dysfunctional attachment with a family-systems play therapy intervention; e) the relationship between play therapists' response to dysfunctional attachment with a family-systems play therapy intervention to competency in family-systems play therapy interventions; f) the relationship of play therapists' theoretical orientation to the utilization of family-systems play therapy interventions; and g) the relationship between competency in family-systems play therapy interventions and the amount of training play therapists report in these interventions; h) the relationship between credentials in play therapy and the utilization of family-systems play therapy interventions; and i) the information necessary for constructing a treatment plan.

The *PTDI-R* is a 22-item instrument developed from a review of play therapy literature and a quantitative pilot study I conducted in March 2012. I developed the items in the *PTDI-R* based on literature surrounding play therapists' training needs and attachment research (see Table 4). The *PTDI-R* consists of three sections. In Section I, play therapists indicated their demographic information, including gender, age, race/ethnicity, mental health credentials, identification as a graduate student in a master's program, interest in credentialing as a Registered Play Therapist, and years of experience providing play therapy services. Additionally, they indicated their primary play therapy practice setting, their theoretical orientation, and the primary age range of their clientele.

In Section II, participants reported their beliefs about play therapy training and competency, families, and attachment using a 6-point Likert scale with response choices of (1) Disagree Strongly, (2) Disagree, (3) Tend to Disagree, (4) Tend to Agree, (5) Agree, and (6) Agree Strongly. First, respondents indicated their perceived importance of the attachment relationship in the treatment planning process. Then, respondents indicated, according to their perception, whether they have received adequate or inadequate training in family-based play therapy interventions. Next, they indicated their beliefs about the role attachment relationships play in the functioning of a family system and an individual. Finally, participants responded to the extent to which they agree with a statement about their perceived competency in family-based play therapy interventions.

In Section III, respondents indicated their practice patterns in conducting play therapy using a 6-point Likert scale with response choices of (1) Never, (2) Very Rarely, (3) Rarely, (4) Occasionally, (5) Frequently, and (6) Very Frequently. First, they indicated frequency of utilization of Filial Therapy, Child-Parent Relationship Therapy, Group Play Therapy, Parent-

Child Interaction Therapy, Individual Play Therapy, and Theraplay. Next, participants indicated the frequency with which they consider the attachment relationship in treatment planning. Then, participants reported their frequency of use of family based interventions as a response to dysfunctional attachment. Finally, two qualitative questions were presented. In the first question, participants were asked their perception of the three most important pieces of information in the construction of a treatment plan. The second qualitative question aimed to gather any information the survey may have missed by asking participants to share any further information about their use of family-systems play therapy interventions.

Table 4

Instrument Development- Play Therapists' Decision-Making Inventory-Revised (PTDI-R)

Questions	Supporting Literature
2-5	Participants' demographics
6-10	Kranz, Kottman, & Lund (1998); Lambert, LeBlanc, Mullen, Ray, Baggerly, White, & Kaplan (2007)
11	Kranz, Kottman, & Lund (1998); Lambert, LeBlanc, Mullen, Ray, Baggerly, White, & Kaplan (2007); Schaefer (2011)
12	Phillips & Landreth (1998)
13	Bowlby (1969/1982); Grossman, Grosssman, & Waters (2005); Haslam & Harris (2011); Main (1983); Martin (2005); Martin (2007); Sroufe (1979)
14	Drewes (2006); Herschell, Calzada, Eyberg, & McNeil (2002); Jernburg (1984); Landreth & Bratton (2006); VanFleet (2011a)
15	Fall, Drew, Chute, & More (2007); Kranz, Kottman, & Lund (1998)
16	Drewes (2006); Herschell, Calzada, Eyberg, & McNeil (2002); Jernburg (1984); Landreth & Bratton (2006); VanFleet (2011a)
17	Haslam & Harris (2011)
18	Baggerly & Bratton (2010); Schaefer (2011)
20-22	Bowlby (1969/1982); Haslam & Harris (2011); Martin (2005); Martin (2007)

Pilot Study

I conducted a pilot study in March 2012 to test the initial construction of the *Play Therapists' Decision-Making Inventory.* First, an expert panel reviewed the survey and suggested revisions. Then, the survey was sent electronically to 125 members of the Louisiana Association

for Play Therapy. A detailed review of the pilot study is available in Appendix A. The following discussion presents key points in an overview of the pilot study.

The research questions and data analysis procedures for the pilot study were:

Research Question 1: What variables contribute to the value LAPT members place on attachment between a client (child) and primary caregiver? Exploratory factor analysis was conducted to analyze the data.

Research Question 2: What percentage of LAPT members are assessing for attachment between (a) a child and primary caregiver; (b) a caregiver and his or her primary caregiver? Descriptive Statistics were computed on survey items # 20 & #22.

Research Question 3: What kind of training experiences do LAPT members have in family-systems play therapy interventions? Descriptive Statistics were computed on survey items # 8, 9, 11, &13.

Research Question 4: What methods of intervention are used most frequently by LAPT members as a response to insecure attachment? Descriptive Statistics were computed on survey item # 26.

Participants in the pilot study included members of the Louisiana Association for Play Therapy (LAPT). The sole criterion for participation in the pilot study was current membership in LAPT. Given this minimal delimitation, an expectation existed that the resulting sample would consist of varying ages, ethnicities/races, gender, and experience. Currently, LAPT has 139 members (E. Dugan, personal communication, March 29, 2012); however, only 125 email addresses for members were available. Members of LAPT can join within the same types of categories as the national Association for Play Therapy. The survey was distributed to 125 members of LAPT, 30 of whom began to complete the survey. A total of 86% of respondents

completed 80% or more of the entire survey with an average survey duration of 8 minutes; 29 of the 30 survey responses were considered appropriate for analysis. The respondents largely consisted of Caucasian females who reported a mean age of 39.5 and a mean of 8 years of experience in play therapy, and held certification as a licensed professional counselor and/or a registered play therapist- supervisor (see Table 3). Most of the participants were not current students in a master's degree program (93%); however, the participants (*n*= 15) who were not already certified as registered play therapists were in the process of gaining education or clinical experience to earn the registered play therapist credential (73%).

The focus of the pilot study was largely on the underlying factors in the *Play Therapists' Decision-Making Inventory* that contribute to the value that play therapists place on the attachment relationship. Additionally, this pilot study examined the prevalence of assessing for attachment, the education play therapists had acquired in family-based play therapy interventions, and the frequency of utilizing family-based interventions after identifying an insecure attachment between a child and caregiver.

Some of the factor loadings resulting from the exploratory factor analysis were lower than expected. Additionally, the small sample size (n=29) inhibited the variance in the scores, thereby reducing the inclusion of many items in the factor analysis. The reduction of 27 items on the instrument to four items included in the factor analysis greatly decreased the confidence in the validity of the instrument. Given that only two factors emerged based on four items, the ability of the instrument to measure the value play therapists attribute to the attachment relationship was deemed to be limited. It was expected that increasing the sample size might result in the occurrence of more factors and stronger loadings of items on these factors. Finally, the connection among the three items loading onto the Experience factor was not clear.

Experience was identified as the common thread through these factors, leading to a conclusion that the more experience play therapists have acquired, the more likely they are to have developed a system for assessing for attachment, witnessed the importance of the caregiver-child bond, and have the right conditions available to implement these practices.

The emerging trend in the descriptive statistics (see Appendix A) suggested that play therapists are aware of the importance of attachment and that they are utilizing assessment procedures to better understand this relationship. However, the majority of surveyed play therapists were not trained in family-based play therapy approaches, which could lead to a lack of preparedness when attempting to respond to identified insecure attachment. For example, inclusion of a client insecurely attached in a group play therapy intervention is not recommended in the literature (Ray, 2011); however, 20% of surveyed play therapists responded to insecure attachment sometimes or often with a group intervention.

Modifications to the Instrument

Following the pilot study, modifications were made to the instrument in its presentation through Qualtrics ™ and survey items were altered to improve data analysis. Thus, the instrument utilized in the final study is referred to as *Play Therapists' Decision-Making Inventory-Revised* (*PTDI-R*) in the remainder of the document. Modifications in the way data were collected assisted in making the responses to the final survey more meaningful. See Appendix A for a detailed discussion of modifications made. With data from the pilot study, Cronbach's alpha was calculated to assess the instrument for internal reliability. After removing four survey items, the instrument obtained an acceptable level of reliability, Cronbach's $\alpha = .86$. See Appendix A for a full discussion of the calculation process.

The expert panel was contacted after revisions were made to the original instrument and the panelists were asked to provide feedback on *Play Therapists' Decision-Making Inventory-Revised* (*PTDI-R).* This expert panel was asked to comment on the clarity of survey questions, completeness of item inclusion, and organization of the survey instrument. Additionally, the expert panel was utilized to increase the content validity of the *Play Therapists' Decision-Making Inventory-R.*

Four recommendations made by the expert panel were implemented. These suggestions included: the addition of a question concerning membership status in the Association for Play Therapy; a response option of "home-based services" under setting for play therapy practice; definitions for Child-Parent Relationship Therapy, Parent-Child Interaction Therapy, Theraplay, and Filial Therapy; expanding a survey item concerning competency in family-systems play therapy interventions into multiple questions addressing each intervention separately; forcing responses for each survey item.

Procedures

The University Committee for the Protection of Human Subjects in Research at the University of New Orleans approved the research and procedures for this study on August 21, 2012 (see Appendix G). Following approval, a Rental List Agreement and description of the research was submitted to the Association for Play Therapy (APT) and available email contact information for the 5,207 members of APT was obtained (see Appendix H and I). An electronic communication (see Appendix J) was sent to the 5,139 APT members who had supplied email addresses. It contained informed consent for participation in the study, a short description of the research purpose, a statement about consent to voluntarily participate, anonymity of response, and an anonymous link to the survey. When potential respondents followed the anonymous link

to the survey, the statement of informed consent to participants was presented and participants indicated consent to participate before proceeding to the survey items.

APT members received a follow-up email two weeks later as a reminder (see Appendix K). The *PTDI-R* survey was available over four weeks (see Appendix L). At the end of the data collection period, all APT members with an email address received an electronic communication thanking them for their participation and providing the option to receive results after data analysis.

The Qualtrics ™ server housed the data under a password-protected account. Once data collection was complete, data extraction occurred converting the Qualtrics ™ data into a Statistical Package for the Social Sciences (SPSS-20; 2011) file for use in analyses. The Qualtrics ™ server will house the data for five years, as required by the American Psychological Association (2010).

Research Questions and Data Analysis

The overall question addressed in this study was: Are play therapists prepared to respond with effective therapeutic interventions to dysfunctional attachment between a child and caregiver? Studies within the field of play therapy have produced evidence that some family-systems interventions have a relationship-enhancing effect through their application (as cited by Schaefer & Drewes, 2011). These interventions include Filial Therapy, Child-Parent Relationship Therapy, Theraplay, and Parent-Child Interaction Therapy. To gain a deeper understanding of play therapists' competence and application of these interventions, play therapists' frequency of usage of family-systems play therapy interventions served as the dependent variable in the current study. The independent variables were perceived importance of the attachment relationship between a child and caregiver, play therapists' perceived level of

competence in family-systems play therapy intervention, play therapists' demographic variables (age, sex, ethnicity, and race), play therapists' theoretical orientation, play therapists' years of experience in play therapy, and play therapists' credentials. The research questions and corresponding methods of data analysis are presented below. Data analysis procedures included descriptive statistics, multiple linear regression, Spearman's rho, and principle component analysis. An alpha of .01 was set to reduce the likelihood of a Type I error.

Research Question 1

What variables contributed to play therapists' frequency of usage of family-systems play therapy interventions?

Research Hypothesis 1: It was hypothesized that there is a significant relationship between frequency of usage of family-systems play therapy interventions and the independent variables (perceived importance of the attachment relationship between a child and caregiver, play therapists' perceived level of competence in family-systems play therapy interventions, play therapists' demographic variables, and play therapists' credentials serve as independent variables).

Data Analysis: Multiple Linear Regression was used to examine survey items #2, 4, 6, 9, 11, 12, 13 (parts 2 & 3), 15, 17, 18 (parts 3-6), 19, and 20.

Research Question 2

Is there a relationship between play therapists' perceived importance of the attachment relationship and their perceived level of competence in family-systems play therapy interventions?

Research Hypothesis 2: It was hypothesized that there is a significant relationship between play therapists' perceived importance of the attachment relationship between child and primary

caregiver and their perceived level of competence in family-systems play therapy interventions.

Data Analysis: Spearman's rho was used to compare survey items #13 (parts 2 & 3) and 17.

Research Question 3

Is there a relationship between play therapists' perceived importance of the attachment relationship and frequency of usage of family-systems play therapy interventions?

Research Hypothesis 3: It was hypothesized that there is a significant relationship between play therapists' perceived importance of the attachment relationship between child and primary caregiver and their frequency of usage of family-systems play therapy interventions.

Data Analysis: Spearman's rho was used to analyze survey items #13 (parts 2 & 3) and 18 (parts 3-6).

Research Question 4

Is there a relationship between play therapists' perceived level of competence in family-systems play therapy interventions and frequency of usage of family-systems play therapy interventions to respond to dysfunctional attachment?

Research Hypothesis 4 It was hypothesized that there is a significant relationship between play therapists' perceived level of competence in family play therapy interventions and their frequency of usage of family-systems play therapy interventions.

Data Analysis: Spearman's rho was used to compare survey item #17 and 20.

Research Question 5

Is there a relationship between play therapists' perceived level of competence in family-systems play therapy interventions and their perception of adequacy of training in family-systems play therapy interventions?

Research Hypothesis 5: It was hypothesized that there is a significant relationship between play

therapists' perceived level of competence in family-systems play therapy interventions and their perception of having experienced adequate training in family-systems play therapy interventions.

Data Analysis: Spearman's rho was used to analyze survey items #15 and 17.

Research Question 6

Is there a relationship between play therapists' theoretical orientation and frequency of usage of family-systems play therapy interventions?

Research Hypothesis 6: It was hypothesized that there is a relationship between play therapists' theoretical orientation and frequency of use of family-systems play therapy interventions.

Data Analysis: Spearman's rho was used to analyze survey items #11 and 18 (parts 3-6).

Research Question 7

Is there a relationship between play therapists' years of experience and frequency of usage of family-systems play therapy interventions?

Research Hypothesis 7: It was hypothesized that there is a relationship between play therapists' years of experience and frequency of use of family-systems play therapy interventions.

Data Analysis: Spearman's rho was used to analyze survey items #9 and 18 (parts 3-6).

Research Question 8

Is there a relationship between play therapists' credentialing as an RPT and frequency of usage of family-systems play therapy interventions to respond to dysfunctional attachment?

Research Hypothesis 8: It was hypothesized that there is a significant relationship between play therapists' possession of the RPT credential and their frequency of usage of family-systems play therapy interventions.

Data Analysis: Spearman's rho was used to analyze #6 and 20.

Research Question 9

Is there a relationship between play therapists' credentialing as an RPT-S and frequency of usage of family-systems play therapy interventions to respond to dysfunctional attachment?

Research Hypothesis 9: It was hypothesized that there is a significant relationship between play therapists' possession of the RPT-S credential and their frequency of usage of family-systems play therapy interventions.

Data Analysis: Spearman's rho was used to analyze #6 and 20.

Research Question 10

What factors contributed to perceived importance that play therapists attribute to the influence of attachment between a client (child) and primary caregiver?

Research Hypothesis 10: It was hypothesized that factors will emerge that are associated with the importance that play therapists place on the influence of the attachment relationship between a child and caregiver.

Data Analysis: Principal Component Analysis was conducted on items 18 (3-6), 19, and 20.

Chapter Four

RESULTS

The purposes of this study were to determine the extent to which play therapists integrate into treatment planning their knowledge of the attachment style between the child and caregiver and to examine the preparedness of play therapists to respond to dysfunctional attachment relationships using family-system play therapy interventions for attachment deregulation.

Data were collected using the *Play Therapists' Decision-Making Inventory-Revised* (*PTDI-R*), a 22-item instrument developed from a review of play therapy literature and a pilot study I conducted in March 2012. The *PTDI-R* was used to examine the following: a) the relationship between the perceptions of competency play therapists have in a family-systems play therapy interventions and their perception of the importance of the attachment relationship; b) the relationship of the amount of play therapists' clinical experience to their utilization of family-systems play therapy interventions; c) the relationship of utilization of family-systems play therapy interventions and play therapists' perception of the importance of the attachment relationship; d) the frequency with which play therapists respond to dysfunctional attachment with a family-systems play therapy intervention; e) the relationship between play therapists' response to dysfunctional attachment with a family-systems play therapy intervention to competency in family-systems play therapy interventions; f) the relationship of play therapists' theoretical orientation to the utilization of family-systems play therapy interventions; and g) the relationship between competency in family-systems play therapy interventions and the amount of training play therapists report in these interventions; h) the relationship between credentials in play therapy and the utilization of family-systems play therapy interventions; and i) the information necessary for constructing a treatment plan. Ten research questions and hypotheses

were constructed to examine these relationships, as well as the issues of frequency of use of FSPTI and role of the attachment relationship in treatment planning. Results of the analyses of these research questions are presented in the following section.

Analysis of Research Questions

Research Question 10

Research question 10 examined the factors that contribute to the perceived importance that play therapists attribute to attachment between a client (child) and primary caregiver. *Hypothesis 10* stated that factors would emerge that are connected with the importance that play therapists place on the influence of the attachment relationship between a child and caregiver.

Research question 10, along with associated hypothesis testing, is discussed first due to its impact on the analysis of the remaining research questions. Items from the *PTDI-R* were analyzed using a principal component analysis to assess the underlying structure of six items (items 18 (3-6), 19, and 20) that addressed participants' frequency of use of FSPTI relative to an understanding of the attachment relationship.

The initial results of the scree plot (see Figure 1) resulted in identification of one factor. Any eigenvalues over 1 are considered to represent a substantial amount of variance attributed to the factor (Field, 2009). The six items from the *PTDI-R* loaded onto a factor with an eigenvalue of 2.7, indicating that it was highly representative of the underlying factor. This factor accounted for 45% of the variance between the six survey items. Rotation was not employed due to the high level of fit achieved without rotation. Table 5 presents the items and their loadings on the factor.

Figure 1

Scree Plot for Principle Component Analysis

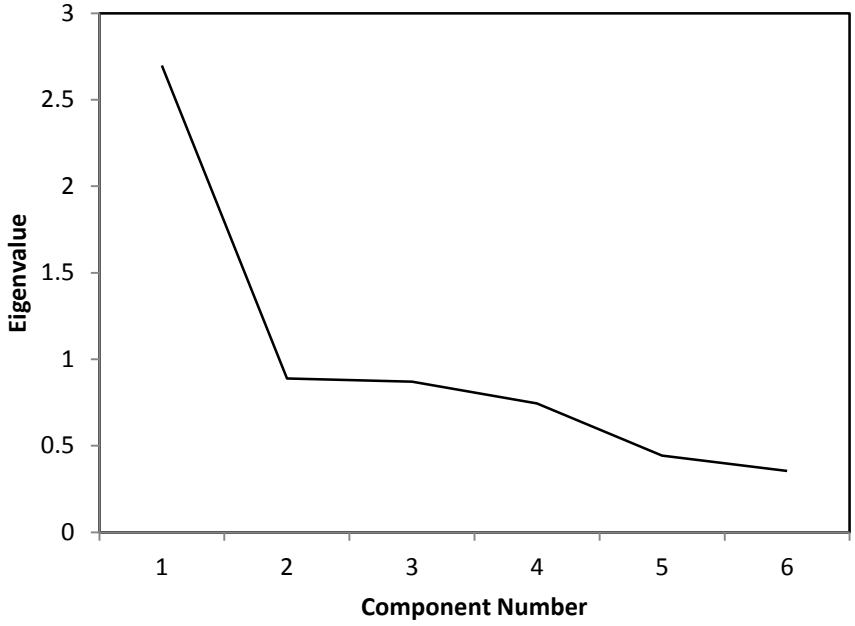

Table 5

Factor Loadings for PTDI-R Survey Items

Survey Item	Factor 1	Communalities
1. How frequently do you use the following interventions? –Filial Therapy	.65	.43
2. How frequently do you use the following interventions? –Child-Parent Relationship Therapy	.77	.60
3. How frequently do you use the following interventions? –Theraplay	.55	.31
4. How frequently do you use the following interventions? –Parent-Child Interaction Therapy	.66	.44
5. When treatment planning, how often do you consider the attachment relationship between a client (child) and a primary caregiver?	.56	.31
6. Dysfunctional attachment occurs when children are consistently unable to depend on their caregivers to meet their needs. If a dysfunctional attachment style is identified between a client (child) and the child's primary caregiver, how frequently do you utilize a family-systems play therapy intervention, such as Filial Therapy, Child- Parent Relationship Therapy, Theraplay, and Parent-Child Interaction Therapy, in the client's (child's) treatment?	.79	.62

Findings. All six items had a strong loading on the factor, ranging from .55 to .79. According to Field (2009), a sample of 300 should have an item loading over .298 to indicate importance of the item in the factor.

Cronbach's alpha was calculated to assess the items for internal reliability. Cronbach's alpha for this analysis was .74. Chronbach's alpha is considered adequate at a level of .7 and above (Field, 2009).

These analyses informed the creation of an enhanced dependent variable developed from the six survey items. Due to the high factor loadings and the acceptable level for Cronbach's alpha, the six items were combined into a composite variable for use in the analysis of the remaining research questions. The composite variable represented the frequency of use of FSPTI by respondents. The consolidation of these items contributed stability to the dependent variable due to the increase in data points informing its construction (Waltz, Strickland, & Lenz, 2005).

Research Question 1

Research question 1 examined the variables that contribute to the frequency with which play therapists use family-systems play therapy interventions. *Hypothesis 1* stated that there would be a significant relationship between frequency of usage of family-systems play therapy interventions and the independent variables. Specifically, the degree to which age, sex, minority status, average number of credentials, years of experience in play therapy, adherence to a child-centered play therapy theoretical orientation, perceived importance of the attachment relationship between a child and caregiver, and perceived level of competence and training in family-systems play therapy interventions effected the usage of FSPTI was explored.

To analyze the research question and its associated hypothesis, a multiple linear regression using the enter method was employed. The data for the dependent variable were developed as a

result of the factor analysis and represent the cumulative of survey items 18 (parts 3-6), 19, and 20. The variables were entered in three steps, resulting in three models of varying strength (see Table 6). The coefficients in the regression models represent a population parameter estimate used to predict the frequency with which respondents use family-systems play therapy interventions. Model 3 emerged as the strongest in predicting the dependent variable (R^2 = .647); additionally, the number of credentials a play therapist holds, adherence to the child-centered theoretical orientation, perceiving attachment as important to treatment planning and development, perceptions of training adequacy in FSPTI, and perceptions about competency with FSPTI contributed to the model's predictive power. Of these variables, perceptions of competency in FSPTI had the greatest impact (t=10.20), followed by beliefs about the importance of attachment (t=4.85), practicing child-centered play therapy (t= -3.09), and number of credentials (t=-3.23). An unexpected result was that it appears that play therapists who do not adhere to a child-centered orientation and have fewer professional credentials might utilize FSPTI more frequently.

Table 6

Predictors of Use of Family-Systems Play Therapy Interventions

		Use of FSPTI					
Model		*B*	*p*	R^2	*F*	ΔR^2	ΔF
1				.03	3.94		
	Constant	17.21					
	Age	.16*	.01				
	Sex	.03	.57				
	Minority	.02	.68				
2				.05	4.00	.02	.06
	Constant	18.09					
	Age	.07	.28				
	Sex	.04	.40				
	Minority	.02	.66				
	Years of Experience in Play Therapy	2.64*	.01				
	Child-Centered Orientation	-1.88	.06				
3				.65	90.65	.60	86.65
	Constant	.99					
	Age	.03	.38				
	Sex	.03	.32				
	Minority	-.01	.63				
	Number of Credentials	-.10*	.00				
	Years of Experience in Play Therapy	.00	.92				
	Child-Centered Orientation	-.09*	.00				
	Perception of attachment	.14*	.00				
	Training in FSPTI	.10	.13				
	Competency in FSPTI	.67*	.00				

FSPTI= family-systems play therapy interventions; *p< .01.

Findings. A statistically significant relationship was found between the number of credentials held by respondents, their perceptions of the importance of the attachment relationship, their identification as child-centered, and their perceptions of competency in FSPTI and their frequency of usage of family-systems play therapy interventions. However, no significant relationship was found between participants' perceptions of the adequacy of their training in FSPTI, years of experience in play therapy, or demographic variables and their frequency of usage of family-systems play therapy interventions.

Research Question 2

Research question 2 examined the relationship between play therapists' perceived importance of the attachment relationship and their perceived level of competence in family-systems play therapy interventions. *Hypothesis 2* stated that there would be a significant relationship between play therapists' perceived importance of the attachment relationship between child and primary caregiver and their perceived level of competence in family-systems play therapy interventions.

A Spearman's rho was used to analyze research question 2 and to test its associated hypothesis. Survey item 17 asked participants to assess their perceived self-competency in Child-Parent Relationship Therapy, Filial Therapy, Parent-Child Interaction Therapy, and Theraplay by selecting one of the following options: disagree strongly, disagree, tend to disagree, tend to agree, agree, and agree strongly. Item 17 was associated with survey item 13 (parts 2 and 3), which asked respondents to respond to the statements "I believe insecure attachment relates to childhood maladjustment" and "I believe that a healthy attachment relationship between a child and caregiver is important to healthy functioning, so the strength of the relationship must be determined in order to develop a comprehensive counseling treatment plan" by selecting one of the following options: disagree strongly, disagree, tend to disagree, tend to agree, agree, and agree strongly.

Findings. A statistically significant relationship was found between the degree to which play therapists felt competent in FSPTI and their perceptions of attachment, $r = .15$, $p < .01$ (see Table 7). Although this is considered a weak relationship, the statistic indicated that play therapists who place more importance on attachment relationships are inclined to indicate a higher level of competency in play therapy interventions utilized to address these relationships,

as referenced in the survey items above.

Research Question 3

Research question 3 examined the relationship between perceived importance of the attachment relationship and frequency of usage of family-systems play therapy interventions. *Hypothesis 3* stated that there would be a significant relationship between play therapists' perceived importance of the attachment relationship between child and primary caregiver and their frequency of usage of family-systems play therapy interventions.

A Spearman's rho analysis was used to analyze this research question. The composite variable for frequency of use of FSPTI was used to assess the association of survey item 13(parts 2 and 3), which asked members of APT to respond to the statement "I believe insecure attachment relates to childhood maladjustment" and "I believe that, 'A healthy attachment relationship between a child and caregiver is important to healthy functioning, so the strength of the relationship must be determined in order to develop a comprehensive counseling treatment plan" by selecting one of the following options: disagree strongly, disagree, tend to disagree, tend to agree, agree, and agree strongly.

Findings. The frequency with which play therapists use FSPTI was significantly related to perceptions of attachment indicated by play therapists, $r = .19$, $p < .01$ (see Table 7). Although this is a weak relationship, the finding indicated that play therapists who place a higher level of importance on attachment relationships for healthy functioning are more inclined to use play therapy interventions to address these relationships more frequently, as referenced in the survey items above.

Research Question 4

Research question 4 asked about the relationship between play therapists' perceived level of competence in family-systems play therapy interventions and frequently of usage of family-systems play therapy interventions to respond to dysfunctional attachment. *Hypothesis 4* stated that there would be a significant relationship between play therapists' perceived level of competence in family play therapy interventions and their frequency of usage of family-systems play therapy interventions.

A Spearman's rho correlation was used to analyze this research question. Survey item 20, which asked play therapists to indicate their frequency of usage of family-systems play therapy interventions to respond to dysfunctional attachment, was used to assess the association of survey item 17, which asked members of APT to respond to the statements concerning perceived self-competency in Child-Parent Relationship Therapy, Filial Therapy, Parent-Child Interaction Therapy, and Theraplay by selecting one of the following options: disagree strongly, disagree, tend to disagree, tend to agree, agree, and agree strongly.

Findings. The level at which play therapists felt competent to utilize FSPTI was significantly related to the frequency with which play therapists implemented these interventions in response to an identified dysfunctional attachment between a child and caregiver, $r = .55$, $p < .01$ (see Table 7). This relationship is considered moderately strong; this finding suggested that play therapists who indicated higher levels of competency in FSPTI might be inclined to use FSPTI more frequently as a response to an assessment of the attachment relationship between a child and caregiver, as referenced in the survey items above.

Research Question 5

Research question 5 asked about the relationship between play therapists' perceived level of competence in family-systems play therapy interventions and their perception of the adequacy of their training in family-systems play therapy interventions. *Hypothesis 5* stated that there would be a significant relationship between play therapists' perceived level of competence in family-systems play therapy interventions and their perception of experiencing adequate training in family-systems play therapy interventions.

A Spearman's rho correlation was used to analyze this research question to better understand the relationship between survey item 15, perceived self-adequacy of training in Child-Parent Relationship Therapy, Filial Therapy, Parent-Child Interaction Therapy, and Theraplay indicated by selecting from the options of disagree strongly, disagree, tend to disagree, tend to agree, agree, agree strongly and survey item 17, which asked members of APT to respond to the statements concerning perceived self-competency in Child-Parent Relationship Therapy, Filial Therapy, Parent-Child Interaction Therapy, and Theraplay by selecting one of the following options: disagree strongly, disagree, tend to disagree, tend to agree, agree, and agree strongly.

Findings. The level at which play therapists felt competent to utilize FSPTI was significantly related to perceptions of training adequacy in these interventions, $r = .90$, $p < .01$ (see Table 7). This indicates the presence of a strong relationship between these two variables. Therefore, this finding suggested play therapists who indicated higher levels of competency in FSPTI were likely to indicate higher levels of self-perceived training adequacy in FSPTI, as referenced in the survey items above.

Research Question 6

Research question 6 asked about the relationship between play therapists' theoretical orientation and frequency of usage of family-systems play therapy interventions. *Hypothesis 6:* stated that there would be a relationship between play therapists' theoretical orientation and frequency of use of family-systems play therapy interventions.

A Spearman's rho correlation was used to analyze this research question to better understand the relationship between survey item 11, identified theoretical orientation in play therapy, and the composite variable for frequency of use of FSPTI.

Findings. Identification as a Child-Centered Play Therapist was significantly negatively related to the frequency with which play therapists use FSPTI, $r = -.12$, $p < .01$ (see Table 7). Although this considered is a weak relationship, the finding indicated that play therapists who practice from a child-centered theoretical orientation are less inclined to utilize family-systems play therapy interventions frequently, as referenced in the survey items above.

Research Question 7

Research question 7 asked about the relationship between play therapists' years of experience and frequency of usage of family-systems play therapy interventions. *Hypothesis 7* stated that there would be a relationship between play therapists' years of experience and frequency of use of family-systems play therapy interventions.

A Spearman's rho correlation was used to analyze this research question to better understand the relationship between survey item 9, number of years practicing play therapy, and the composite variable for frequency of use of FSPTI.

Findings. The number of years of experience in play therapy reported by play therapists was significantly related to the frequency with which play therapists use FSPTI, $r = .19$, $p < .01$

(see Table 7). Although this is a weak relationship, the finding indicated that play therapists who have more experience in play therapy are also inclined to utilize family-systems play therapy interventions more frequently, as referenced in the survey items above.

Research Question 8

Research question 8 asked about the relationship between play therapists' credentialing as an RPT and frequency of usage of family-systems play therapy interventions to respond to dysfunctional attachment. *Hypothesis 8* stated that there would be a significant relationship between a play therapists possession of the RPT credential and their frequency of usage of family-systems play therapy interventions.

A Spearman's rho correlation was used to analyze this research question to better understand the relationship between survey item 6, current credentials, and survey item 20, frequency of response to dysfunctional attachment utilizing a family-systems play therapy intervention, indicated by selecting from among the options of never, very rarely, rarely, occasionally, frequently, and very frequently.

Findings. Credentialing as a Registered Play Therapist was not significantly related to the frequency with which play therapists implemented FSPTI interventions in response to an identified dysfunctional attachment between a child and caregiver, $r = -.06$, $p > .01$ (see Table 7).

Research Question 9

Research question 9 asked about the relationship between play therapists' credentialing as an RPT-S and frequency of usage of family-systems play therapy interventions to respond to dysfunctional attachment. *Hypothesis 9* stated that there would be a significant relationship between play therapists' possession of the RPT-S credential and their frequency of usage of family-systems play therapy interventions.

A Spearman's rho correlation was used to analyze this research question to better understand the relationship between survey item 6, current credentials, and survey item 20, frequency of response to dysfunctional attachment utilizing a family-systems play therapy intervention, indicated by selecting from among the options of never, very rarely, rarely, occasionally, frequently, and very frequently.

Findings. Credentialing as a Registered Play Therapist- Supervisor was significantly related to the frequency with which play therapists implemented FSPTI interventions in response to an identified dysfunctional attachment between a child and caregiver, $r = .18$, $p < .01$ (see Table 7). Although this is a weak relationship, the finding indicated that play therapists who hold a Registered Play Therapist- Supervisor credential are inclined to use FSPTI more frequently as a response to an assessment of the attachment relationship between a child and caregiver as referenced in the survey items above.

Table 7

Correlation Matrix

Variable	1	2	3	4	5	6	7	8	9	10	11	12
1. Sex	-----											
2. Age	-.08**	-----										
3. Minority	-.07	-.04	-----									
4. Perceptions about Attachment	-.02	.10	0	-----								
5. Training in FSPTI	-.04	.17*	.02	.15*	-----							
6. Competency in FSPTI	-.04	.14*	.03	.15*	.90*	-----						
7. RPT	-.05	.02	-.10*	.06	.06	.03	-----					
8. RPT-S	-.18*	.19*	.05	.06	.17*	.12*	-.11*	-----				
9. Years of Experience in Play Therapy	-.13*	.60*	-.02	.12	.26*	.20*	0	.34*	-----			
10. Child-Centered Orientation	.01	-.02	0	-.07	-.06	-.03	-.07	-.11	-.12	-----		
11. Tx based on Attachment	-.06	.07	-.01	.27*	.52*	.55*	-.06	.18*	.20*	-.07	-----	
12. Frequency of use of FSPTI	0	.10*	.01	.19*	.72*	.61*	-.03	.11	.19*	-.12*	.70*	-----

FSPTI= family-systems play therapy interventions; RPT= Registered Play Therapist; RPT-S= Registered Play Therapist- Supervisor; Tx= treatment; *p> .01;
**Pearson's r statistic

Perceptions of Training and Competency

Respondents were asked to indicate their perceptions of adequate training and competency in FSPTI. Frequencies for survey item 15, perceived self-adequacy of training in Child-Parent Relationship Therapy, Filial Therapy, Parent-Child Interaction Therapy, and Theraplay indicated by selecting from the options of disagree strongly, disagree, tend to disagree,

tend to agree, agree, agree strongly and survey item 17, which asked members of APT to respond to the statements concerning perceived self-competency in Child-Parent Relationship Therapy, Filial Therapy, Parent-Child Interaction Therapy, and Theraplay by selecting one of the following options: disagree strongly, disagree, tend to disagree, tend to agree, agree, and agree strongly were calculated to reflect participants' responses (see Table 8). Overall, the majority of play therapists indicated adequate training and competency in Child-Parent Relationship Therapy. However, the majority of play therapists tended to disagree that they were adequately trained and perceived themselves as competent in Filial Therapy and Parent-Child Interaction Therapy. Play therapists felt even less adequately trained and competent in Theraplay.

Table 8

Frequency Distribution of Participants' Perception of Adequacy of Training and Competency in FSPTI (n=456)

	Training		Competency	
Variable	*n*	%	*n*	%
Child-Parent Relationship Therapy				
Disagree Strongly	30	6.6	29	6.4
Disagree	67	14.7	64	14
Tend to Disagree	76	16.7	88	19.3
Tend to Agree	93	20.4	101	22.1
Agree	118	25.9	104	22.8
Strongly Agree	72	15.8	70	15.4
Filial Therapy				
Disagree Strongly	24	5.3	27	5.9
Disagree	69	15.1	60	13.2
Tend to Disagree	101	22.1	107	23.5
Tend to Agree	100	21.9	101	22.1
Agree	97	21.3	97	21.3
Strongly Agree	65	14.3	64	14
Parent- Child Interaction Therapy				
Disagree Strongly	41	9	51	11.2
Disagree	94	20.6	90	19.7
Tend to Disagree	116	25.4	114	25
Tend to Agree	75	16.4	81	17.8
Agree	85	18.6	77	16.9
Strongly Agree	45	9.9	43	9.4
Theraplay				
Disagree Strongly	59	12.9	70	15.4
Disagree	105	23	103	22.6
Tend to Disagree	102	22.4	97	21.3
Tend to Agree	89	19.5	94	20.6
Agree	61	13.4	57	12.5
Strongly Agree	40	8.8	35	7.7

Responses to Qualitative Items

Treatment Planning.

At the conclusion of the survey, in a free response item, participants were asked to list the top three pieces of information they considered a necessity when constructing a treatment plan. Overall, family dynamics or family history, presenting issues, and client characteristics were the most frequently provided responses (see Table 9). The most commonly occurring theme involved information about the family system. This theme was differentiated from an attachment theme through categorizing responses as "family dynamics" only if respondents did not specifically indicate attachment or a caregiver and child relationship. Play therapists believed that a thorough understanding of family history and family patterns was integral to the treatment planning process. For example, play therapists identifying family system information as important shared the following statements:

Family structure, history, genogram, etc.

Who the child is living with, if multiple homes, are their established routines, communication and common disciplinary practices.

Familial relationships/structure, roles within the family, whether an organic cause is present.

Stability of placement in family system.

Participants also indicated that presenting symptoms were vital to developing a treatment plan. The following statements are examples of responses that illustrate this theme:

Child's perception of the problem, Caregiver's perception of the problem

Presenting problem

How the child defines the presenting problem

Presentation of the presenting problem by the parent(s) and child

Finally, play therapists believed that the client's characteristics play a role in determining the construction of an appropriate treatment plan. Typically, the client's characteristics included age, personality, behavior, and developmental level. Examples of responses that addressed the necessity of considering clients' characteristics are:

Where the child is in his/development

Child's intellectual level

Mood, age

Child's strengths, intellectual level, impulse control

Table 9

Play Therapists' Intake Concerns by Theme

Theme	*n*	%
Family Dynamics/ Family History	201	17.8%
Presenting Symptoms	197	16.8%
Client Characteristics	195	16.6%
Child History	137	11.6%
Attachment or Relationship with Caregiver	104	8.8%
Trauma	91	7.7%
Parental and/or Client Engagement in Therapy	54	4.6%
Treatment Goals	47	4.0%
Client's Environment	35	3.0%
Support Systems	30	2.6%
Diagnosis	25	2.1%
Past Therapy Experiences	13	1.1%
Recent Events in Client's Life	11	1.0%
Possible Treatment Direction	8	0.7%
Assessment Results	8	0.7%
Client and Therapist Variables	7	0.6%
Barriers to Treatment	6	0.5%
Medical Concerns	4	0.3%
Birth Order	1	0.1%
Sleep Patterns	1	0.1%
Current Research	1	0.1%

Note: Because respondents were asked to list three intake concerns, the number of responses exceeded the number of respondents.

Supplemental Information.

At the conclusion of the instrument, respondents were asked to supply any further information that the survey did not capture. There were 153 responses to this item, which is a smaller response rate than previous totals because this was the only item that was not forced. The relatively large number of responses, despite optional completion of this item, indicated that there was high interest among the respondents in the topics of play therapy and attachment. The information provided by the respondents varied widely and dominant themes did not emerge. Examples of response included:

> *Play therapy with children necessitates family systems play therapy or we would be sending the child back into the same situation over and over again with nothing changing.*
>
> *Parent Child Rel. Therapy requires a level of devotion and follow through that many parents are not willing to do. Therefore, I can't/don't use it as often as I would like to.*
>
> *Over the years I am increasingly aware that social work education does not include training in child development.*
>
> *I WISH I had training in all these modalities.*
>
> *I work with children & families where there has been experience of sexual and/or physical trauma & neglect. When the parents are available and can provide safety for their child it is easier to involve them in play therapy. When the child comes to our agency and is in foster care or cannot be an ally due to their own issues it is harder to involve them.*

Because I often work with children in foster care (often a temporary status), the attachment issues are especially acute. There is usually no family with whom to develop increased attachment.

Alas, I do not engage the parents enough. It is difficult to do parent-child therapy at school. I do use psychoanalytically-informed approaches, including consulting with parent educators who work with the relationship between mothers and their infants, 0 - 3 years of age.

Summary of Findings

Items from the *PTDI-R* were analyzed using a principal component analysis to assess the underlying structure of six items (items 18 (3-6), 19, and 20) that addressed participants' frequency of use of FSPTI relative to their understanding of the attachment relationship. The initial results of the scree plot and eigenvalue resulted in identification of one factor named frequency of use of FSPTI. This factor accounted for 45% of the variance between the 6 survey items. These items from the *PTDI-R* were combined into one variable for use in the analysis of the remaining research questions; this variable represented the frequency of use of FSPTI by respondents. This consolidation of survey items, based on a principal component analysis, led to more stability for the dependent variable due to the increase in data points informing its construction.

Using this enhanced dependent variable representing frequency of use of FSPTI by play therapists, three multiple regression models were built. Of these, the third model had the most power, explaining 65% of the variance in the dependent variable. Of the predictor variables included in the analysis, perceptions of competency in FSPTI had the greatest impact, followed by beliefs about attachment, subscribing to a child-centered theoretical orientation, and the

number of credentials held. An unexpected finding was that it appears that play therapists who do not adhere to a child-centered orientation and have fewer professional credentials utilize FSPTI more frequently.

When examining the relationships between play therapists' demographic variables, beliefs about attachment, and play therapy practice patterns, significant relationships were identified among all but one set of variables. The degree to which play therapists felt competent in FSPTI had a significant, positive relationship to perceptions of importance of attachment. This finding suggests that play therapists who place more importance on attachment relationships are inclined to indicate a higher level of competency in play therapy interventions utilized to address these relationships.

The frequency with which play therapists use FSPTI had a significant, positive relationship to their perceptions of the importance of attachment. This finding indicated that play therapists who place a higher level of importance on attachment relationships for healthy functioning are inclined to use play therapy interventions to address these relationships more frequently.

The level at which play therapists felt competent to utilize FSPTI had a significant, positive relationship to the frequency with which play therapists implemented these interventions in response to an identified dysfunctional attachment between a child and caregiver. This finding suggested that play therapists who indicate higher levels of competency in FSPTI might be inclined to use FSPTI more frequently as a response to an assessment of the attachment relationship between a child and caregiver.

The level at which play therapists felt competent to utilize FSPTI had a significant, positive relationship to their perception of the adequacy of their training in these interventions.

This finding suggested a strong association between a perception of higher levels of competency in FSPTI and perceived higher levels of training adequacy in FSPTI.

Identification as a Child-Centered Play Therapist had a significant, negative relationship to the frequency with which play therapists use FSPTI. This finding indicated that play therapists who practice from a child-centered theoretical orientation are less inclined to utilize family-systems play therapy interventions frequently.

The number of years of experience in play therapy reported by play therapists had a significant, positive relationship to the frequency with which play therapists use FSPTI. This finding indicated that play therapists who have more experience in play therapy are also inclined to utilize family-systems play therapy interventions more frequently.

Credentialing as a Registered Play Therapist was not significantly related to the frequency with which play therapists implemented FSPTI interventions in response to an identified dysfunctional attachment between a child and caregiver.

Finally, credentialing as a Registered Play Therapist- Supervisor had a significant, positive relationship to the frequency with which play therapists implemented FSPTI interventions in response to an identified dysfunctional attachment between a child and caregiver. This finding indicated that play therapists who hold a Registered Play Therapist- Supervisor credential are inclined to use FSPTI more frequently as a response to an assessment of the attachment relationship between a child and caregiver.

Overall, six relationships indicated significant positive correlation, one relationship indicated a significant negative correlation, and one relationship was not statistically significant. Play therapists' reported use of FSPTI had a significant, positive relationship to their number of years of experience in play therapy and their perceptions of the importance of attachment

between a child and caregiver. The frequency with which play therapists implemented FSPTI in response to an identified dysfunctional attachment between a child and caregiver had a significant, positive relationship to perceptions of competency in FSPTI and credentialing as a Registered Play Therapist- Supervisor. Play therapists' perceptions of competency in FSPTI had a significant, positive relationship to their perception of the adequacy of their training in these interventions and play therapists' perceptions of importance of attachment relationships between a child and caregiver. Theoretical orientation as a Child-Centered Play Therapist had a significant, negative relationship to the frequency with which play therapists use FSPTI. Finally, credentialing as a Registered Play Therapist was not significantly related to the frequency with which play therapists implemented FSPTI interventions in response to an identified dysfunctional attachment between a child and caregiver.

The qualitative items in the survey provided information about play therapists' primary concerns when constructing a treatment plan. Most commonly, play therapists indicated that familial dynamics, clients' presenting issues, and clients' characteristics were necessary for treatment development. Additionally, play therapists were eager to provide supplemental information in the final qualitative item.

Chapter Five

DISCUSSION

Included in chapter 5 is a discussion of the results of this study. Reminders about the purpose of the study and methodology, as well as results from the data analysis, are presented. Additionally, statistical results are discussed in relation to literature on attachment and play therapy. Next, limitations of the study are examined. Implications are suggested for play therapists, counselor education programs, and the Association for Play Therapy. Finally, suggestions for future research in the field of play therapy are offered.

Overview of the Study

Attachment is one ingredient that contributes to the complicated formula of family dynamics. Evaluating the attachment strength between the child and primary caregiver(s) can help mental health clinicians determine the direction they will take in providing treatment to children who are externalizing or internalizing problems and thereby contributing to familial disharmony. The purposes of this quantitative study were to determine the extent to which play therapists integrate into treatment planning their knowledge of the attachment style between the child and caregiver, and to examine the preparedness of play therapists to respond to dysfunctional attachment relationships using family-system play therapy interventions for attachment deregulation. Haslam and Harris (2011) recommended that future play therapy research examine the "practice patterns of play therapists working with families and what factors influence these behaviors" (p. 64).

It was anticipated that the results of this study might support the need for required play therapy education that applies family systems approaches to address attachment dysfunction in the caregiver-child relationship, as well as the need to seek additional or more advanced

education and training in play therapy to meet the needs of the clients served. A review of the literature suggested that it was unclear whether play therapists are competent in interventions used to remediate dysfunctional attachment and whether they design appropriate treatment plans for these clients. This study sought to understand the extent to which play therapists are prepared to respond with effective therapeutic interventions to dysfunctional attachment between a child and caregiver. Studies within the field of play therapy have produced evidence that some family-systems interventions have a relationship-enhancing effect (as cited by Schaefer & Drewes, 2011). These interventions include Filial Therapy, Child-Parent Relationship Therapy, Theraplay, and Parent-Child Interaction Therapy.

The members of the Association for Play Therapy (APT) were the population of interest. APT membership is 5,207 individuals (C. Guerrero, personal communication, March 27, 2012), which includes 915 Registered Play Therapists and 992 Registered Play Therapist-Supervisors (APT, 2012c). All members who supplied an email address to the Association for Play Therapy (n= 5,139) were invited to participate in the study. The survey was distributed to 5,139 members; 513 surveys were returned. Due to incomplete or unusable responses, listwise deletions were used to reduce the sample to 456 members of APT, representing a response rate of 8.9%. A quantitative method was chosen to gain an understanding of the practices and beliefs of members of a large organization by generalizing results from the sample to the larger population of members in APT.

A survey, *Play Therapists' Decision-Making Inventory-R* (*PTDI-R*), which was created by me based on relevant play therapy literature and my pilot study, was used for data collection. The *PTDI- R* was used to assess play therapists' perceptions of the role of attachment in the treatment process, the frequency with which play therapists feel competent to use family-systems

play therapy, and the frequency with which they utilize these interventions. Specifically, the *PDTI- R* examined: a) the relationship between the perceptions of competency play therapists have in family-systems play therapy interventions and their perception of the importance of the attachment relationship; b) the relationship of the amount of play therapists' clinical experience to their utilization of family-systems play therapy interventions; c) the relationship of utilization of family-systems play therapy interventions and play therapists' perception of the importance of the attachment relationship; d) the frequency with which play therapists respond to dysfunctional attachment with a family-systems play therapy intervention; e) the relationship between play therapists' response to dysfunctional attachment with a family-systems play therapy intervention to competency in family-systems play therapy interventions; f) the relationship of play therapists' theoretical orientation to the utilization of family-systems play therapy interventions; g) the relationship between competency in family-systems play therapy interventions and the amount of training play therapists report in these interventions; h) the relationship between credentials in play therapy and the utilization of family-systems play therapy interventions; and i) the information necessary for constructing a treatment plan.

Data analysis procedures included descriptive statistics, multiple linear regression, Spearman's rho, and principal component analysis. An alpha of .01 was set to reduce the likelihood of a Type I error.

Discussion of Findings

Competency and Training

Ryan and Bratton (2008) indicated that "Attachment theory and research is a well-established framework for understanding children's normal and atypical social/emotional development. It is used extensively by clinicians to design interventions, understand interactions,

and assess clinical progress" (p. 28). This assertion supports a key assumption underlying this study, that play therapists should be equipped to understand the importance of attachment and should perceive themselves as adequately prepared to implement an intervention aimed at strengthening the caregiver and child relationship. The present study sought to identify variables that influence play therapists' initiation of a family-focused intervention. Identification of these variables was supported by Haslam and Harris' (2011) recommendation that future play therapy research examine the "practice patterns of play therapists working with families and what factors influence these behaviors" (p. 64). Variables that influence play therapists' initiation of a family-focused intervention emerged during analysis and are discussed below.

The level at which play therapists felt competent to utilize FSPTI was significantly related to perceptions of the level of training adequacy in these interventions *(r*= .90, *p*< .01). In addition, a statistically significant relationship was found between the degree to which play therapists felt competent in FSPTI and their perceptions of the importance of attachment (*r*= .15, *p*< .01). Finally, the level at which play therapists felt competent to utilize FSPTI was significantly related to the frequency with which play therapists implemented these interventions in response to an identified dysfunctional attachment between a child and caregiver *(r*= .55, *p*< .01). These results indicated that play therapists who had more training in FSTPI felt more competent to utilize FSPTI. Higher levels of perceived competence were associated with stronger agreement about the importance of the role of attachment in treatment development and lifespan development, which was associated, in turn, with an increased utilization of FSPTI in response to identification of dysfunctional attachment. It seems reasonable to assume that play therapists' beliefs about attachment could manifest in their application of the theories and treatments that address attachment dysfunction. As Martin (2005) recommended, assessing for

attachment styles between children and their identified primary and secondary caregivers could greatly assist professionals in understanding the needs of the child before they initiate therapeutic services.

As required by the RPT certification guidelines developed by APT, training specifically in the field of play therapy is essential to skill development, play therapy knowledge, and clinician competence. Ryan, Gomory, and Lacasse (2002) and Phillips and Landreth (1995) reported that a small percentage of play therapists have acquired graduate level training specifically in family-systems play therapy interventions. Research points to the positive effect of training on play therapists' skills and confidence (Homeyer & Rae, 1998; Kao & Landreth, 1997); however, Haslam and Harris (2011) found that graduate training in family play therapy did not fully prepare play therapists to engage families. Play therapy interventions for the family are not included in the required training to become a registered play therapist/supervisor (Association for Play Therapy, 2012b). It appears that a majority of play therapists do not feel competent in the utilization of family-systems play therapy (Haslam & Harris, 2011), and no known research exists indicating whether play therapists are adequately prepared to intervene in dysfunctional attachment styles between child and caregivers. The current study added to previous research by reporting that play therapists indicated low levels of adequate training and self-reported competency in Filial Therapy, Parent-Child Interaction Therapy, and Theraplay.

Relationships found in the present study suggest the possibility that play therapists who do not report high levels of training will not perceive themselves as competent in FSPTI and are less likely to consider attachment to be important, which might result in a lack of attachment assessments in their intake procedures. It seems reasonable to assume that a decrease in assessment of attachment relationships will result in a decrease of utilization of interventions to

address attachment deregulation. No previous literature examined the relationship between competency in FSPTI to training in FSPTI and beliefs about attachment between a child and caregiver. Of those who responded to the qualitative item that asked play therapists to name the three most important pieces of information in the intake process, only 8.8% specified attachment as one of those factors. Because no previous research has looked at this relationship, my study makes a contribution to the literature by increasing our understanding of variables that may influence play therapists' use of FSPTI.

Frequency of Use of FSPTI

A statistically significant relationship was found between the number of credentials held by respondents, their perceptions of the importance of the attachment relationship, their identification as child-centered, and their perceptions of competency in FSPTI and their frequency of usage of family-systems play therapy interventions. Further, play therapists who identified as child-centered utilized FSPTI less frequently. The effect size for all significant variables was small, except for the influence of competency in FSPTI on frequency of utilization. These effect sizes indicate that, although the relationship is statistically significant, the number of credentials, theoretical orientation, and perceptions of attachment have a small effect on the frequency with which play therapists utilize FSPTI. No significant relationships were found between participants' perceptions of the adequacy of their training in FSPTI, years of experience in play therapy, or demographic variables and their frequency of usage of family-systems play therapy interventions. Although the number of years of experience in play therapy was not significantly predictive in play therapists' use of FSPTI, it was significantly related to the frequency with which play therapists use FSPTI ($r = .19$, $p < .01$).

Competency in FSPTI contributed the most to play therapists' frequency of use of FSPTI. This finding is consistent with play therapy literature supporting the necessity for competency in promoting utilization of interventions (Haslam & Harris, 2011). Findings related to the relationship between frequencies of use of FSPTI and identifying with a child-centered orientation also were consistent with findings in previous research studies. For instance, Phillips and Landreth (1995) reported that child-centered play therapists and therapists newer to the field were more likely engage in play therapy solely with the child in their sessions. However, the finding in this study that indicated that more credentials were related to less frequent use of FSPTI was unexpected. Phillips and Landreth (1995) found that newer therapists, who reasonably could be assumed to have fewer credentials, tended to work solely with children. Thus, the finding of an inverse relationship in the present study is inconsistent with the findings of Phillips and Landreth (1995). A possible explanation for the inverse relationship found in the present study is that play therapists with more credentials are less likely to utilize FSPTI frequently due to time constraints. These individuals might be in more demand for treatment due to their extensive experience and training, and therefore they may have less time to engage families.

Although an inverse relationship was found between credentials, generally, and frequency of use of FSPTI, credentials when examined individually reflected a different relationship. Holding a RPT-S credential was significantly related to the frequency with which play therapists implemented FSPTI interventions in response to an identified dysfunctional attachment between a child and caregiver ($r = .18$, $p < .01$), but credentialing as a Registered Play Therapist was not significantly related to the frequency with which play therapists implemented FSPTI interventions in response to an identified dysfunctional attachment between a child and

caregiver (r= -.06, p> .01). Possibly, the increase in experience and training required to obtain a RPT-S increases play therapists' skill sets to include implementing FSPTI interventions.

Additionally, play therapists' perceptions of attachment were individually related to frequent utilization of FSPTI (r= .19, p< .01). Haslam and Harris (2011) reported that play therapists believed environmental issues in the home affect children who come for play therapy services and that involvement of parents in the treatment process is effective and imperative. Whereas Haslam and Harris focused on beliefs, reporting that play therapists believe in the importance of involving families in treatment, findings of the present study point to practice patterns, suggesting the possibility of increased implementation of these interventions when caregiver and child attachment relationships are considered important.

Relationships Related to Training in Play Therapy.

The present study investigated, in addition to the importance that play therapists place on the attachment relationship, the role that training plays in play therapists' implementation of FSPTI. Specifically, theoretical orientation, years of experience in play therapy, and credentialing through APT as a play therapist were examined. Identification as a Child-Centered Play Therapist was significantly negatively related to the frequency with which play therapists use FSPTI (r= -.12, p< .01), which is similar to findings reported by Phillips and Landreth (1995). Additionally, given that a large majority of APT members identify as child-centered play therapists (Lambert et al., 2007), this finding suggests that play therapists may not engage in FSPTI frequently. The inverse relationship between a child centered theoretical orientation and frequency of use of FSPTI might be related to Virginia Axline's beliefs about children. Axline, a founder of the play therapy movement, believed that all children have the inner resources to resolve their problems; in play therapy, this occurs within the context of certain conditions in the

therapeutic relationship (Landreth, 2002). Child-centered play therapists might be less likely to persist in obtaining parental engagement based on their adherence to this belief. Theorists other than Axline (e.g., Bratton et al., 2005), however, believe that although play therapy works without caregiver involvement, it is more effective when the caregivers play a primary role.

Limitations

Confidence in the results of the study are based in the assumption that the *PTDI-R* is valid and accurately measured play therapists' perceptions of the importance of assessing for attachment and their readiness to utilize appropriate therapeutic interventions to remediate a dysfunctional attachment between a child and caregiver. After initially designing the *PTDI-R* instrument, I conducted a pilot study of the instrument with a sample of members from the Louisiana Association for Play Therapy. Cronbach's alpha was calculated to assess several items for internal reliability. Cronbach's alpha for this analysis was .74. Chronbach's alpha is considered adequate at a level of .7 and above (Field, 2009). An expert panel also reviewed the instrument. Despite these precautions, the *PTDI-R* may have lacked reliability in reporting play therapists' beliefs and practice patterns in treatment planning. Future researchers might further test the *PTDI-R* in order to strengthen its validity and reliability.

Additionally, use of an online survey might have resulted in a reduction of responses and selection bias (Granello, 2007). Using the total number of individuals surveyed (N= 5,139) divided by the number of usable surveys returned (*n*=456), the response rate for this survey was 8.9%. Krejcie and Morgan (1970) recommended a sample size of 357 for a population of 5000 with a 95% confidence level, supporting the conclusion that the results of this study are likely to be representative of all members of the Association for Play Therapy. To the extent that the sample is representative, the results of this study are generalizable to mental health professionals

trained in play therapy who are members of APT. The results are not generalizable to mental health professionals who are not APT members. Finally, all play therapists may not be current members of APT; thus, the results are not generalizable to play therapists who are not APT members.

Members of the population may have been reluctant or unable to participate in the survey due to difficulty of use and lack of access to technology (Granello, 2007). Additionally, lack of interest in use of FSPTI may have resulted in participants discontinuing the survey or failing to initiate response altogether. Whereas the technology inherent in an Internet survey may have discouraged participation for some members of the population, other members may have not have been aware of the email containing information about the survey. An inability to outmaneuver the participants' email spam filter may have led to members of the population overlooking or not receiving the participation inquiry (Granello, 2007).

Finally, I assumed that all participants submitting surveys were honest in their responses to the survey items and that these respondents were representative of all APT members. Siah (2005) indicated that internet-based surveys are vulnerable to subject fraud, which occurs when participants are dishonest about their demographic variables or when participants submit responses to the survey one than once. To reduce the likelihood that participants would provide dishonest responses, I included a detailed introductory letter to participants. Buchanan and Hvizdak (2009) recommended inclusion of such a letter to increase participants' trust in the researcher. To further promote truthfulness, confidentiality and anonymity of response were highlighted in the consent to participate (Siah, 2005). Additionally, I controlled for multiple submissions through an option in the Qualtrics ^{TM} software, which prevented ballot stuffing. Although respondents may have been able to complete the survey multiple times using different

computers, it is unlikely participants were motivated to do so because there were no incentives (Siah, 2005).

Implications of the Study

This study sought to understand the variables that contribute to play therapists' preparedness to respond to a dysfunctional attachment relationship between a child and caregiver. Specifically, the study examined the effects that training, competency, and perceptions of attachment had on the frequency with which play therapists implemented FSPTI. The results of this study suggest implications for play therapists, counselor education programs, and the Association for Play Therapy.

Play therapists who are interested in attachment relationships probably have more training in interventions related to addressing this relationship, which is associated with a higher level of perceived competency in these interventions. Starting at the beginning of the process of establishing competency, a solid foundation in the significance of attachment relationships is necessary to encourage practitioners' curiosity in interventions with a focus on the caregiver-child relationship. Curiosity is satisfied through training, which is associated with competency. Counselor education programs might incorporate the findings from this study by building a targeted focus on early childhood development, such as offering a class specifically addressing birth to young adulthood. Additionally, offering courses beyond an introduction to play therapy and advanced skills in play therapy should be considered. Particularly, classes in various family-systems play therapy models, such as Child-Parent Relationship Therapy, are recommended. These courses could be offered in a play therapy track delivered through formal graduate course work, seminars open to graduate and non-graduate students, and/or a formal certificate of advanced study in play therapy.

Results of this study may help play therapists increase their awareness of the interventions available to address a dysfunctional attachment; further, awareness about play therapists' views on attachment and its relationship to clinical procedures may be increased. Play therapists practicing from a child-centered play therapy theoretical orientation may be encouraged to assess for the strength of the attachment relationship and implement FSPTI when needed.

Finally, the Association for Play Therapy might use the results of this study to amend credentialing guidelines to include required education on family-systems based interventions. The significant relationship between credentialing as an RPT-S, but not between credentialing as an RPT, and frequency of use of FSPTI supports a recommendation to add a focus on family play therapy interventions in the credentialing requirements so that beginning play therapists are better prepared and more competent to utilize these interventions with more frequency.

Additionally, increased access to training in family-systems play therapy approaches is essential to providing play therapists with the skills needed to implement such interventions. The Association for Play Therapy, approved providers of play therapy training, and counselor and other mental health professions' education programs might take into account the following statements from participants:

I would like more training in these areas!

It would be helpful if more concrete and affordable training were available on the play aspect of family-systems therapy. Mostly what is offered near us is strictly play or strictly family systems CBT.

I believe very few therapists have the basic knowledge of family-systems play therapy and I myself could use more training.

Highly specialized, expensive training prevents me from becoming more knowledgeable and skilled in specific interventions named.

I would love more training, specifically TheraPlay and PCIT, but I can't afford to pay for it myself, and my agency won't pay for it. I believe TheraPlay and PCIT modalities would be enormously beneficial for the client population with which I work.

It is very important and I wish I had better training/knowledge about this.

There needs to be more workshops/seminars for filial and CPRT.

Implications for Future Research

The field of attachment theory and its use by play therapists is relatively unexplored. To expand the available knowledge base, several variables within the present study could be examined for future research. For example, the interaction of gender with frequency of use of family systems play therapy interventions might be investigated. FSPT interventions remediate the relationship between a caregiver and child, which is synonymous with the attachment relationship. Attachment is said to manifest differently in behavior according to the gender of the caregiver (Grossman et al., 2008). Examining the relationship of play therapists' gender with respect to their use of FSPTI might give insight into variations by gender in assessing for attachment, what characteristics of attachment play therapists of each gender look for in their clinical practice, and which interventions they select to engage the families.

Additionally, insight is needed into the barriers that prevent play therapists from engaging in FSPTI. Particularly, further investigation into the practice setting in which play therapists work and its relationship to engaging caregivers in a family-systems intervention is desirable. Whereas most respondents in the current study practiced in a private practice, the next most common work site was in an agency, followed by a school setting. Accessibility to the

caregiver might be more limited for play therapists who practice in agencies and schools, affecting the rates at which play therapists in these settings utilize FSPTI. Participants in this study provided the following statements:

Alas, I do not engage the parents enough. It is difficult to do parent-child therapy at school.

The school based access really limits access to caregivers.

I work with children in the foster care system. Many times the legal parents are not available for therapy. I spend time supporting the foster parent in their interaction with the children.

I am in a residential setting with children whose parents have had their rights terminated or their parents are inactive in treatment.

A qualitative study examining the process of integrating attachment theory into play therapy practice would be illuminating. Results garnered from studying the process through with attachment theory is applied during intake, how it informs treatment, and how the treatment is implemented would be useful. Such a study would provide the play therapy field with a concrete application of attachment theory from assessment to treatment. Further, play therapists who have limited understanding of practical applications of FSPTI could gain awareness into obstacles, successes, and procedures when implementing these approaches.

Finally, the current study could be extended beyond play therapists to include all counselors who work with children. A study of this sort could continue to focus on counselors' awareness of attachment relationships and preparedness to respond to a dysfunctional attachment. Results garnered from of a study of this sort might be generalizable to a larger

population, thereby offering implications on practice and training for a larger number of mental health professionals.

Conclusions

The current study added to the literature surrounding family-systems play therapy and integration of attachment theory into clinical practice. Overall, play therapists' perceptions of competency had the greatest impact in predicting use of FSPTI, and had a positive relationship with implementing these interventions based on an assessment of attachment.

Understanding the importance of the attachment relationship between a child and caregiver was associated with adequate training and perceiving self to be competent in FSPTI, which is related to increased use of FSPTI. Identification as a child-centered play therapist was negatively associated with frequency of use of FSPTI; increased experience in play therapy, either indicated through credentialing as an RPT-S or clinical years of experience, was associated positively with FSPTI use. Most play therapists identify with a child-centered orientation, so these findings point to supplemental educational opportunities sought by more experienced play therapists.

The results suggested a need for more training and promotion of competency in FSPTI, which should be considered by counselor education programs and the Association for Play Therapy. A lack of requirements in the play therapist credentialing process may be leaving practitioners unprepared to respond to clients' needs. Increasing opportunities to broaden play therapists' skill set and knowledge base may foster comprehensive service provision and effective practice.

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APPENDIX A

Pilot Study

Expert panel.

An expert panel was assembled to provide feedback on *Play Therapists' Decision-Making Inventory (PTDI)* before electronic distribution to LAPT. The expert panelists were asked to comment on the clarity of survey questions, completeness of item inclusion, and organization of the survey instrument. Additionally, the expert panel was utilized to increase the content validity of the *PTDI.* The expert panel consisted of five mental health professionals. Three panel members were full-time professors at universities and one was an adjunct professor. Four panel members were licensed professional counselors and approved supervisors in the state of Louisiana. One panel member was registered as a counselor intern with the state of Louisiana and was in training to become a licensed professional counselor. Finally, one panel member was a certified rehabilitation counselor. Four panel members had a doctorate degree and one had a master's degree. One panel member was a registered play therapist supervisor, one panel member was a registered play therapist, and one had approximately 500 hours in direct play therapy experience. All panel members had received training in play therapy and all but one had presented at national or state play therapy conferences. Four panel members were Caucasian and one was African-American; all panel members were female. Two panel members were serving on the board of the Louisiana Association for Play Therapy.

Each panel member was sent an electronic communication inviting her participation in the expert panel. The survey was attached in a Microsoft Word document to the email and feedback was requested through email or telephone contact. Responses were requested within a one-week time period. Two panel members provided feedback over the telephone and through

multiple email exchanges. One panel member returned the Microsoft Word document with feedback inserted using the track changes option. The remaining two panel members replied to the original email with suggestions for revision.

Ten recommendations made by the expert panel were implemented. These suggestions included: replacing the term "certifications" with "credentials;" eliminating qualitative fields after the "other" option in five survey questions; rewording a question to gather data only on respondents who were not an RPT or RPT-S; including a drop down list for respondents to indicate the number of years of play therapy experience; inclusion of definitions for "Filial Therapy," "Child-Parent Relationship Therapy," "Theraplay," and "insecure attachment" in order to capture more accurate data; removing specification of an RPT-S play therapy instructor; adding an option for respondents who were unsure of their theoretical orientation; inserting a Likert scale in front of each play therapy treatment option used in response to insecure attachment; adding a qualitative question to capture any additional data from the participants about their practices in assessing for attachment; adding an additional quantitative question addressing the frequency with which respondents indicate the importance of attachment assessment in the treatment planning process; clarifying a question concerning respondents' propensity to assess for attachment style; and suggesting minor changes to the format, including consistency with phrasing and capitalization, as well as instructions for specific questions.

Procedures.

The University of New Orleans Institutional Review Board (see Appendix B) approved this pilot study on March 19, 2012. Email contact information for the 139 members of LAPT was obtained from the LAPT's current President. An electronic communication (see Appendix C) was sent through Qualtrics™ to 125 LAPT members with supplied email addresses, containing

the informed consent for participation in the *PTDI* quantitative survey with a qualitative adjunct (see Appendix D), a short description of the research purpose, a statement about consent to voluntarily participate, anonymity of response, and an anonymous link to the survey. A follow-up email (see Appendix E) was sent one week later to remind those who had not completed the survey. After one week, the response rate was 21% and I was concerned that Internet servers were flagging the request for participation as spam due to the large volume of recipients and the "noreply" address used by Qualtrics, ™ resulting in a lower response rate. Following the recommendation of Qualtrics™ University help center, I sent a second reminder email (see Appendix F) through my own server in an effort to bypass spam filters. The survey was available initially for two weeks and was extended an additional week upon the request of interested participants. The final response rate was 24%. Data were analyzed using descriptive statistics, thematic and content analysis, and exploratory factor analysis. Results of the pilot study were used to understand the variables that contribute to the value ascribed to assessing for the attachment relationship between a child and caregiver by a play therapist in Louisiana. Furthermore, the analyses of the qualitative items in the pilot study informed options for forced-choice responses in the final *PTDI-R*. Additionally, results and patterns observed based on submitted responses to survey items informed modifications to the instrument in the larger study with members of the Association for Play Therapy.

Participants.

Participants in the pilot study included members of the Louisiana Association for Play Therapy (LAPT). The sole criterion for participation in the pilot study was current membership in LAPT. Given this minimal delimitation, an expectation existed that the resulting sample would consist of varying ages, ethnicities/races, gender, and experience. Currently, LAPT has

139 members (E. Dugan, personal communication, March 29, 2012); however, only 125 email addresses for members were available. Members of LAPT can join within the same types of categories as the national Association for Play Therapy. The survey was distributed to 125 members of LAPT, 30 of whom began to complete the survey. A total of 86% of respondents completed 80% or more of the entire survey with an average survey duration of 8 minutes; 29 of the 30 survey responses were considered appropriate for analysis. The respondents largely consisted of Caucasian females with a mean age of 39.5 and a mean of 8 years of experience in play therapy, and held certification as a licensed professional counselor and/or a registered play therapist- supervisor (see Table 10). Most of the participants were not current students in a master's degree program (93%); however, the participants (*n*= 15) who were not already certified as registered play therapists were in the process of gaining education or clinical experience to earn the registered play therapist credential (73%).

Pilot Study Results.

Table 10

Frequency Distribution of Pilot Study Participants by Sex, Race/Ethnicity, and Current Credentials (n=29)

Variable	*n*	%
Sex		
Male	3	10
Female	26	90
Race/Ethnicity		
African American	3	10
Asian American	0	0
Caucasian	26	90
Hispanic	0	0
Native American	0	0
Middle Eastern	0	0
Pacific Islander	0	0
Other	0	0
Credentials*		
Counselor Intern	4	8
Licensed Clinical Social Worker	6	11
Licensed Marriage and Family Therapist	4	8
Licensed Professional Counselor	14	26
National Certified Counselor	6	11
National Certified School Counselor	0	0
Other	5	9
Psychiatric Nurse	0	0

*Total responses exceeds number of participants due to multiple certifications held by respondents

Exploratory factor analysis with direct oblimin rotation was used to assess the underlying structure of the 27 items of the *PTDI*. However, the small sample size led to results that were not conclusive. A Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy determined if adequate responses per item were present to analyze through a factor analysis. The KMO statistic was .625. The desirable level for the statistic is .70, but the statistic is acceptable at a .50 level. Additionally the statistical significance was .000, leading to a rejection of the null hypothesis that there was no difference between the identity matrix and the correlation matrix. This means that the correlations between the variables are significantly different from a matrix indicating that there was no relationship at all.

To perform the factor analysis, only items that had a large variance were included. Inclusion of four survey items for final analysis occurred following inconclusive outputs from a combination of survey items. Identification of two factors occurred based on the initial results of the scree plot (see Figure 2). After rotation, the first factor accounted for 46.8% of the variance and the second factor accounted for 10.6% of the variance, with a cumulative variance of 57.4%. Table 11 presents the items and their loadings on each factor after rotation, as well as the relationship of each variable to all other variables, or the communalities. Factor loadings that were less than .4 were omitted from the chart.

Figure 2

Scree Plot for Pilot Study Exploratory Factor Analysis

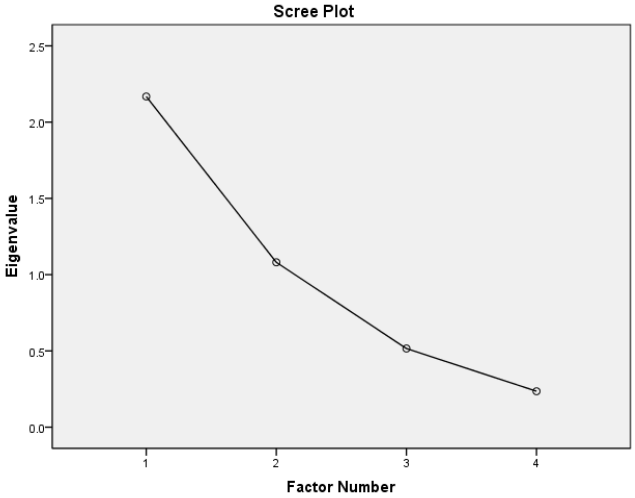

Table 11

Pilot Study: Factor Loadings for the Rotated Factors

Item	Factor Loading		Communality
	1	2	
1. How many years of experience do you have in providing play therapy services?	.585	-.405	.507
2. In what setting do you primarily provide play therapy?		.484	.261
3. How often do you consider assessing for attachment between a client (child) and the child's primary caregiver to be important in the treatment planning process?	.904		.818
4. When treatment planning, how often do you consider the attachment relationship between a client (child) and a primary caregiver?	.830		.713

Note: Loadings < .40 were omitted

The first factor, which seems to indicate an Experience factor, had strong loadings on the last two items and a moderate loading from the first item. This factor was seen as an Experience factor based on the assumption that play therapists who have more experience with play therapy will understand the importance of considering the attachment relationship between a child and caregiver. The second factor, which seemed to indicate a Location factor, had a moderate to low loading on the second item. The first item, years of experience, had an almost equally strong loading in the opposite direction on the second factor, as well as a moderate loading on the first factor. Although this is not desirable, I made the decision to include the first item in the "Experience" factor due to more logical connection to the other items in this factor. The last two items shared a large amount of variance with the other items; however, the first item had a moderate relationship to the other items and the second item had a weak connection to the other items.

In addition to the value a play therapist places on assessing for attachment, the prevalence of conducting an assessment for attachment was examined. Of the participants (see Table 12), 65% indicated that they assessed for the attachment relationship between a client (child) and primary caregiver. The main theme emerging as the method of assessment was a questionnaire or intake procedure (n=8), with standardized assessments (n=4) identified as the second most common method, followed by observations (n=3), and choosing their assessment method based on the client (n=1). Of the respondents, 52% indicated that they assessed for the attachment relationship between a caregiver and his or her primary caregiver. Interviews (n=6) with the caregiver emerged as the most common method of assessment, with an equal utilization of standardized assessments (n=1), observations (n=1), and play therapists choosing their assessment method based on the client (n=1).

The total number of responses to classes or hours in each category (e.g. none, 1, 2, 3, 4, 5 or more) for each type of training was calculated and then divided by the total number of responses for each type of training (e.g. graduate, half-day, full day, and two day) to arrive at a cumulative percentage of the amount of training play therapists had experienced in family-based play therapy interventions, (see Table 13). The majority of respondents indicated no training, regardless of type, in the family-based play therapy interventions. Reports of one training or course for a category were the next most common experience, followed by two trainings or courses in the various training types. Very few respondents indicated three or four courses or trainings in any type of training modality. However, 11% of respondents had five or more half-day workshops and 8% of respondents reported five or more full day workshops.

Participants indicated the frequency with which they utilize a play therapy intervention to respond to insecure attachment (see Table 14), reflecting a range of treatment responses. Of the participants, 62.5% utilized individual play therapy often or almost always, with the remaining 37.5% using it sometimes or less frequently. Most respondents (80%) never or rarely responded to insecure attachment with a group-based play therapy intervention. Half of respondents responded to insecure attachment often or almost always using a family play therapy intervention, while 29% of respondents never used this intervention as a response. One-third of the respondents (33%) never used filial therapy; however, 24% of play therapists surveyed often used filial therapy when they found an insecure attachment. Nearly one in four of play therapists surveyed (39%) often used Child-Parent Relationship Therapy and 22% almost always implemented this intervention when insecure attachment is identified. A substantial majority (85%) of surveyed play therapists never used Theraplay to remediate an insecure attachment.

Table 12

Percentage of Respondents Indicating Assessment for Attachment

% of Respondents	Yes	No
Do you assess for the attachment style between the client (child) and the primary caregiver?	65	35
Do you assess for the attachment style of the primary caregiver according to his/her relationship with their identified primary caregiver? (e.g. The mother's relationship with her mother)	52	48

Table 13

Cumulative Percentage of Family Play Therapy, Filial Therapy, Child-Parent Relationship Therapy, and Theraplay Training Responses

% of Respondents	None	1	2	3	4	5 or more
Graduate Courses	76	17	3	1	0	3
½ Day Workshop	53	26	8	2	1	11
Full Day Workshop	62	17	8	1	3	8
Two Day Workshop	80	9	4	1	1	5

Table 14

Percentage of Respondents Indicating Frequency of Play Therapy Interventions as a Response to Client's Insecure Attachment

% of Respondents	Never	Rarely	Sometimes	Often	Almost Always
Individual	12.5	12.5	12.5	37.5	25
Group	60	20	10	10	0
Family	29	13	8	42	8
Filial	33	14	19	24	10
CPRT	17	9	13	39	22
Theraplay	85	10	5	0	0

CPRT- Child-Parent Relationship Therapy

Pilot Study Discussion.

The focus of study was largely on the underlying factors in the *Play Therapists' Decision-Making Inventory* that contribute to the value that play therapists place on the attachment relationship. Additionally, this pilot study examined the prevalence of assessing for attachment, the education play therapists had acquired in family-based play therapy interventions, and the frequency of utilizing family-based interventions after identifying an insecure attachment between a child and caregiver.

Some of the factor loadings resulting from the exploratory factor analysis were lower than expected. Additionally, the small sample size (n=35) inhibited the variance in the scores, thereby reducing the inclusion of many items in the factor analysis. The reduction of 27 items on the instrument to four items included in the factor analysis greatly decreased the confidence in the validity of the instrument. Given that only two factors emerged based on four items, the ability of the instrument to measure the value play therapists attribute to the attachment relationship is limited. It might be expected that increasing the sample size would result in the occurrence of more factors and stronger loadings of items on these factors. Finally, the connection among the three items loading onto the Experience factor was not clear. Experience was identified as the common thread through these factors, leading to a conclusion that the more experience play therapists have acquired, the more likely they are to have developed a system for assessing for attachment, witnessed the importance of the caregiver-child bond, and have the right conditions available (i.e. school settings make parental involvement more difficult) to implement these practices.

The emerging trend in the descriptive statistics (see Tables 12-14) suggested that surveyed play therapists are aware of the importance of attachment and that they are utilizing assessment procedures to better understand this relationship. However, the majority of surveyed play therapists were not trained in family-based play therapy approaches, which could lead to a lack of preparedness when attempting to respond to identified insecure attachment. For example, inclusion of a client insecurely attached in a group play therapy intervention is not recommended in the literature (Ray, 2011); however, 20% of surveyed play therapists responded to insecure attachment sometimes or often with a group interventions.

APPENDIX B

University Committee for the Protection of Human Subjects in Research
University of New Orleans

Campus Correspondence

Principal Investigator:	Barbara Herlihy
Co-Investigator:	Jaime Parker
Date:	March 19, 2012
Protocol Title:	"Play Therapists' Decision-Making Based on the Child-Caregiver Relationship"
IRB#:	04Mar12

The IRB has deemed that the research and procedures described in this protocol application are exempt from federal regulations under 45 CFR 46.101category 2, due to the fact that the information obtained is not recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects.

Exempt protocols do not have an expiration date; however, if there are any changes made to this protocol that may cause it to be no longer exempt from CFR 46, the IRB requires another standard application from the investigator(s) which should provide the same information that is in this application with changes that may have changed the exempt status.

If an adverse, unforeseen event occurs (e.g., physical, social, or emotional harm), you are required to inform the IRB as soon as possible after the event.

Best wishes on your project.
Sincerely,

Robert D. Laird, Ph.D., Chair
UNO Committee for the Protection of Human Subjects in Research

APPENDIX C

March 27, 2012

Hello APT member,

I am a doctoral graduate student in Counselor Education under the direction of Professor Barbara Herlihy in the Department of Educational Leadership, Counseling, & Foundations at the University of New Orleans and Professor Erin Dugan in the Department of Rehabilitation Counseling at the Louisiana State University Health Sciences Center.

I am conducting a research study to identify whether members of the Louisiana Association for Play Therapy assess for attachment styles between children and their identified caregivers, how play therapists make this assessment, and whether play therapists are prepared to use play therapy interventions as a response to their assessment of attachment styles. My study has IRB approval through the University of New Orleans, IRB# 04Mar12.

I am requesting your participation, which will involve completion of a survey, Play Therapists' Decision-Making Inventory, that should take approximately 15 minutes of your time. Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. The results of the research study may be published, but your name will not be used. The questionnaire is anonymous. Return of the questionnaire will be considered your consent to participate.

Follow this link to the Survey: ${l://SurveyLink?d=Take the Survey}

Or copy and paste the URL below into your internet browser: ${l://SurveyURL

If you have any questions concerning the research study, please call Dr. Herlihy or myself at (504) 280-6661.

Thank you for your time and interest in this study

Sincerely,

Jaime Parker, LPC, NCC

Doctoral Candidate
The University of New Orleans
Department of Educational Leadership, Counseling & Foundations
Lakefront Campus
2000 Lakeshore Drive
New Orleans, LA 70148
jkparker@my.uno.edu

APPENDIX D

Play Therapists' Decision-Making Inventory

Q1 Sex

Male (1)
Female (2)

Q2 Age

Q3 Ethnicity

African American (1)
Asian American (2)
Caucasian (3)
Hispanic (4)
Native American (5)
Middle Eastern (6)
Pacific Islander (7)
Other (8) _____

Q4 Current Credentials (Please check all that apply)

- ❑ Counselor Intern (CI) (1)
- ❑ Licensed Marriage and Family Therapist (LMFT) (2)
- ❑ Licensed Professional Counselor (LPC) (3)
- ❑ Licensed Clinical Social Worker (LCSW) (4)
- ❑ National Certified Counselor (NCC) (5)
- ❑ National Certified School Counselor (NCSC) (6)
- ❑ Registered Play Therapist (RPT) (7)
- ❑ Registered Play Therapist Supervisor (RPT-S) (8)
- ❑ School Psychologist (9)
- ❑ Psychiatric Nurse (10)
- ❑ Other (11)

Q5 Are you a currently enrolled as a graduate student in a Master's level mental health degree program?

Yes (1)
No (2)

Q6 If you are not an RPT or RPT-S, indicate if you are (select one)

Currently in training to acquire the RPT credential (1)
Not planning to become credentialed as an RPT (2)

Q7 How many years of experience do you have in providing play therapy services?
None (1)

1 (2)
2 (3)
3 (4)
4 (5)
5 (6)
6 (7)
7 (8)
8 (9)
9 (10)
10 (11)
11 (12)
12 (13)
13 (14)
14 (15)
15 (16)
16 (17)
17 (18)
18 (19)
19 (20)
20 (21)
21 (22)
22 (23)
23 (24)
24 (25)
25 (26)
26 (27)
27 (28)
28 (29)
29 (30)
30 (31)
over 30 years (32)

Q8 Filial Therapy is a "psychoeducational intervention" (VanFleet, 2011, p.154) based in family therapy and utilizing play where parents are trained in nondirective play therapy to improve family relationships (VanFleet, 2011). Please answer the following questions with respect to Filial Therapy specifically:

	None (1)	1 (2)	2 (3)	3 (4)	4 (5)	5 or more (6)
How many graduate-level courses have you completed? (1)						
How many ½ day workshops (3 hours or less) have you completed? (2)						
How many full day [more than 3 hours) workshops have you completed? (3)						
How many 2-day (or longer) workshops have you completed? (4)						

Q9 Child-Parent Relationship Therapy is an intervention requiring 10 skill-based sessions (Landreth & Bratton, 2006, p. 15) Please answer the following questions with respect to Child-Parent Relationship Therapy specifically:

	None (1)	1 (2)	2 (3)	3 (4)	4 (5)	5 or more (6)
How many graduate-level courses have you completed? (1)						
How many ½ day workshops (3 hours or less) have you completed? (2)						
How many full day [more than 3 hours) workshops have you completed? (3)						
How many 2-day (or longer) workshops have you completed? (4)						

Q10 Please answer the following questions with respect to Group Play Therapy specifically:

	None (1)	1 (2)	2 (3)	3 (4)	4 (5)	5 or more (6)
How many graduate-level courses have you completed? (1)						
How many ½ day workshops (3 hours or less) have you completed? (2)						
How many full day [more than 3 hours) workshops have you completed? (3)						
How many 2-day (or longer) workshops have you completed? (4)						

Q11 Please answer the following questions with respect to Family Play Therapy specifically:

	None (1)	1 (2)	2 (3)	3 (4)	4 (5)	5 or more (6)
How many graduate-level courses have you completed? (1)						

How many ½ day workshops (3 hours or less) have you completed? (2)						
How many full day [more than 3 hours) workshops have you completed? (3)						
How many 2-day (or longer) workshops have you completed? (4)						

Q12 Please answer the following questions with respect to Individual Play Therapy specifically:

	None (1)	1 (2)	2 (3)	3 (4)	4 (5)	5 or more (6)
How many graduate-level courses have you completed? (1)						
How many ½ day workshops (3 hours or less) have you completed? (2)						
How many full day						

[more than 3 hours) workshops have you completed? (3)						
How many 2-day (or longer) workshops have you completed? (4)						

Q13 Theraplay is therapy modeled after a healthy parent-child relationship, in which the therapist concentrates on providing the child with "Structure, Challenge, Intrusion, and Nurture" (Jernburg, 1984, p.40). Please answer the following questions with respect to Theraplay specifically:

	None (1)	1 (2)	2 (3)	3 (4)	4 (5)	5 or more (6)
How many graduate-level courses have you completed? (1)						
How many ½ day workshops (3 hours or less) have you completed? (2)						
How many full day [more than 3 hours) workshops have you completed? (3)						
How many						

2-day (or longer) workshops have you completed? (4)						

Q14 In what setting do you primarily provide play therapy?

Agency (1)
Private Practice (2)
School (3)
University (4)
Hospital (5)
Other (6)

Q15 When providing play therapy, what theoretical orientation do you use most often?

Child-Centered (1)
Jungian (2)
Adlerian (3)
Cognitive- Behavioral (4)
Ecosystemic (5)
Psychodynamic (6)
Object Relations (7)
Gestalt (8)
Prescriptive (9)
Unsure of theoretical orientation (10)
Other (11)

Q16 Primarily, what ages are the children to whom you provide play therapy services?

0-5 (1)
6-10 (2)
11-15 (3)
16-20 (4)
21-25 (5)
Other (6)

Q17 What play therapy services do you provide? (Check all that apply)

- ❑ Individual Play Therapy (1)
- ❑ Group Play Therapy (2)
- ❑ Family Play Therapy (3)
- ❑ Filial Therapy (4)

- ❑ Child-Parent Relationship Therapy (5)
- ❑ Theraplay (6)
- ❑ Other (7)

Q18 At the initial intake, what information do you consider when constructing a treatment plan?

Q19 How often do you consider assessing for attachment between a client (child) and the child's primary caregiver to be important in the treatment planning process?
(1= Never; 2= Rarely; 3= Sometimes; 4= Often; 5= Almost Always)

1 (1)
2 (2)
3 (3)
4 (4)
5 (5)

Q20 Do you assess for the attachment style between the client (child) and the primary caregiver?

Yes (1)
No (2)

Q21 If yes, how?

Q22 Do you assess for the attachment style of the primary caregiver according to his/her relationship with their identified primary caregiver? (e.g. The mother's relationship with her mother)

Yes (1)
No (2)

Q23 If yes, how?

Q24 When treatment planning, how often do you consider the attachment relationship between a client (child) and a primary caregiver?
(1= Never; 2= Rarely; 3= Sometimes; 4= Often; 5= Almost Always)

1 (1)
2 (2)
3 (3)
4 (4)
5 (5)

Q25 Insecure attachment occurs when children are consistently unable to depend on their caregivers to meet their needs. If an insecure attachment style is identified between a client

(child) and the child's primary caregiver, how frequently do you utilize a family-systems intervention, such as filial therapy, family play therapy, or Child-Parent Relationship therapy, in the client's (child's) treatment?
(1= Never; 2= Rarely; 3= Sometimes; 4= Often; 5= Almost Always)

1 (1)
2 (2)
3 (3)
4 (4)
5 (5)

Q26 How frequently do you use the following interventions as a response to an insecure attachment style identified between a client (child) and their identified primary caregiver? (1= Never; 2= Rarely; 3= Sometimes; 4= Often; 5= Almost Always)

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)
Individual Play Therapy (1)					
Group Play Therapy (2)					
Family Play Therapy (3)					
Filial Therapy (4)					
Child-Parent Relationship Therapy (5)					
Theraplay (6)					

Q27 Is there anything else you would like to share about your practices in assessing for attachment?

APPENDIX E

April 3, 2012

Hello LAPT member,

As a reminder, I would like to encourage you to take about 15 minutes to complete my survey, Play Therapists' Decision-Making Inventory. The opportunity to contribute to this study is closing on Monday, April 9th. The only criteria for participating in the survey is membership in the Louisiana Association for Play Therapy. Thank you to those who have already contributed their time. I am a doctoral graduate student in Counselor Education under the direction of Professor Barbara Herlihy in the Department of Educational Leadership, Counseling, & Foundations at the University of New Orleans and Professor Erin Dugan in the Department of Rehabilitation Counseling at the Louisiana State University Health Sciences Center.

I am conducting a research study to identify whether members of the Louisiana Association for Play Therapy assess for attachment styles between children and their identified caregivers, how play therapists make this assessment, and whether play therapists are prepared to use play therapy interventions as a response to their assessment of attachment styles. My study has IRB approval through the University of New Orleans, IRB# 04Mar12.

I am requesting your participation, which will involve completion of a survey, Play Therapists' Decision-Making Inventory, that should take approximately 15 minutes of your time. Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. The results of the research study may be published, but your name will not be used. The questionnaire is anonymous. Return of the questionnaire will be considered your consent to participate.

Follow this link to the Survey: ${l://SurveyLink?d=Take the Survey}

Or copy and paste the URL below into your internet browser: ${l://SurveyURL

If you have any questions concerning the research study, please call Dr. Herlihy or myself at (504) 280-6661.

Thank you for your time and interest in this study!

Sincerely,

Jaime Parker, LPC, NCC

Doctoral Candidate
The University of New Orleans
Department of Educational Leadership, Counseling & Foundations
Lakefront Campus
2000 Lakeshore Drive
New Orleans, LA 70148
jkparker@my.uno.edu

APPENDIX F

April 6, 2012

Hello LAPT member,

I would like to encourage you to take about 15 minutes to complete my survey, *Play Therapists' Decision-Making Inventory*. The opportunity to contribute to this study is closing on Monday, April 9th and I need to collect **10 more responses**. The only criteria for participating in the survey is membership in the Louisiana Association for Play Therapy. Thank you to those who have already contributed their time.

I am a doctoral graduate student in Counselor Education under the direction of Professor Barbara Herlihy in the Department of Educational Leadership, Counseling, & Foundations at the University of New Orleans and Professor Erin Dugan in the Department of Rehabilitation Counseling at the Louisiana State University Health Sciences Center.

I am conducting a research study to identify whether members of the Louisiana Association for Play Therapy assess for attachment styles between children and their identified caregivers, how play therapists make this assessment, and whether play therapists are prepared to use play therapy interventions as a response to their assessment of attachment styles. My study has IRB approval through the University of New Orleans, IRB# 04Mar12.

I am requesting your participation, which will involve completion of a survey, *Play Therapists' Decision-Making Inventory*, that should take approximately 15 minutes of your time. Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. The results of the research study may be published, but your name will not be used. The questionnaire is anonymous. Return of the questionnaire will be considered your consent to participate.

Follow this link to the Survey: http://neworleans.us2.qualtrics.com/SE/?SID=SV_9RWwTvAeVOuYIdu
Or copy and paste the URL below into your internet browser:

If you have any questions concerning the research study, please call Dr. Herlihy or myself at (504) 280-6661.

Thank you for your time and interest in this study!

Sincerely,

Jaime Parker, LPC, NCC
Doctoral Candidate
The University of New Orleans
Department of Educational Leadership, Counseling & Foundations
Lakefront Campus
2000 Lakeshore Drive
New Orleans, LA 70148
jkparker@my.uno.edu

APPENDIX G

University Committee for the Protection of Human Subjects in Research
University of New Orleans

Campus Correspondence

Principal Investigator:	Barbara Herlihy
Co-Investigator:	Jaime Parker
Date:	August 21, 2012
Protocol Title:	"Factors Associated with Play Therapists' Use of Family-Systems Play Therapy Interventions"
IRB#:	05Aug12

The IRB has deemed that the research and procedures described in this protocol application are exempt from federal regulations under 45 CFR 46.101category 2, due to the fact that the information obtained is not recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects.

Exempt protocols do not have an expiration date; however, if there are any changes made to this protocol that may cause it to be no longer exempt from CFR 46, the IRB requires another standard application from the investigator(s) which should provide the same information that is in this application with changes that may have changed the exempt status.

If an adverse, unforeseen event occurs (e.g., physical, social, or emotional harm), you are required to inform the IRB as soon as possible after the event.

Best wishes on your project.
Sincerely,

Robert D. Laird, Ph.D., Chair
UNO Committee for the Protection of Human Subjects in Research

APPENDIX H

Mailing List Rental Agreement
Association for Play Therapy

The Association for Play Therapy (APT) is a national non-profit professional organization that advances play therapy and serves the professional needs of its member mental health professionals and students. It maintains and exclusively owns the list of its members and their names and contact information and only rents the use of such list per the individual preferences of its members to benefit them or advance the mission of APT per these guidelines:

1. The list may not be shared under any conditions with other parties by Renter.
2. The list may not be utilized more than one (1) time by Renter who, if discovered to have re-used or shared the list, will immediately be charged a second fee identifical to the first fee and may be prohibited from renting the list in the future.
3. The Renter must complete and submit this a) rental order agreement with b) a sample of the message, mailing, or product to be disseminated via the list and c) the applicable payment in full (in US dollars) to Carol Guerrero, APT Product Services Coordinator, 3198 Willow Ave., #110, Clovis, CA 93612 USA, (559) 294-2128 ext 1, Fax (559) 294-2129, cguerrero@a4pt.org.
4. The rental fee schedule per 1,000 names is below. **Please select a "Type of List" ordering.**

Select Type of List	APT Approved Providers	Others
___ Mailing Addresses	$50.00 / per 1,000	$100.00 / per 1,000
✓ Email Addresses	$75.00 / per 1,000	$150.00 / per 1,000
___ Both Addresses	$100.00 / per 1,000	$200.00 / per 1,000

5. The rental fee schedule above includes ground shipping charges if the list is mailed to Renter. Other shipping options are available and, if applicable, at additional cost to Renter. Note: Most Renters prefer that the list be transmitted electronically as an Excel attachment.
6. Payment of rental fee may be made by check, money order, credit card (only Mastercard or Visa), and valid institutional purchase order. If credit card, Renter must provide this information:

   Credit Card: _____ MasterCard _____ Visa

   Credit Card account number: _____ Expiration Date: _____

   Amount authorized: $_____ Name on Credit Card: _____

   Signature: _____ Date: _____
7. The submission of purchase orders represents a guarantee and promise that that the institution will immediately forward payment upon receipt of an invoice and mailing list from APT. Purchase orders net 30 days.
8. Rental orders faxed to APT are accepted only if paid by credit card or accompanying purchase order with sample piece.
9. APT reserves the right to reject any rental request.
10. APT strives to maintain an accurate and complete list but cannot and does not guarantee such to Renter.

Renter is asked to provide the following information to APT:

1. Date list ordered: 8/15/12 Date list required: 8/17/12 APT CE Provider #_____
2. Name of Renter: Jaime Parker
3. Billing/Shipping Address: 104 Barbara Ct
4. Telephone: 228-217-2114 Email: jaimekparker@yahoo.com
5. Geographic area (complete US list will be sent unless specified): _____
6. Sequence Desired (by Zip Code, alphabetical, etc.): alphabetical
7. Method of Delivery (by email as Excel attachment, ground shipping, etc.): Excel attachment
8. Format Desired (pressure sensitive labels, Excel attachment, etc.): Excel attachment

* need all email addresses provided by APT members.

As the authorized representative of the Renter, I agree to abide by the terms and condition in this agreement.

Renter Name (print): Jaime Parker Date: 8/14/12

Renter Signature: Jaime Parker

For office use only

Date Received:_____ Total Sent:_____ Total Cost:_____ Date Mailed:_____

Rev. 2006, 2008, 2009

APPENDIX I

Request for Mailing List and Research Guidelines

The Association for Play Therapy will provide one mailing list to those conducting research consistent with the mission and goals of APT. The following information must be provided, along with a completed Mailing List Rental Form at least 2-3 days prior to date needed.

1. Requestor Information:
Jaime Parker, LPC, NCC
Doctoral Candidate
The University of New Orleans
Department of Educational Leadership, Counseling & Foundations Lakefront Campus
2000 Lakeshore Drive
New Orleans, LA 70148

2. Final copies of all instruments and cover letters (and consent forms, if any).

See attached.

3. Short discussion of each of the following proposal (1 page total):

a. The members of the Association for Play Therapy (APT) are the population of interest. At a minimum, 300 responses are expected.

b.

An electronic communication will be sent to APT members through my own server in an effort to bypass spam filters on August 17, 2012. It will contain the informed consent for participation in the study, a short description of the research purpose, a statement about consent to voluntarily participate, anonymity of response, and an anonymous link to the survey. When potential respondents follow the anonymous link to the survey, the statement of informed consent to participants will be presented, and participants will indicate consent to participate before proceeding to the survey items.

APT members will receive a follow-up email two weeks later as a reminder. The Play Therapists' Decision-Making Inventory-Revised survey will be available over four weeks. Near the end of the data collection period, I will make a decision about extending the availability of the survey for an additional two weeks based on whether the desired 300 responses (Mertler & Vannatta, 2010) have been received. At the end of the data collection period, all APT members with an email address will receive an electronic communication thanking them for their participation and providing the option to receive results after data analysis.

The Qualtrics TM server will house the data under a password-protected account. Once data collection is complete, data extraction will occur converting the Qualtrics TM data into a Statistical Package for the Social Sciences (SPSS) file for use in analyses. The Qualtrics TM server will house the data for five years, as required by the American Psychological Association

(2010).

c. The purposes of this quantitative with qualitative adjunct study are to determine the extent to which play therapists integrate into treatment planning their knowledge of the attachment style between the child and caregiver, and to examine the preparedness of play therapists to respond to dysfunctional attachment relationships using evidence-based, family-system play therapy interventions for attachment deregulation. It is hoped that the findings of this study will increase awareness of play therapists' attitudes towards attachment relationships and their readiness, based on their training in family-systems play therapy interventions, to respond to an insecure attachment in a child client.

d. There are no known risks to the participants.

e. Information from this survey will be analyzed using logistic regression, correlation coefficients, factor analysis, spearman rho, chi-square, and descriptive statistics. The openended, qualitative questions will be analyzed using content and thematic analyses. Results will be disseminated through a dissertation, submitted for publication, and submitted for presentations at state and national conferences.

f. There is no funding supporting the project.

4. Evidence of approval by a Human Subjects Review/IRB Committee at outside institution.

See attached IRB approval letter.

APPENDIX J

Hello APT member,

My name is Jaime Parker and I am a doctoral candidate in Counselor Education under the direction of Professor Barbara Herlihy in the Department of Educational Leadership, Counseling, & Foundations at the University of New Orleans. I am requesting your assistance with my dissertation study titled *Factors Related to the Association for Play Therapy Members' Frequency of Usage of Family-Systems Play Therapy Interventions.* My purpose is to understand interventions used by play therapists in their work with children and families. **The only criteria for participating in the survey is membership in the Association for Play Therapy**.

I developed this survey (Play Therapists Decision-Making Inventory-R) specifically for the purpose of my dissertation that asks play therapists to respond to questions about their use of family-systems play therapy interventions, their beliefs concerning attachment theory, and their beliefs about perceived competency and training adequacy. My hope is that the information obtained from this survey will provide valuable information regarding family-systems play therapy intervention practice patterns of the Association for Play Therapy members for use by educators, clinicians, and the play therapy credentialing body.

I am requesting your participation, which will involve completion of a survey that should take approximately 10 minutes of your time. Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. The results of the research study may be published, but your name will not be used. The questionnaire is anonymous.

Follow this link to the Survey:
http://neworleans.us2.qualtrics.com/SE/?SID=SV_79w6D9R339ejoWN
Or copy and paste the URL below into your internet browser

If you have any questions concerning the research study, please call Dr. Herlihy or myself at (504) 280-6661.

Thank you for your time and interest in this study

Sincerely,

Jaime Parker, LPC, NCC
Doctoral Candidate
The University of New Orleans

APPENDIX K

Dear APT member,

Please be advised that the time to participate in my dissertation study titled Factors Associated with Play Therapists' Use of Family-Systems Play Therapy Interventions, which has been approved by the UNO IRB (protocol # 05Aug12), has ended. Data collection ran from September 4, 2012 to October 2, 2012.

The data gleaned from this survey will provide information about play therapists' use of family-systems play therapy interventions, their beliefs concerning attachment theory, and their beliefs about perceived competency and training adequacy. My hope is that the information obtained from this survey will provide valuable information regarding family-systems play therapy intervention practice patterns of the Association for Play Therapy members for use by educators, clinicians, and the play therapy credentialing body.

If you have would like to receive the results of the study, please send an email request to Jaime Parker at jkparker@uno.edu.

Thank you for taking the time to provide information about your practices with children and families.

Finally, if you have any questions or comments about the study, please contact the faculty advisor, Dr. Herlihy at bherlihy@uno.edu or (504) 280-6661. Additionally, you may also contact the investigator, Jaime Parker at jkparker@uno.edu.

Sincerely,
Jaime Parker, LPC, NCC
Doctoral Candidate
University of New Orleans
${l://SurveyLink?d=Closed%20Survey}

APPENDIX L

Play Therapists' Decision-Making Inventory- Revised

Q1 Hello,
My name is Jaime Parker and I am a doctoral candidate in Counselor Education under the direction of Professor Barbara Herlihy in the Department of Educational Leadership, Counseling, & Foundations at the University of New Orleans. I am requesting your assistance with my dissertation study titled Factors Associated with Play Therapists' Use of Family-Systems Play Therapy Interventions, which has been approved by the UNO IRB (protocol # 05AUG12). The only criteria for participating in the survey is membership in the Association for Play Therapy. My purpose is to understand interventions used by play therapists in their work with children and families.

I developed this survey (Play Therapists Decision-Making Inventory-R or *PTDI-R*) specifically for the purpose of my dissertation that asks play therapists to respond to questions about their use of family-systems play therapy interventions, their beliefs concerning attachment theory, and their beliefs about perceived competency and training adequacy. My hope is that the information obtained from this survey will provide valuable information regarding family-systems play therapy intervention practice patterns of the Association for Play Therapy members for use by educators, clinicians, and the play therapy credentialing body.

I am requesting your participation, which will involve completion of a survey that should take approximately 10 minutes of your time. Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. The results of the research study may be published, but your name will not be used. The questionnaire is anonymous.

If you have any questions concerning the research study, please call Dr. Herlihy or myself at (504) 280-6661.

Thank you for your time and interest in this study

If you are willing to participate, please indicate your consent below.

Sincerely,
Jaime Parker, LPC, NCC
Doctoral Candidate
The University of New Orleans

I give my consent. (1)

I DO NOT give my consent. (2)

If I DO NOT give my consent. Is Selected, Then Skip To End of Survey

Q2 Sex

Male (1)
Female (2)

Q3 Age

Q4 Ethnicity

African American (1)
Asian American (2)
Bi-racial/ multi-racial (3)
Caucasian (4)
Hispanic (5)
Middle Eastern (6)
Native American (7)
Pacific Islander (8)
Other (9)

Q5 Are you a current member of the Association for Play Therapy?

Yes (1)
No (2)

Q6 Current Credentials (Please check all that apply)

- ❑ Counselor Intern (1)
- ❑ Licensed Clinical Social Worker (2)
- ❑ Licensed Marriage and Family Therapist (3)
- ❑ Licensed Professional Counselor (4)
- ❑ National Certified Counselor (5)
- ❑ National Certified School Counselor (6)
- ❑ Psychiatric Nurse (7)
- ❑ Registered Play Therapist (8)
- ❑ Registered Play Therapist- Supervisor (9)
- ❑ School Psychologist (10)
- ❑ Other (11)

Q7 Are you currently enrolled as a graduate student in a Master's level mental health degree program?

Yes (1)
No (2)

Q8 If you are not a Registered Play Therapist (RPT), are you (select one):

Planning to acquire the RPT credential (1)

NOT planning to acquire the RPT credential (2)

This question is not applicable to me. (3)

Q9 How many years of experience do you have in providing play therapy services? (Please round up to the nearest whole number.)

I have never practiced play therapy. (1)
Less than 1 (2)
1 (3)
2 (4)
3 (5)
4 (6)
5 (7)
6 (8)
7 (9)
8 (10)
9 (11)
10 (12)
11 (13)
12 (14)
13 (15)
14 (16)
15 (17)
16 (18)
17 (19)
18 (20)
19 (21)
20 (22)
21 (23)
22 (24)
23 (25)
24 (26)
25 (27)
26 (28)
27 (29)
28 (30)
29 (31)
30 (32)
over 30 (33)

Q10 In what setting do you primarily provide play therapy?

Agency (1)
Home-based Services (2)
Hospital (3)
Private Practice (4)
School (5)
University (6)
Other (7)
Not applicable (8)

Q11 When providing play therapy, what theoretical orientation do you use most often?

Adlerian (1)
Child-Centered (2)
Cognitive-Behavioral (3)
Eclectic (4)
Ecosystemic (5)
Gestalt (6)
Jungian (7)
Object Relations (8)
Prescriptive (9)
Psychodynamic (10)
Unsure of theoretical orientation (11)
Other (12)

Q12 Primarily, what ages are the clients to whom you provide play therapy services?

0-5 (1)
6-10 (2)
11-15 (3)
16-20 (4)
21-25 (5)
Other (6)
Not Applicable (7)

Q13 Please rate how strongly you identify with the following statements.

	Disagree Strongly (1)	Disagree (2)	Tend to Disagree (3)	Tend to Agree (4)	Agree (5)	Strongly Agree (6)
It is important for me to consider the strength of attachment between a client (child) and the child's primary caregiver in the treatment planning process. (1)						
I believe that, "A healthy attachment relationship between a child and caregiver is important to healthy functioning, so the strength of the relationship must be determined in order to develop a comprehensive counseling treatment plan." (2)						
I believe insecure attachment relates to childhood maladjustment. (3)						

Q14

Child- Parent Relationship Therapy is an filial therapy intervention requiring 10 sessions grounded in "enhancing and strengthening the parent-child relationship" (Landreth & Bratton, 2006, p. 15)

Filial Therapy is a "psychoeducational intervention" (VanFleet, 2011a, p.154) developed by the Guerney's, based in family therapy, and utilizing play where parents are trained in nondirective play therapy to improve family relationships (VanFleet, 2011a).

Parent-Child Interaction Therapy is based in the belief that a healthy attachment is necessary for behavioral change to occur within the context of the parent-child relationship. Furthermore, through a combination of behavioral techniques, play therapy techniques, family systems, and the social learning theory, parent-child interaction therapy teaches parental skills in the context of a healthy child-caregiver relationship (Drewes, 2006; Herschell, Calzada, Eyberg, & McNeil, 2002)

Theraplay is modeled after a healthy parent-child relationship, in which the therapist concentrates on providing the child "Structure, Challenge, Intrusion, and Nurture" (Jernburg, 1984, p. 40).

Q15 Please rate how strongly you identify with the following statements.

	Disagree Strongly (1)	Disagree (2)	Tend to Disagree (3)	Tend to Agree (4)	Agree (5)	Strongly Agree (6)
I believe I have adequate training in Child-Parent Relationship Therapy. (1)						
I believe I have adequate training in Filial Therapy. (2)						
I believe I have adequate training in Parent-Child Interaction Therapy. (3)						
I believe I have adequate training in Theraplay. (4)						

Q16

Child- Parent Relationship Therapy is a filial therapy intervention requiring 10 sessions grounded in "enhancing and strengthening the parent-child relationship" (Landreth & Bratton, 2006, p. 15)

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Theraplay is modeled after a healthy parent-child relationship, in which the therapist concentrates on providing the child "Structure, Challenge, Intrusion, and Nurture" (Jernburg, 1984, p. 40).

Q17 Please rate how strongly you identify with the following statement.

	Disagree Strongly (1)	Disagree (2)	Tend to Disagree (3)	Tend to Agree (4)	Agree (5)	Strongly Agree (6)
I believe I am competent in the utilization of Child-Parent Relationship Therapy. (1)						
I believe I am competent in the utilization of Filial Therapy. (2)						
I believe I am competent in the utilization of Parent-Child Interaction Therapy. (3)						
I believe I am competent in the utilization of Theraplay. (4)						

Q18 How frequently do you use the following interventions?

	Never (1)	Very Rarely (2)	Rarely (3)	Occasionally (4)	Frequently (5)	Very Frequently (6)
Individual Play Therapy (1)						
Group Play Therapy (2)						
Filial Therapy (3)						
Child-Parent Relationship Therapy (4)						
Theraplay (5)						
Parent-Child Interaction Therapy (6)						

Q19 When treatment planning, how often do you consider the attachment relationship between a client (child) and a primary caregiver?

Never (1)
Very Rarely (2)
Rarely (3)
Occasionally (4)
Frequently (5)
Very Frequently (6)

Q20 Dysfunctional attachment occurs when children are consistently unable to depend on their caregivers to meet their needs.If a dysfunctional attachment style is identified between a client (child) and the child's primary caregiver, how frequently do you utilize a family-systems play therapy intervention, such as Filial Therapy, Child- Parent Relationship Therapy, Theraplay, and Parent-Child Interaction Therapy, in the client's (child's) treatment?

Never (1)
Very Rarely (2)
Rarely (3)
Occasionally (4)
Frequently (5)
Very Frequently (6)

Q21 During the initial intake, what are the THREE most important pieces of information you consider when constructing a treatment plan?

Q22 Is there anything else you would like to share about your use of family-systems play therapy?

VITA

The author is a native of the Mississippi Gulf Coast. She received her Bachelor of Science degree in Psychology from Millsaps College in 2005, her Master of Science degree in Organizational Counseling from William Carey University Traditions Campus in 2008, and her Ph.D. in Counselor Education from the University of New Orleans in Fall 2012. She looks forward to continually developing her play therapy practice, expanding research in play therapy and attachment, and educating other practitioners about the significance of both.