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Play Therapists' Practice Patterns and Perceptions of the Factors that Influence Caregiver Engagement in Play Therapy

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Dedication

I dedicate this dissertation to my parents, Sam and Linda Lolan. Dad, your belief in me has always inspired me to never give up. Mom, you have always shown me the value of kindness, compassion, and patience. You are the reason I knew I could do this! I will be forever grateful to you both for your unconditional love, support, and encouragement throughout my educational pursuits.

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ABSTRACT

Much effort has been expended to increase the awareness and understanding of play therapy among consumers and practitioners (Landreth, 1991) since its introduction by Virginia Axline during the 1940s. As with any form of counseling, Leblanc and Ritchie (1999) have noted there are factors considered key to successful play therapy treatment outcomes. Play therapy research shows a positive relationship between parent's involvement in play therapy and successful outcomes (LeBlanc & Ritchie, 1999; Bratton, Ray, Rhine, & Jones, 2005) but little research exists to document specific practice patterns and perceptions of play therapists in relation to achieving caregiver engagement. The purpose of this study was to identify the practice patterns of play therapists, their perceptions of the factors that influence caregiver engagement, their perceptions of the relationship between caregiver engagement and the therapeutic outcome for the child client, and their perceptions of the barriers to achieving caregiver engagement in play therapy. The *Caregiver Engagement Inventory* (CEI), a 36-item, structured and semi-structured questionnaire developed for this research, was electronically sent to 4854 members of the Association for Play Therapy (APT), resulting in 539 responses, 431 of which were deemed appropriate for inclusion. Of the 423 participants who responded, 292 (69%) strongly agreed and 107 (25%) agreed that caregiver engagement is related to a child's therapeutic outcome in play therapy. Fifty-three percent (n=228) of respondents strongly agreed that they are prepared to facilitate caregiver engagement in play therapy, and 35% (n=151) agreed. These results suggested that, while 94% of play therapists who responded believe caregiver engagement is a large factor in successful play therapy outcomes, only 88% of the participants feel prepared to accomplish the task with caregivers of their child clients. The results indicated a relationship between training and play therapists' practice patterns related to caregiver engagement, but

participants reported minimal exposure to training specific to working with caregivers in both their graduate programs and workshops. Findings indicated that play therapists value caregivers' roles in play therapy; however, barriers exist to caregiver engagement. Implications for play therapists, educators of mental health professionals, and future research are discussed.

Keywords: play therapy, caregiver, engagement

CHAPTER ONE

INTRODUCTION

The surgeon general's most recent report (2000) on mental illness in the United States estimated that four million, or approximately one in five children in the United States, experiences symptoms associated with mental health issues, and that these challenges create difficulty in many aspects of their lives, including family, social, and academic concerns. Identifying effective treatments for mental health issues and providing access to quality treatment is an issue of national concern. Research has suggested a lack of agreement on which treatment is most effective; however, one factor that has been shown to positively influence outcomes across mental health disciplines is the involvement of caregivers in a child's therapeutic process (LeBlanc & Ritchie, 1999; Ray, Bratton, Rhine, & Jones, 2001). The surgeon general also reported that over time, the role of families in their child's mental health treatment has evolved from that of being blamed for causing the problem to being an active participant in the child's care (2000). Considering the fact that a critical determinant of a child's ability to learn is his/her mental health (American School Counselor Association; ASCA, 2009), the need for qualified mental health clinicians prepared to meet the complex needs of families is clear.

The term "caregiver" can refer to a variety of different people depending on the family dynamics of each individual child client. For the purpose of this study, the term caregiver referred to person(s) primarily responsible for a child's care who also transports child to and from play therapy and is responsible for communicating with his/her child's play therapist regarding progress and continued challenges for the child client. Caregivers can include biological parents, appointed guardians, family members, or others legally designated as

responsible for the child (Garfinkel, 2010). Caregivers who seek mental health services for their children often lack knowledge or understanding about the process their family is about to embark on, or the role expectations for both the caregiver and the child. Communicating effectively with caregivers from the onset of therapy can positively affect therapeutic outcomes for children (Cates, Paone, Packman, & Margolis, 2006). A review of current literature suggests that leaders in the fields of counseling, consultation, and play therapy agree that caregiver engagement in the therapeutic process is important to the collaborative relationship between clinician and caregiver, and the therapeutic outcome for the child client (Brown, Pryzwansky, & Shulte, 1998; Gil, 1994; Holcomb-McCoy & Bryan, 2010; Kottman & Ashby, 1999).

Play Therapy

Piaget (1962) believed that children under the age of 11 often lack the abstract thought processes necessary to understand or verbally express many feelings and emotions. Thus, they turn to their natural medium of expression—play. Sigmund Freud (1905/1955) and Klein (1955) initially documented support for the benefits of play. Freud's work with "Little Hans" (1909/1955) was rooted in psychoanalysis and included ongoing consultation between Hans's father and Freud. Freud instructed Hans's father to monitor his play, to respond to him therapeutically, and to report his observations back to Freud. Following Freud was Melanie Klein, (1955) who used toys during her psychoanalysis sessions with children, based on her belief that they should be analyzed based on their actions, rather than their verbalizations (A. Freud, 1946).

Around the same time, Anna Freud (1946) used play in therapy to build a therapeutic relationship with the child in order to evaluate his/her unconscious motivation. Freud (1946) realized that psychoanalysis with children required "special modifications" to the traditional

psychoanalysis used by her father, Sigmund Freud, with adults (p. 4). Another distinction Freud recognized between working with adults and children was that while adults typically seek therapy on their own accord, children's decisions are made for them, often without their knowledge or input. A further contribution of Freud's work that is relevant today is her acknowledgement of the importance of establishing a working relationship with the child's caregiver to receive history and information regarding the child's progress in treatment.

Moving away from psychoanalytical underpinnings, Axline used Carl Rogers' person-centered therapy as the foundation for nondirective, or client-centered, play therapy (Landreth, 1991). In 1950 Axline defined nondirective play therapy as "a play experience that is therapeutic because it provides a secure relationship between the child and the adult, so that the child has the freedom and room to state himself in his own terms, exactly as he is at that moment in his own way and in his own time" (p. 68). Axline (1969) suggested that a play therapist should hold certain positive beliefs about children and offered eight basic principles for working with children from a non-directive approach (see conceptual framework, p. 17).

Building upon the foundation laid by Axline, Landreth (2002) has put a contemporary spin on non-directive play therapy by developing child-centered play therapy. He views play therapy as a relationship between a child and a trained play therapist wherein the permission given to the child allows him or her to be expressive in the safe relationship, through the natural communication of play (Landreth, 2002). Landreth (2002) also believes that the child-centered play therapy relationship must be different from any other relationship that the child has experienced and cites the unconditional acceptance of a child as a distinctive relational component and foundation for the child-centered therapeutic relationship. Additionally,

Landreth (2002) believes that the child should guide the work in the playroom while the play therapist acts as a mirror for his or her emotions without interpretation of the child's actions.

Play therapy has evolved tremendously from its beginning, and continues to grow as a field of interest for clinicians, educators, and researchers. To date, two meta-analyses of play therapy studies have been conducted to determine the effectiveness of play therapy and to ascertain the factors that lead to successful outcomes (LeBlanc & Ritchie, 1999; Ray, Bratton, Rhine, & Jones, 2001). Two key predictors of positive effects in both studies were found to be caregiver involvement and the length of time in therapy (Ray et al.). After analyzing 93 studies, Ray, Bratton, Rhine, and Jones (2001) found play therapy to be an effective practice with children experiencing a variety of emotional and behavioral challenges, regardless of age, gender, or setting.

The Role of a Play Therapist

Although results of a survey of APT's membership (Ryan, Gomery, & Lacasse, 2002) reflected that play therapists originate from a variety of training backgrounds such as counseling, social work, and psychology, the researchers also found that play therapists strive to establish a therapeutic relationship grounded in the belief that play is the natural language of children (Axline, 1969). This, according to Jackson (1998), is a medium that can lead to healing. "The primary responsibility of the play therapist is to conduct therapy that respects the dignity, recognizes the uniqueness, and promotes the best interests and welfare of the child" (*Play Therapy Best Practices*, 2009.) Caregivers who lack knowledge about what play therapy is and what they can expect from the process may be more likely to terminate their child's treatment (Athanasiou, 2001). This concept confirms the importance of the play therapist's professional obligation to "maintain current and accurate knowledge" of play therapy (*Play Therapy Best*

Practices, 2009) so that he or she can provide the most accurate and up-to-date information to caregivers.

The Role of a Caregiver in Play Therapy

Leblanc and Ritchie (1999) considered several factors related to successful treatment outcomes with any form of counseling. Play therapy research (e.g. LeBlanc & Ritchie, 1999; Ray et al., 2001) shows a positive relationship between caregiver's involvement in play therapy and successful outcomes, but little research exists to document the amount of information caregivers know about play therapy prior to seeking services, or what information play therapists believe is important for caregivers to receive (Axline, 1969). According to Phillips and Landreth (1998), practicing male and female play therapists consistently identify two factors necessary for successful play therapy outcomes: the relationship between child and therapist, and involvement of caregivers/family in treatment. For play therapists to obtain a complete picture of a child's history and daily experiences, they must look to caregivers for information. Landreth (2002) stated that providing a child's primary caregivers with insight about their child's play therapy experience could enhance the therapeutic process by facilitating appropriate communication. Providing caregivers with information about effectively communicating and supporting their children can enhance their relationship with the child, and the child's individual functioning will be more likely to improve as well.

Play therapists reported that caregivers might demonstrate resistance to play therapy for a variety of reasons and in a variety of ways (VanFleet, 2000). These reasons include, but are not limited to, lack of education, unfamiliarity with play therapy, and lack of knowledge of their role. VanFleet (2000) stated, "A climate of understanding can set the stage for more collaborative relationships with even challenging caregivers" (p. 36). However, no research exists on the

specific practice patterns that play therapists employ to achieve caregiver engagement. Additionally, no research touches on play therapists' perceptions of the factors that lead to successful caregiver engagement. Kottman and Ashby (1999) have argued that the best hope for lasting change for a child client is to educate the child's caregiver(s) about necessary changes in their own attitudes and behaviors. Play therapy research has shown that involving a caregiver in his/her child's play therapy process is positively related to successful outcomes for the child client (Guernsey & Stover, 1971; LeBlanc, 1998). Cates et al. (2006) and Kottman and Ashby (1999) both provided recommendations for effective caregiver consultation in play therapy, such as establishing a consistent consultation structure and utilizing basic counseling skills to build a collaborative therapeutic relationship.

Conceptual Framework

The conceptual framework of this study was based on (1) Axline's (1947) theory about play as a child's natural form of communication, and (2) Landreth's (1991) tenets for relating to children from a child-centered perspective. Axline identified the fundamental principles of nondirective play therapy as: (a) relationship development, (b) acceptance of the child, (c) permissiveness for expression, (d) recognition of feelings and reflection of feelings, (e) respecting the child's inherent ability to find solutions to problems and providing the child space to do so, (f) the child as leader, (g) the therapist as follower, and (h) minimal limitations to child's expression within the confines of safety. Like Axline, Landreth (2002) recognized the uniqueness of children, and thus identified the following ten tenets as key to understanding and effectively communicating with children: (a) children should not be considered small adults and should not be communicated with as if they were, (b) children, like all humans, are capable of experiencing both positive and negative emotions, (c) the uniqueness of each child should be

honored and respected, (d) children are resilient, (e) children gravitate toward growth and maturity with inherent wisdom, (f) children are able to self-direct, (g) the natural language of children is play, (h) children possess the right to remain quiet, (i) children will direct their own therapeutic experiences, (j) children cannot be hurried developmentally and patience is required on the part of adults. Both Axline and Landreth have identified necessary elements for successfully building relationships with children, which are appropriate for use by caregivers and play therapists alike.

Purpose of the Study

Noticing a gap in literature surrounding specific practice patterns and attitudes involved in clinical decisions made by play therapists, Haslam and Harris (2011) surveyed 295 play therapists regarding their attitudes toward integrating traditional family therapy and play therapy, along with the methods chosen and frequency of involving families in their child's play therapy treatment. Results of the study indicated that 94% of respondents believed involving families in children's treatment is important. This investigation into play therapists' comfort levels with working with caregivers showed 84.9 % of respondents feel "very comfortable" working with children and caregivers in session together, and 90% of play therapists who responded are "very comfortable" working with caregivers alone. Particularly relevant to my study is the finding that only 35.9% of play therapists who responded perceive caregivers as typically willing to be involved, either directly or indirectly, in their child's play therapy process.

Sibley (2009) studied outcome data from 62 randomly selected cases at a community mental health center to examine the effect of parental involvement on the child's treatment outcome when either child-centered play therapy or filial therapy was provided. Three elements identified to distinguish the existence of parental involvement included empathy toward their

child, frequency of use of imaginary play skills, and frequency of attending consultations (Sibley, 2009). The findings suggested that the more evidence of parental involvement found, the better the therapeutic outcome for the child client (Sibley). Despite the fact that research has found caregiver engagement to be a predictor of successful therapeutic outcomes in play therapy, recommendations for practice remain vague (LeBlanc & Ritchie, 1999; Ray et al., 2001). Additionally, play therapists' perceptions regarding the factors that influence caregiver engagement and their practice patterns to move past resistance to engagement with a caregiver in play therapy are unknown.

The purpose of the current quantitative survey was to identify the factors that play therapists believe influence caregiver engagement in play therapy, the utilization of those factors in clinical practice, play therapists' perceptions of how those factors influence caregiver engagement, and play therapists' perceptions of how successful caregiver engagement influences therapeutic outcomes for the child client. As used in my study, the term caregiver engagement was defined by considering three sources (Athanasiou, 2001; Lolan & Dugan, 2010; Sibley, 2009), and refers to the mutual commitment to developing and maintaining a productive working relationship between a child's primary caregiver and the play therapist, as demonstrated by the caregiver's frequency of attending scheduled sessions for both child and self and frequency of utilizing suggested strategies or community resources outside of the child's play therapy session.

Research Questions

The overall research question was, "What are play therapists' perceptions of the factors that influence caregiver engagement in play therapy?" Play therapists who chose to participate were asked to complete a checklist by selecting the following personal characteristics: sex, years

of experience, highest level of education, mental health discipline, and setting in which they practice play therapy. The questionnaire contained 36 structured items.

Additional research questions were:

1. What are the practice patterns of play therapists when working with a caregiver to achieve caregiver engagement?
2. What are play therapists' perceptions of various practice patterns as they relate to caregiver engagement?
3. What do play therapists identify as the top three strategies for achieving caregiver engagement?
4. What training specific to working with caregivers have play therapists received in educational programs, work settings, and continuing education experiences?
5. Is there a relationship between play therapists' primary worksite and their practice patterns in relation to caregiver engagement?
6. Is there a relationship between years practicing as a mental health professional and play therapists' perceptions of the factors that influence caregiver engagement?
7. Is there a relationship between perceived ability to facilitate caregiver engagement and the use of caregiver engagement strategies?
8. What level of formal play therapy training do play therapists receive?
9. Are there differences in the number of credentials obtained and the use of caregiver engagement strategies by play therapists?
10. Are there sex differences in play therapists' use of caregiver engagement strategies?
11. Is there a relationship between play therapists' levels of education and their use of caregiver engagement strategies?

12. Is there a relationship between play therapists' training status (registered play therapist or registered play therapist supervisor) and their use of caregiver engagement strategies?
13. Is there a relationship between play therapists' formal training in play therapy and their use of caregiver engagement strategies?
14. Is there a relationship between play therapists having a dedicated room to meet with caregivers separate from the playroom and their use of caregiver engagement strategies?
15. Is there a relationship between play therapists having a dedicated waiting room and their use of caregiver engagement strategies?
16. What have play therapists identified as the top three barriers to achieving caregiver engagement?
17. What methods have play therapists used to overcome their top three barriers to achieving caregiver engagement?
18. Is there a relationship between the type of population served and the use of caregiver engagement strategies?
19. What do play therapists identify as their primary theoretical orientation?
20. Does theoretical orientation influence play therapists' approach to achieving caregiver engagement in play therapy?

Assumptions of the Study

An assumption of this study was that the *Caregiver Engagement Inventory* (CEI; see Chapter Three) is valid and accurately measured play therapists' perceptions of the factors that influence caregiver engagement in play therapy, their implementation of these factors, and their

beliefs regarding the influence of these factors on counseling outcomes for the child client. Additionally, I assumed that play therapists answered the survey honestly based on their own experiences. I also assumed that members on the Association for Play Therapy's mailing list are graduates or current students of clinical training programs.

Terminology

Association for Play Therapy (APT): A national professional society based in the United States whose mission is to promote the value of play, play therapy, and credentialed play therapists (APT, 2007b).

Caregiver: The person(s) primarily responsible for child's care who also transports child to and from play therapy and is responsible for communicating with their child's play therapist regarding progress and continued challenges for the child client. Caregivers can include biological parents, appointed guardians, family members, or others legally designated as responsible for the child (Garfinkel, 2010).

Child Centered Play Therapy: Play therapy in which the child is allowed the freedom to choose materials for play to achieve self-awareness and self-direction with little direction from the therapist (Landreth, 2002).

Consultation: A structured, collaborative relationship between caregiver and play therapist (Holcomb-McCoy & Bryan, 2010).

Directive Play Therapy: Play therapy in which the play therapist assumes responsibility for the direction of the session and utilizes therapeutic interventions to guide the child (Axline, 1947).

Engagement: The mutual commitment to developing and maintaining a productive working relationship between a child's primary caregiver and play therapist as demonstrated by the caregiver's frequency of attending scheduled sessions for both child and self and frequency of

utilizing suggested strategies or community resources outside of the child's play therapy session (Athanasiou, 2001; Sibley, 2009; Lolan & Dugan, 2010).

Playroom: A space for providing play therapy services with deliberately selected toys and play media representing the following themes: (1) real-life, (2) acting-out, (3) aggressive-release, (4) creative expression, and (5) emotional release toys (Landreth, 2002).

Play Therapy: The application of a theoretical model by trained play therapists in establishing a therapeutic relationship with clients and helping them resolve issues and achieve optimal growth and development through the powerful use of play (APT, 2007b)

Play Therapy session: A designated time, typically 45 minutes (Landreth, 2002) wherein a play therapist provides play therapy to individuals, families, or groups from their own theoretical perspective (Kottman, 2001).

Registered Play Therapist (RPT): A play therapist that has applied to the Association for Play Therapy and met the criteria in all five areas (license/certification, educational degrees, clinical experience, play therapy training, and supervised play therapy experience) for certification.

Registered Play Therapist Supervisor (RPT-S): A play therapist that has applied to the Association for Play Therapy and met the required criteria in six areas: license/certification, educational degrees, clinical experience, play therapy training, supervised play therapy experience, and supervisory training (APT, 2007c).

Resistance in Play Therapy: An attitude of belief held by the caregiver that manifests itself in such a way as to disrupt the therapeutic process, thus hindering progress (VanFleet, 2000)

CHAPTER TWO

REVIEW OF THE LITERATURE

This chapter contains a review of the literature and research related to play therapy, including the use and efficacy of techniques to engage caregivers in play therapy, the benefits of successful caregiver engagement in play therapy, barriers to engaging caregivers in play therapy, and the impact of caregiver engagement on child clients receiving play therapy services.

The Value of Play

Although the value of play has long been recognized by well-known figures in and outside the mental health field, from as far back as Plato to more modern times with the works of Piaget, current trends in education place a strong emphasis on academic success and leave little time for activities that don't prepare children for achievement tests (Baumer, 2010). Critics of this approach believe that play is children's natural way of learning valuable lessons that cannot be taught to them (Frank, 1982). Because play is considered a child's natural form of communication, expressive play can be likened to verbal expression of an adult (Landreth, 1991). Through spontaneous, free play, a child can release the "feelings and attitudes that have been pushing to get out into the open" (Axline, 1969, p. 23). According to Piaget, as cited in Landreth, 2002, "Play bridges the gap between concrete experience and abstract thought, and it is the symbolic function of play that is so important" (p. 11).

The human spirit is elevated through play and can provide relief from stress, foster creativity, and facilitate connections with others (Landreth, 2002). The American Academy of Pediatrics (AAP, 2007) reported that free and unstructured play is healthy and beneficial for helping children reach important social, emotional, and cognitive developmental milestones, as well as for developing stress management skills and resilience.

Rationale for Use of Play Therapy

Play therapy as a discipline is young and has attracted both supporters and skeptics. Some, like Landreth (2002), believe that non-directive play therapy is a "complete therapeutic system, not just the application of a few rapport-building techniques" (p. 59). Others agree with O'Conner (2000), who identified models that include play therapy techniques as a beneficial supplement to traditional therapeutic approaches. Conversely, Lebo (1953), some 60 years ago expressed doubt about play therapy as a sound approach because of the lack of statistically significant research to support its effectiveness. Recently, two separate meta-analyses were conducted in hopes of responding to the scientific community's doubts by investigating the effectiveness of play therapy and the factors that influence successful outcomes for the client (LeBlanc & Ritchie, 1999; Ray, Bratton, Rhine, & Jones, 2001). Results of both meta-analyses reported that two factors—caregiver involvement and the number of sessions the child client attended—consistently affected positive play therapy outcomes. LeBlanc and Ritchie's meta-analysis included studies of play therapy with children aged 1-12 dating back to 1945. Analysis of 13 variables resulted in findings that support play therapy as an effective intervention with children, regardless of their presenting issues, and that children receiving play therapy scored .66 standard deviations higher than those who did not participate in play therapy. Two years later, Ray et al. conducted a meta-analysis of 93 studies published from 1940-2000, retrieved both electronically and in print. Their analysis of each study included the following variables: (a) play therapy, filial therapy, or both, (b) published or non-published, (c) number of participants, (d) age of subjects, (e) gender, (f) ethnicity, (g) random assignment, (h) characteristics of the population, including presenting issue, (i) type of outcome measures (clinical or analog), (j) theoretical approach to play therapy, (k) frequency and total number of sessions, (l) individual,

group, or filial, and (m) play therapists' training. In all, 70 play therapy, 27 filial therapy, and 94 play/filial combination studies were analyzed, and the results found the use of play therapy to be an effective practice for use with any age, gender, culture, or presenting issue. Overall, the most significant finding was that a combination of play and filial therapy appeared to be the most effective approach, with an effect size of .80 standard deviations. Treatment groups who received play therapy alone performed .73 standard deviations above groups who did not receive play therapy and groups who received filial therapy alone. In short, the results of the meta-analysis showed agreement with LeBlanc and Ritchie in that the two most significant predictors of outcome were parental involvement in therapy and the number of play sessions attended. The effect size increased along with the number of sessions received until a maximum effect size was realized at 35-45 sessions. In a similar fashion, the more caregiver involvement noted, the larger the effect on a positive play therapy outcome (p=.008). While these findings are encouraging and warrant recognition in the mental health field, the authors did recognize that a need exists for additional research in effort to gain insight into which therapy is most effective with which population, and under what circumstances (Ray et al.).

Implications for the Future

The Association for Play Therapy (2009) developed a strategy in 2006 to encourage and guide researchers to conduct relevant and experimental studies that promote the professionalism of play therapy and garner recognition from "public policymakers, insurers, and the general mental health community" (para. 2) as evidence-based practice for counseling children, adolescents, families, and adults. APT's Chief Executive Officer (CEO) Bill Burns (personal communication, January 18, 2011) reported that APT has a committee that is devoted to research and headed by a member acting as chair. In the research strategy document currently available

for review on their website, the APT stated that while it acknowledges the importance of all play therapy research, it wishes to emphasize the need for quantitative studies that compare the effectiveness of play therapy to traditional psychotherapeutic methods in the following instances: (1) trauma and attachment, (2) anxiety, (3) behavioral disorders, and (4) adjustment to life changes. Both supporters and skeptics of play therapy agree that additional research is needed to investigate the effectiveness of play therapy as a therapeutic approach to counseling children (Association for Play Therapy, 2006).

Approaches to Play Therapy

O'Connor and New (2003) recognized three elements key to an effective play therapy model: (1) an underlying philosophy, (2) an explanation of personality, and (3) a psychopathological base. An advantage of the acquisition of play therapy skills and techniques is that they further enhance the clinician's existing skill set, and the skills and techniques can be utilized as the method of delivery for various theoretical approaches. The play therapist's chosen theoretical approach to play therapy will most likely influence his/her approach to working with caregivers, so an explanation of how the play therapist will conceptualize goals and monitor progress for clients should be provided to caregivers in the initial stage of therapy (Kottman, 2001). Theories of play therapy commonly used and empirically studied include child-centered (Landreth, 2003), ecosystemic (O'Conner, 2000), psychodynamic (Kottman, 2001), cognitive behavioral (Rasmussen & Cunningham, 1995), Adlerian (Kottman & Ashby, 1999), Jungian (Allan & Brown, 1993) and gestalt (Oaklander, 2001).

Child-Centered Play Therapy

Child-centered play therapy, initially developed by Axline (1965) and more recently adapted by Landreth (2002), is based in the idea that children are naturally resilient and

inherently strive toward positive self-growth. The child-centered play therapist's role is to convey genuine acceptance of children without directing their play in any way, except when limits are needed to ensure safety of both the child and play therapist. To foster this type of therapeutic relationship, Kao and Landreth (1997) noted that child-centered play therapists should possess an understanding of basic skills, including (a) tracking, (b) restating content, (c) returning responsibility, and (d) setting limits.

Another therapeutic intervention that is grounded in the principles of child-centered play therapy is filial therapy. Filial therapy is a type of therapy in which caregivers are taught the basic skills of child-centered play therapy so that they, rather than the play therapist, can become the therapeutic change agents for their children (VanFleet, 2005). B. G. Guerney (1964) developed filial therapy as a way to improve the attachment and relationship between caregiver and child through structured weekly play sessions in which the caregiver utilized child-centered play therapy techniques. Filial therapy is different from family therapy in the sense that the primary caregiver, rather than the therapist, acts as the change agent for the child client. A study conducted in 1967 compared play therapists trained in nondirective play therapy with parents who received similar training. Observers who were familiar with nondirective play therapy skills were unable to tell the difference between the play therapists and parents, thereby suggesting parents possess the ability to be effective therapeutic change agents for their children (VanFleet, 2005). In filial therapy and child-parent relationship therapy (CPRT), a condensed model of filial therapy developed by Bratton, Landreth, Kellam, and Blackard (2006), caregivers meet with the play therapist outside of their child's play therapy session. CPRT includes both psychoeducation and emotional support components, with the end goal being the caregiver's ability to facilitate child-centered play therapy sessions at home.

Ecosystemic Play Therapy

According to Boyer (2010), O'Connor developed ecosystemic therapy to create a single play therapy model that encompasses all aspects of a child's ecosystem, including culture and caregiver participation in therapy. O'Connor (2000) maintained that ecosystemic play therapists may interact with caregivers to exchange important information about the child's history and session themes, consult about parenting skills, or decide on the best way to support children while they are experiencing changes as a result of their play therapy sessions.

Psychodynamic Play Therapy

Building upon the work of Freud and Klein, play therapists who utilize a psychodynamic approach may exclude complex toys from their playroom (McCalla, 1994) and may utilize therapeutic games that can provide an opportunity for the play therapist to observe the client's internal drives, defenses, and conflicts (Swank, 2009). Kottman (2001) reported that no specific recommendation is given for working with caregivers in psychodynamic play therapy, but general considerations may include conversations about developmental history, specific behavior management techniques, and acknowledgement of the caregiver's own needs for therapeutic intervention.

Cognitive Behavioral Play Therapy

Knell (1993a, 1993b, 1994, 1997) described cognitive behavioral play therapy as an integration of play therapy skills and developmentally appropriate cognitive behavioral techniques. Rasmussen and Cunningham (1995) were in agreement with Knell and described cognitive behavioral play therapy as a combination of the reinforcement and social learning models in order to aid in cognitive restructuring and change distorted thinking in children. More recently, Green (2008) cited several of the cognitive behavioral techniques commonly utilized in

play therapy as cognitive restructuring, disputing irrational beliefs, and cognitive distortions. To promote the likelihood of successful generalization of healthy thoughts and behaviors outside of the play session, play therapists who utilize cognitive behavioral therapy usually involve the child's caregivers in the development of treatment goals, and they meet regularly to review and revise the approach as both the play therapist and caregiver see fit (Knell, 1997).

Adlerian Play Therapy

Kottman (2001) stated that the goal of Adlerian play therapy was to help move the client toward a feeling of connectedness, confidence, and competence. Morrison (2009) believed that children aspired to change and were able to experience mastery over their challenges. She (2009) believed that this aligned with the fundamental Adlerian principles, which asserted that individuals are naturally social, goal-oriented, and imaginative.

Morrison (2009) ascertained that children begin to develop their sense of self through their interactions with their family. Adlerian play therapists believe it is important to understand children's family system in order to understand their play, therefore placing particular emphasis on caregiver consultation (Kottman, 2001). The play therapist may utilize Adlerian personality profiles to personalize the consultation process for each parent, with the hope of minimizing defensiveness and maximizing willingness to utilize suggested interventions and resources (Kottman & Ashby, 1999).

Jungian Play Therapy

A Jungian approach to play stresses the value of a strong therapeutic relationship between the play therapist and his/her child client in order to stimulate the child's inherent drive toward healing that Jungian play therapists believe is entrenched in the psyche (Allan & Brown, 1993). Green (2008) described Jungian analytical play therapy as "a creative, play-based treatment

approach that both meets children where they are developmentally, and integrates more directive techniques to help reshape disordered behaviors" (p. 103). Typical techniques utilized by Jungian play therapists may include sandtray, art activities, and games (Kottman, 2001).

Gestalt Play Therapy

The principles of gestalt play therapy (Botha & Dunn, 2009) focus on observing and accepting the totality of a child and are holistically applied, with an emphasis on mind-body connection (Oaklander, 2001). Gestalt play therapy enables children to develop a strong sense of self, accept responsibility for their choices, and progress toward homeostasis (Botha & Dunn). Botha and Dunn (2009) identified the stages of gestalt play therapy as (1) relationship building, (2) observing sense of self, (3) self-nurturing, and then (4) termination. In gestalt play therapy, both directive and non-directive techniques are used to focus on the here and now, and caregivers are ideally involved in their child's play therapy process every week (Oaklander).

The Association for Play Therapy

The Association for Play Therapy (APT) is a national professional society established by Charles Schaefer and Kevin O'Conner in 1982 with the mission of promoting the value of play, play therapy, and credentialed play therapists on both local and national levels (The Association for Play Therapy, 2011). APT's membership is currently comprised of over 5000 counselors, social workers, psychologists, marriage and family therapists, and other mental health professionals. Article II of the Association for Play Therapy Bylaws (2006) recognizes three categories of membership: professional, international, and affiliate. A professional member is identified as a person living in the United States who holds a master's degree in a mental health field. The professional membership also includes membership in a state branch, if applicable. The association characterizes an international member as a mental health professional who

resides outside of the United States. Full-time students, parents, non-mental health professionals, or retired or inactive play therapists may become affiliate members of the association.

APT (Association for Play Therapy, 2009) developed a strategy in 2006 to encourage and guide researchers to conduct relevant and experimental studies that promote the professionalism of play therapy and garner recognition from "public policymakers, insurers, and the general mental health community" as evidence-based practice for counseling children, adolescents, families, and adults. The rationale for using any type of therapeutic intervention often has to be backed by data supporting its efficacy, particularly in the case of legal issues and third-party payers (Bratton, Ray, Rhine, & Jones, 2005). While APT (2009) encourages all play therapy research, the association emphasizes the need for quantitative studies that compare the effectiveness of play therapy against traditional psychotherapeutic approaches.

The Registered Play Therapist

Acquiring the registered play therapist (RPT) and registered play therapist-supervisor (RPT-S) credentials can be time consuming and expensive. According to APT's RPT and RPT-S guide, RPT applicants must have earned at least a master's degree in a mental health field, and hold a state mental health license or certification. Applicants must have completed coursework in ethics, child development, theories of personality, principles of psychotherapy, and child/adolescent psychopathology. Play therapy-specific education must have included at least 150 hours of instruction from an APT-approved provider or institution of higher education. Clinical experience must include at least two years and 2000 hours of supervised experience, 500 of which must be specifically play therapy. After receiving the RPT credential, play therapists must complete 36 hours of continuing education every three years, 18 of which must be specific to play therapy. The Association for Play Therapy (APT, 2011) website directory states there are

currently 796 RPTs and an additional 163 RPT-Ss. These numbers are larger than Ryan, Gomery, and Lacasse (2002) found, but not inclusive of all 5464 members of APT, which includes student members and professional members who have not earned either credential. The gap in these numbers is large and suggests that further research is needed on the perceived and actual value of holding the RPT and RPT-S credentials, as well as the availability of educational hours to meet the requirements necessary for the credential. Currently, the APT (2011) website identifies only 13 approved centers of play therapy and 204 universities that offer at least one graduate level course in play therapy.

As an increasing number of qualified mental health professionals and researchers join the field of play therapy, the availability of supportive resources is key to furthering the profession. The Association for Play Therapy's website, www.a4pt.org, offers a variety of resources for both members and non-members of APT. Resources of particular value to members of APT are access to the online archive of *Play Therapy* magazine, the ability to participate in electronic mailing lists dedicated to research and professional consultation, continuing education opportunities, and up-to-date directories of RPTs and RPT-Ss (Association for Play Therapy, 2011).

The registered play therapist (RPT) credential is a secondary credential, and all who receive it are required to be licensed or certified in the state in which they practice (Association for Play Therapy, 2009). Based on this requirement, it is assumed that clinicians will have both a solid understanding of psychotherapeutic approaches and experience utilizing the theory with which they most identify.

The Registered Play Therapist-Supervisor

As the number of consumers of play therapy services increases, so should the number of qualified play therapists prepared to provide those services. Kranz, Kottman, and Lund (1998)

found that play therapists reported a need for more qualified supervisors with play therapy expertise. The APT recognized this demand, and the registered play therapist-supervisor credential (RPT-S) was created. Requirements for receiving the RPT-S credential are in addition to those set forth for RPT and include being a state-approved supervisor or at least 24 hours of supervisor training, an additional three years and 3000 hours of clinical experience, and 500 non-supervised clinical play therapy hours. Section G.3 of the APT's *Best Practices* (2009) outlines standards, expectations, and limitations of the supervisor and trainee relationship during play therapy supervision.

Play Therapy and Caregivers

The Role of Caregivers

Providing counseling services to families and children can be both challenging and rewarding. While most counseling graduate programs include education about working within a family system that equips graduates with basic knowledge and skills for working with families, some offer an emphasis in either marriage and family therapy or play therapy. Mental health clinicians from various backgrounds including counseling, social work, psychology, and psychiatry choose to specialize in addressing the needs of families and children by obtaining licensure as a marriage and family therapist (MFT) or the registered play therapist (RPT) credential (American Association for Marriage and Family Therapy, 2002; Association for Play Therapy, 2009).

Play therapy research has linked caregiver participation in play therapy, in the form of either consultation or actual participation in the intervention, to successful outcomes for the child client (Cates, Paone, Packman, & Margolis, 2006). Ray et al.'s meta-analysis (2001) found parental involvement to be a strong predictor of play therapy outcomes. For the purpose of the

meta-analysis, parental involvement meant that the parent was involved in every play therapy session, usually using a filial therapy approach. Lolan and Dugan (2010), in their recent qualitative study of play therapists in Louisiana, found that play therapists reported caregivers initially seek play therapy services with a general lack of knowledge regarding play therapy, or hold misconceptions about the benefits of play therapy. Historically, caregivers have been involved in their child's treatment in a variety of ways (Gil, 1994). A thorough review of literature revealed that while much research has been conducted on the outcome of caregiver participation in their child's play therapy sessions, minimal research was found on the specific practice patterns that a play therapist employs to educate and work with caregivers outside of their child's play therapy session, or which techniques they believe lead to success for both the caregiver and the child client.

While researchers (LeBlanc & Ritchie, 1999; Ray et al., 2001) and practitioners (McGuire & McGuire, 2001) agree that play therapy is an effective intervention augmented by caregiver engagement, minimal research exists on the beliefs and practice patterns of play therapists (Haslam & Harris, 2011). In a study of 295 members of APT, Haslam and Harris distributed a quantitative survey that sought to answer: (1) How and with what frequency do family therapists include play therapy in their approaches to treatment? (2) What are the beliefs associated with integrating play therapy into family therapy? (3) What are the perceptions of barriers to the inclusion of play therapy in family therapy? and (4) How do play therapists feel about their training in play therapy and family therapy, and what are their beliefs about incorporating one approach within another? Results of the study indicated that 94% of respondents believed involving families in children's treatment is important. This investigation into play therapists' comfort levels with working with caregivers showed 84.9 % of respondents

feel “very comfortable” working with children and caregivers in session together, and 90% of play therapists who responded are “very comfortable” working with caregivers alone. Relevant to this study is the finding that only 35.9% of play therapists who responded perceive caregivers as typically willing to be involved, either directly or indirectly, in their child’s play therapy process.

In an exploratory quantitative secondary data analysis, Sibley (2009) studied outcome data from 62 randomly selected cases at a community mental health center to examine the effect of parental involvement on the child’s treatment outcome when either child-centered play therapy or filial therapy was provided. Three elements identified to distinguish the existence of parental involvement included empathy toward their child, frequency of use of imaginary play skills, and frequency of attending consultations (Sibley). Sibley found that the more parental involvement evident in both child-centered play therapy and filial therapy, the better the therapeutic outcome was for the child client. Despite the fact that research (LeBlanc & Ritchie, 1999; Ray et al., 2001) has found caregiver engagement to be a predictor of successful therapeutic outcomes in play therapy, recommendations for practice remain vague, thereby suggesting a need for more information. Specifically, this includes information regarding the strategies play therapists employ and their perceptions about the effect each strategy has on the caregiver and therapeutic outcome for the child client.

Common Strategies for Educating and Engaging Caregivers

Educational materials.

APT, in keeping with their mission of promoting the general awareness and positive reception of play therapy (APT, 2011), published the *Why Play Therapy*? brochure to educate caregivers, clients, mental health professionals, educators, family court officers, managed care

providers, and anyone else interested in play therapy, about why play therapy works. The full-color 10-panel brochure is recommended for "display, inserts, and handouts," and packs of 50 are available for $12 through APT's online bookstore (APT, 2010). *Play Therapy Makes a Difference* (APT) is an online article intended for use by mental health professionals and the public. The article can be found at www.a4pt.org/ps.play therapy.cfm?=1653 and is available in Chinese, English, French, German, Italian, Japanese, Korean, and Spanish. Also available through the online bookstore (www.a4pt.org/bookstore.cfm) are a variety of books and multimedia material specifically about play therapy history, practice and research.

Other tools for educating professionals and the public include APT's (2011) four publications: the *International Journal of Play Therapy*, the *Member Flash*, the *Mining Reports*, and the *Play Therapy* magazine. The *International Journal of Play Therapy* is mailed in January, April, July, and October, and focuses on research, current practices, and case studies (Association for Play Therapy, 2011). The *Member Flash* is distributed bi-weekly via email and aims to raise awareness about upcoming training opportunities and recognize play therapists' accomplishments (Association for Play Therapy, 2011). *Mining Reports* are sent to members via email to keep play therapists abreast of best practices and trends in the field. Finally, *Play Therapy* magazine is mailed in March, June, September, and December. The magazine includes research-based practices, applications, association news, and resourceful information for clinicians regarding purchasing play therapy materials and locating providers of play therapy education (Association for Play Therapy, 2011).

Playroom tour.

Landreth (2002) suggests inviting caregivers to view the playroom as part of the initial consultation. This may provide an opportunity for the play therapist and the caregiver to discuss

specifics about what will occur when the caregiver brings the child to play therapy, and it may also generate questions for the caregiver about the play therapist's policies and overall therapeutic process. A supplement to the tour may include a description of what a session may entail, including what the play therapist and child typically do, or say (Kottman, 2001).

Consultation with caregivers.

Routine meetings between the caregiver and play therapist provide caregivers with a sense of connection and significance to their child's therapeutic process (McGuire & McGuire, 2001). Kottman and Ashby (1999) found that caregiver consultation as a supplement to play therapy can improve therapeutic outcomes for the child client. Consistent, clear structure during caregiver consultations may minimize skepticism and defensive caregiver reactions, therefore eliciting a more positive response to the play therapist's recommendations (Kottman & Ashby, 1999).

In the event that a child client or caregiver requires services outside of the play therapist's scope of expertise, the play therapist should have knowledge of community resources available and have a system in place for providing referrals to caregivers (Cateset al., 2006; McGuire & McGuire, 2001). In the event that the child is experiencing difficulties outside of the play session and the home, the play therapist can use consultations as a time to help caregivers advocate for their child through effective communication with teachers and other professionals who may work with the child.

McGuire and McGuire (2001) have recommended 15-minute check-ins with caregivers every session, highlighting new and significant things that happened in the past week, processing homework when appropriate, and discussing themes observed by the play therapist. Although they acknowledge this may not always be possible due to circumstances that may prevent

meeting with the caregiver alone, they report that regular meetings with caregivers can significantly impact caregivers' attitude and commitment toward their child's play therapy. It is important that the child client understand their caregiver's role in the play therapy process, and that children feel comfortable with the therapist consulting with their caregiver. Knowledge of confidentiality and the limits involved are necessary conversations between a play therapist, the client, and the caregiver. McGuire and McGuire suggested providing the child with a choice about when their play therapist meets with their caregiver by stating, "I'm going to meet with your mom each week before or after our time in the playroom. I will not tell your mother what you say or do, but I will tell her things you may need. I may even make suggestions to your mom about how to try to make things better at home or school for you. Please ask me any questions you may have about this. I'd like for you to decide if you want your mom to go before or after our playtime" (p.128).

Filial therapy.

Bowlby (1951) introduced the concept of attachment styles, in which a child and parent form a bond that can predict the child's social development over time. B. G. Guerney (1964), recognizing the significance of the relationship between caregiver and child, developed filial therapy as a way to enhance the caregiver/child attachment and relationship through structured weekly play sessions in which the caregiver became the therapeutic change agent for the child by utilizing child-centered play therapy techniques. Guerney and Stover (1971), who studied 51 mothers with children ranging in age from three to 10 years old, conducted initial research on filial therapy outcomes. After participating in a small group from one year to 18 months, mothers reported an increase in feelings of empathy for their children and their satisfaction with their children, along with an increase in desirable social behaviors and a decrease in behavioral

concerns. Van Fleet (1994) refined the model for working with modern-day caregivers. The efficacy of filial therapy continues to be studied, particularly with families of various ethnic and cultural backgrounds, including Native Americans (Glover & Landreth, 2008), African Americans (Solis, Meyers, & Varjas, 2004), Chinese (Chau & Landreth, 1997; Yuen, Landreth, & Baggerly, 2002), Israelis (Kidron & Landreth, 2010), Hispanics (Garza, Kinsworthy, & Watts, 2009), Germans (Grskovic & Goetze, 2008), and Jamaicans (Edwards, Ladner, & White, 2007).

Child-parent relationship training.

Landreth and Bratton (2006) developed child-parent relationship therapy (CPRT) to provide play therapists with a structured, 10-session curriculum for teaching parents basic child-centered play therapy skills for utilization in home-based filial therapy sessions. CPRT is a training program designed to equip caregivers with basic child-centered play therapy skills so that they can facilitate play sessions at home with their children (VanFleet, 1994). A number of quantitative studies have reported the effectiveness of CPRT with varying populations including incarcerated mothers (Harris & Landreth, 1997) and fathers (Landreth & Lobaugh, 1998), caregivers of children with chronic mental illness (Tew, Landreth, Joiner, & Solt, 2002), single caregivers of children with behavioral issues (Bratton & Landreth, 1995), nonoffending parents of sexually abused children (Costas & Landreth, 1999), caregivers of children with learning disabilities (Kale & Landreth, 1999), "at risk" children (Ray, 2003), and caregivers of various ethnic and racial backgrounds (Chau & Landreth, 1997; Glover & Landreth, 2000; Kidron, 2004; Lee & Landreth, 2003; Yuen, Landreth & Baggerly, 2002).

Caregiver support groups.

Support groups can assist caregivers with forming a network of assistance (*U.S. Surgeon General Report*, 2000). While format, topic, and membership can vary, the general goals of

caregiver support groups are to provide both education and emotional support to caregivers who share a common concern (e.g., physical or mental disability). A meta-analysis compared more than 200 caregiver support programs and their effect on (1) changing caregiver attitudes and behaviors, (2) the caregiver's mental health and overall family functioning, and (3) the child (Goodson, 2005). The findings showed the largest effect on ability to change caregiver attitudes and behaviors, with an effect size of .24. The impact on family functioning and the caregiver's mental health was slightly smaller, with an effect size of .20. Goodson reported the benefits for the child as well, with the largest impact realized in social (effect size of .22) and cognitive development (effect size of .29). Caregivers interested in groups centered on specific topics can seek resources through organizations such as the national mental health association (NAMI), children and adolescents with attention deficit disorder (CHADD), or the national federation of families for children's mental health (ffcmh.org).

Barriers to Caregiver Engagement

Most caregivers who seek mental health services for their child or family do so with varying degrees of confusion, skepticism, and anxiety (VanFleet, 2000). Often times, caregivers want help, but are either frustrated with the fact that they have not been able to elicit change in their child themselves or embarrassed by the product of their child's problematic behaviors (Garfinkel, 2010). Caregivers play a key role in the success of their child's play therapy, so it is vital that play therapists work on establishing a collaborative relationship early in the therapeutic process (Cates, Paone, Packman, & Margolis, 2006).

Barriers to working with families have been identified in literature as either attitudinal (e.g., beliefs and perceptions of the clinician or mental health service) or structural (e.g., transportation, scheduling conflicts, and childcare needs) (Mendez, Carpenter, LaForett, &

Cohen, 2009). Hill (2009) conducted a qualitative study of four therapists to gain insight into their perceptions of the factors that influenced caregiver engagement with nonoffending parents of children who experienced sexual abuse. Hill's work identified perceptions held by all parties involved (i.e., caregiver, child, and play therapist) that may influence involvement during treatment. According to Hill, caregivers hold the following concerns regarding becoming involved in play sessions with their child, or utilizing techniques outside of session with their child: (1) They are too emotionally involved to help their own child, (2) They believe they do not know how to help, (3) They believe they need an expert opinion, (4) They lack confidence in their caregiving skills. Children and adolescents may prefer speaking confidentially to someone other than their caregiver (Hill, 2009). Finally, play therapists' beliefs about caregivers' ability to help their own child may influence their approach to working with the caregiver (Hill, 2009).

Ethical and Legal Issues

Counselors, social workers, and psychologists depend on their respective codes of ethics to guide their practices (American Counseling Association, 2005; American Association for Marriage and Family Therapy, 2001; American Psychological Association, 2002; National Association of Social Work, 1999). Remley and Herlihy (2009) noted the purposes for codes of ethics as follows: (1) to keep the public safe, (2) to educate professionals on how to keep the public safe, (3) to keep mental health professionals accountable for their actions, (4) to supply a channel for improving quality of services provided, (5) to enable the profession to function autonomously, (6) to minimize internal disagreement and maximize professional stability, and (7) to protect practitioners from malpractice suits or licensing board complaints. Since the RPT credential is secondary to a license or certification in the state in which they practice, RPTs are required to be familiar with and adhere to their respective codes of ethics (Association for Play

Therapy, 2009). Based on this requirement, it is assumed that a clinician will have a solid understanding of psychotherapeutic approaches, and experience utilizing the theory he or she identifies with the most.

Mental health professionals who work with children should prioritize attending continuing education seminars to remain informed about changes to their licensing board's code of ethics and changes within the play therapy association (Reamer, 2005). The Association for Play Therapy identifies the child as the client and therefore designates special considerations when working with children (Association for Play Therapy Best Practices, 2009).

Play Therapy Best Practices

The Association for Play Therapy established *Play Therapy Best Practices* (2009) to promote and protect the welfare of children who receive play therapy services. The Association (2009) requires play therapists to adhere to the ethical standards set by their own licensing board but also encourages them to follow the voluntary play therapy practice guidelines. The guidelines offer suggestions for establishing and respecting the therapeutic relationship, keeping proper documentation, being non-discriminatory, and obtaining proper informed consent. According to Section F.1 of APT's *Play Therapy Best Practices* (2009), play therapists should be aware of limitations to their competence, and provide only services they are properly trained to provide.

APT's Chief Executive Officer (CEO) Bill Burns (personal communication, January 18, 2011) reported that APT has an ethics committee headed by a member acting as chair. This person, along with the CEO, reviews complaints submitted after an individual's state licensing or certifying board has made a decision, and then decides whether their RPT or RPT-S credential should be suspended or withdrawn.

The P3 Model

An additional consideration for play therapists facing ethical concerns is Seymour and Rubin's (2006) ethical model, the Principles, Principals, Process (P3) Model. Social context is central to the foundation of the P3 Model because of the relational base of counseling. The P3 Model is based on the idea that since counseling is relational, social context should be considered when making ethical decisions (Betan, 1997; Cottone & Claus, 2000). In addition to prioritizing the ethical and legal codes set by their state and primary mental health credential, play therapists with ethical dilemmas should follow the three-step approach of identifying both the relevant principles and principals and then following a process of dialogue and consultation (Seymour & Rubin, 2006).

Confidentiality

Limits to confidentiality.

Counseling children, particularly in an age where technology is a vital part of communication, involves special considerations regarding confidentiality (Reamer, 2005). Child clients do not have rights to confidentiality under the law and may disclose sensitive topics to their counselor or play therapist without understanding the limits to confidentiality (Reamer). Additionally, parents may demand access to information shared by their child, and the play therapist should be prepared to handle such a situation. Counselors must be informed of current ethical and legal standards to make an appropriate decision regarding limits to confidentiality (Remley & Herlihy, 2009). Corey, Corey, and Callanan (1998) have noted the following potential limits to confidentiality: (1) the child's legal guardian has requested and/or provided permission to disclose information, (2) duty to warn must be exercised due to existing knowledge that requires protecting the child client or another person, (3) a legal obligation to

report knowledge of or suspected child abuse, (4) emergency situations, (5) disclosure is necessary due to legal action taken by the guardian against the counselor, and (6) disclosure is necessary for the therapist to obtain payment for services provided. Proper informed consent should detail, both in writing and verbally, all information above (Jackson, 1998).

Obtaining informed consent.

Section A.2.a of The American Counseling Association's (ACA) *Code of Ethics* (2005) states that informed consent is an ongoing process in which counselors are ethically obligated to inform their clients, both in writing and verbally, of their rights and their counselor's role throughout the counseling process. In the event that a client is a minor, a counselor must be sensitive to the privacy and feelings of the child while also respecting their guardian's legal right to certain information. According to Carmichael (2006), The Association for Play Therapy states that written informed consent documents should include purpose and goals of treatment, limitations to treatment, potential risks and benefits of treatment, fees for services, other practice policies, and limits to confidentiality. Informed consent must be obtained from a child's legal guardian, or in the event of divorce, the custodial caregiver (Stein, 1990). Additional efforts should be made to include the non-custodial caregiver if the custodial caregiver agrees in writing.

According to Section B.5 of the ACA Code of Ethics (2005), counselors should rely upon laws and ethical guidelines when making decisions regarding disclosing information shared by a minor client. If possible, the child should be encouraged to share the information the counselor deems necessary to disclose to his/her guardian with the support of the counselor (ACA). Additionally, when counselors obtain signed consent from a client's guardian to release information to an outside party such as a teacher or other professional, the counselor should

consider informing clients that their information will be shared and the reason it will be shared (ACA). *Play Therapy Best Practices* (Association for Play Therapy, 2009) states that counselors should consider the child their primary client and should educate the child and his or her guardian about confidentiality, including potential limits. Efforts should be made to speak in age-appropriate language and to allow questions to enhance the child's understanding. Specifically, the child should understand that his or her caregiver has the right to request information regarding the play therapy sessions, and that the caregiver can choose to disseminate the child's personal information to others. *The Paper on Touch* (Association for Play Therapy, 2009) encourages the use of an additional informed consent for touch and suggests including examples for guardians and child clients about both deliberate and non-deliberate (initiated by the child) touch in session, including an open discussion for questions and concerns.

Multicultural Competence of Clinician

Chang, Ritter, and Hays (2005), in their phenomenological study of a purposive sample of 505 members of APT, found that play therapists perceived caregivers of diverse cultural and ethnic backgrounds were often skeptical about play therapy, and often unwilling to be involved in their child's play therapy process. Considering this perception, sensitivity should be given to multicultural populations in every aspect of treatment, including toys and office décor, and educational materials should be available in various languages (Cates, Paone, Packman, & Margolis, 2006). Additionally, as Hinman (2003) noted, play therapists should take care to gain understanding of the child's and family's perception of play therapy services, the child's ethnic identity, and the cultural experiences of the child.

Summary

This chapter explored play therapy literature and research, including the use and efficacy of techniques to engage caregivers in play therapy, the benefits to successful caregiver engagement in play therapy, barriers to engaging caregivers in play therapy, and the impact of caregiver engagement on child clients receiving play therapy services. Gaps in the literature that support the need for future research were discovered and noted.

CHAPTER THREE

METHOD

This chapter contains a description of the methodology used in this study and includes the purpose, research questions, population studied, selection of participants, instrumentation development and utilization, data collection and data analysis methods.

Purpose of the Study

The purpose of this study was to examine the perceptions of play therapists as they relate to the factors that influence caregiver engagement in a child client's play therapy process. Additional purposes of this study were to examine the relationship between engagement strategies utilized by play therapists and play therapists' perceptions of what defines successful caregiver engagement and the impact of caregiver engagement on the therapeutic outcome for the child client. This study also sought to determine differences among play therapists based on sex, age, type of licensure, theoretical orientation, play therapy training, and training specific to working with caregivers of child clients.

Research Questions

The general research question that served as the overarching question for this study was: What are play therapists' perceptions of the factors that influence caregiver engagement in play therapy? Other research questions included the following:

1. What are the practice patterns of play therapists when working with a caregiver to achieve caregiver engagement?
2. What are play therapists' perceptions of various practice patterns as they relate to caregiver engagement?

3. What do play therapists identify as the top three strategies for achieving caregiver engagement?
4. What training specific to working with caregivers have play therapists received in educational programs, work settings, and continuing education experiences?
5. Is there a relationship between play therapists' primary worksite and their practice patterns in relation to caregiver engagement?
6. Is there a relationship between years practicing as a mental health professional and play therapists' perceptions of the factors that influence caregiver engagement?
7. Is there a relationship between perceived ability to facilitate caregiver engagement and the use of caregiver engagement strategies?
8. What level of formal play therapy training do play therapists receive?
9. Are there differences in the number of credentials obtained and the use of caregiver engagement strategies by play therapists?
10. Are there sex differences in play therapists' use of caregiver engagement strategies?
11. Is there a relationship between play therapists' levels of education and their use of caregiver engagement strategies?
12. Is there a relationship between play therapists' training status (registered play therapist or registered play therapist supervisor) and their use of caregiver engagement strategies?
13. Is there a relationship between play therapists' formal training in play therapy and their use of caregiver engagement strategies?

14. Is there a relationship between play therapists having a dedicated room to meet with caregivers separate from the playroom and their use of caregiver engagement strategies?
15. Is there a relationship between play therapists having a dedicated waiting room and their use of caregiver engagement strategies?
16. What have play therapists identified as the top three barriers to achieving caregiver engagement?
17. What methods have play therapists used to overcome their top three barriers to achieving caregiver engagement?
18. Is there a relationship between the type of population served and the use of caregiver engagement strategies?
19. What do play therapists identify as their primary theoretical orientation?
20. Does theoretical orientation influence play therapists' approach to achieving caregiver engagement in play therapy?

Participants

Participants in this study consisted of members of APT and include student and professional members who may or may not have achieved status as a registered play therapist (RPT) or registered play therapist-supervisor (RPT-S). The association for play therapy (APT) is a national organization dedicated to promoting the play therapy profession and providing resources to its membership of mental health professionals (Association of Play Therapy *Bylaws,* 2006). According to APT's online directory (2011), there are currently 4854 registered members of APT. A list of potential participants was obtained from the Association of Play Therapy by completing the "Mailing List Rental Agreement" (see Appendix A). Members of APT who

conduct research focused on play therapy are provided with one free electronic email directory. Email addresses for all 4854 APT members were entered into a generic electronic mailing list through Qualtrics,™ to ensure anonymity for the recipients. For adequate sampling and statistical power, responses were expected from at least 300 participants. Multiple responses from the same participant were controlled by selecting the "prevent ballot stuffing" option in the Qualtrics,™ software survey options. I intended to post an invitation to participate in the survey on APT's research listserv, to which members of the association voluntarily sign up to exchange information about play therapy research. Approximately 200 people voluntarily currently participate in this particular research listserv (D.Leon, personal communication, June 27, 2011). However, because members of the listserv are also members of APT and would receive an invitation twice, thus creating potential for the same participant to take the survey twice, the decision was made to not post an invitation on the listserv. A total of 539 people responded to the survey, and 431 participants were deemed eligible for inclusion. This represents an overall response rate of 9%. Respondents who did not complete more than 50% of the survey were eliminated from the study. Pairwise deletion was used for the remainder of the responses.

Of the 431 study participants, 405 (94%) were females and 26 (6%) were males, whose ages ranged from 22-77, with a mean age of 30. Participants identified themselves by ethnicity in the following categories: 374 Caucasian (88%), 18 (4%) Hispanic, 7 (2%) African American, 7 (2%) Asian, 3 (1%) Native American, and 15 (3%) other. Due to the dominance of White/Caucasian reports, the ethnicity category was subsequently collapsed into two categories, majority (White/Caucasian) and minority, for data analysis purposes. Participants worked primarily in private practice (52%). Play therapists reported a variety of licenses and certifications, so the decision was made to tally the number of licenses and certifications for ease

during data analysis. Most respondents identified themselves as either licensed professional counselors (34%) or licensed clinical social workers (26%). Psychiatrists (0%) and nurse practitioners (0%) had the smallest representation. Descriptive data for the participants' age, sex, ethnicity, years worked as a mental health professional, years worked as a registered play therapist, primary worksite, and type of licenses and certifications are presented in Table 1.

Table 1

Participant Demographics by Frequency or Means, Standard Deviations, and Ranges (n=431)

Variable	n	%	*M*	*SD*	Range
Age (in years)			47.16	12.38	23-77
Sex					
Male	26	6%			
Female	405	94%			
Ethnicity *					
African American	11	3%			
Asian American	7	2%			
Caucasian	374	86%			
Hispanic	18	4%			
Native American	3	1%			
Other	15	4%			
Years Worked as Mental Health Professional**			14.35	9.63	0-41
Years as Registered Play Therapist****			5.66	6.71	0-30
Primary Worksite*					
School	38	9%			
Community agency	108	25%			
Private practice or group	223	52%			
Psychiatric hospital	2	0%			
Medical hospital	2	0%			
University	29	7%			
Other	26	6%			

Table 1 continued

Participant Demographics by Frequency or Means, Standard Deviations, and Ranges (n=431)

Variable	n	%	*M*	*SD*	Range
Primary Theoretical Orientation**					
Child Centered Play Therapy	246	56%			
Cognitive Behavioral Play Therapy	35	8%			
Gestalt Play Therapy	12	3%			
Ecosystemic Play Therapy	8	2%			
Psychoanalytic Play Therapy	12	3%			
Adlerian Play Therapy	37	9%			
Jungian Play Therapy	17	4%			
Other	63	15%			
Number of Licenses or Credentials***			1.22	0.48	
Type of Licenses and Certifications****					
Licensed Marriage and Family Therapist	61	14%			
Counselor Intern	15	4%			
Licensed Professional Counselor	146	34%			
Licensed Clinical Social Worker	111	26%			
Licensed School Psychologist	9	2%			
Licensed Psychologist	33	8%			
Licensed Professional Counselor-Supervisor	39	9%			
Nurse Practitioner	0	0%			
Psychiatrist	0	0%			
Post master's intern pursuing status as GSW or LCSW	8	2%			
Other	96	23%			

Note. *3 participants missing, **2 participants missing, ***6 participants missing, ****145 participants missing. Since it is common for play therapists to hold multiple certifications, totals for the frequencies of responses exceeded the total number of respondents.

Participants were asked in which state they currently work. Of the 431 respondents, 428 people responded to this item. The two states with the highest representation were California (6%) and Texas (12%). The participant pool resembles APT's population in the sense that the APT's membership base is largest in Texas (Ryan, Gomery, & Lacasse, 2002).

Instrument Development

No previous studies have examined the specific interventions clinicians utilize to achieve caregiver engagement in play therapy or their perceptions as to how the identified interventions relate to the outcome for the child client; therefore, no appropriate survey existed for this study. As such, the *Caregiver Engagement Inventory* (CEI) was created by me specifically for this study to determine the following: (a) the frequency of the use of caregiver engagement strategies by counselors who conduct play therapy; (b) play therapists' formal training in play therapy; (c) play therapists' formal training in working with caregivers of child clients; (d) play therapists' beliefs regarding caregiver engagement strategies; (e) play therapists' incorporation of their theoretical orientation when utilizing caregiver engagement strategies (f) play therapists' identified barriers to achieving caregiver engagement in play therapy; (g) methods play therapists used to overcome barriers to achieving caregiver engagement in play therapy; (h) the practice patterns utilized by play therapists at their worksite; (i) sex differences in play therapists' practice patterns related to caregiver engagement; (j) the relationship between play therapists' level of education and their practice patterns related to caregiver engagement; (k) the relationship between play therapists' formal training in play therapy and their use of play therapy; (l) the relationship between the play therapists' status as a play therapist and their practice patterns related to caregiver engagement; (m) the differences in play therapists' licensure type and practice patterns related to caregiver engagement; (n) the differences in having a designated room for meeting with caregivers and practice patterns related to caregiver engagement; (o) the differences in having a designated waiting room and practice patterns related to caregiver engagement (p) the relationship between years as a mental health professional and practice patterns related to caregiver engagement; (q) the relationship between status as a registered play

therapist (RPT) or registered play therapist-supervisor (RPT-S) and the practice patterns related to caregiver engagement.

The CEI (see Appendix B) is a 36-item instrument developed from a review of play therapy literature and a qualitative pilot study that I conducted on play therapists' perceptions of caregiver misconceptions about play therapy. Also, I developed the CEI based on relevant literature regarding play therapists' training and their perceptions of such training, their common practice patterns with regard to working with caregivers, their perceptions of effective caregiver engagement, their perceptions of the impact of caregiver engagement on the therapeutic outcome for the child client, and their perceived barriers to achieving caregiver engagement in play therapy (see Table 2). The CEI is divided into five sections. Section I: Personal Information refers to the participants' demographic information including sex, age, ethnicity, state of residence, educational level, professional certifications and licenses, and length of time practicing as a mental health professional. This information was used to construct the independent variables. Section II: Training and Preparedness refers to the participants' training in play therapy, including the number of graduate level courses completed and workshops or special institutes attended on play therapy. This section also includes play therapists' perceptions of training in their graduate programs or play therapy workshops that prepared them for working with caregivers. Section III: Practice Patterns and Perceptions refer to the participants' practice decisions and perceptions of strategies that lead to successful therapeutic outcomes for the child client and engagement for the caregiver. Participants were asked to rate their perceptions on a 7-point Likert scale with anchored responses including (1) strongly disagree, (2) somewhat disagree, (3) disagree, (4) neither agree nor disagree, (5) somewhat agree, (6) agree and, (7) strongly agree. Additionally, participants were asked to respond to an open-ended question about

what they identify as the top three caregiver engagement strategies that positively impact the therapeutic outcome for the child client. Section IV: Perceived Barriers refers to the participants' top three (3) identified barriers to achieving caregiver engagement. Responses are open ended. Section V: Additional information refers to an open-ended question that invites participants to share anything additional they believe is important for the researcher to know about achieving caregiver engagement in play therapy.

Table 2
Instrument Development-Caregiver Engagement Inventory

Items	Literature Reference
1-15	Participants' Demographic Information
16-17	McGuire & McGuire, (2001); Sibley (2009)
18	Ryan, Gomory, & Lacasse, (2002)
19	Cates, Paone, Packman, & Margolis, (2006); Kottman & Ashby, (1999)
20-21	McGuire & McGuire, (2001)
23-24	Bratton, Ray, Rhine, & Jones (2005); Haslam & Harris, (2011), LeBlanc & Ritchie, (2001)
25	McGuire & McGuire, (2001)
26-30	Cates, Paone, Packman, & Margolis, (2006); McGuire & McGuire, (2001)
31-34	Cates, Paone, Packman, & Margolis, (2006); McGuire & McGuire, (2001)
35-36	Haslam & Harris, (2011)

Expert Panel

An expert panel was identified and asked to test the ease, administration, and content validity of the *Caregiver Engagement Inventory* (CEI). The expert panel consisted of six people, including three registered play therapist supervisors (RPT-S), one licensed professional counselor supervisor (LPC-S) with experience in play therapy research, one licensed professional counselor (LPC) currently pursuing status as an RPT, and one doctoral student in Counselor Education. All members of the expert panel were currently practicing in the mental health field, and three provided

exclusively play therapy services. All members of the panel were female. Five members of the panel were Caucasian, and one member was African American. Similarly to the expert panel, results of a membership survey of the APT reflect membership of APT, which is comprised of predominantly Caucasian/non-Hispanic females (Ryan, Gomery, &Lacasse, 2002). However, a few notable differences between the expert panel members and the average APT member do exist. The majority (76.9%) of APT's membership base does not earn beyond a master's degree and typically works in private practice. All members of the expert panel either had earned or were pursuing a doctorate. Three members of the expert panel provided play therapy services in university settings, and two worked in private practice. One member provided community based clinical services to children and their families in their homes and schools.

Two of the panel members have served on the board of the Louisiana chapter of the Association for Play Therapy, and a third member served on a committee for the Louisiana chapter of the Association for Play Therapy. Five of the expert panel members held licensure as licensed professional counselors in the state of Louisiana, and one was pursuing licensure. Five of the six panel members had presented at either national or state play therapy conferences.

The expert panel members were contacted via email to request voluntary participation in the expert panel. Upon receipt of either an email or verbal consent to participate, the researcher emailed a copy of the proposed letter to participants, which included the electronic link to the survey instrument. Also included in the email was an attachment of the survey in Microsoft Word for easier review and provision of feedback.

Two of the panel members were able to meet with the researcher in person at their respective offices to discuss the survey. Two panel members provided feedback on the

telephone. Last, two members provided feedback through track changes in the Microsoft Word document, accompanied by multiple email exchanges.

The expert panel suggested using dropdown menus for questions for easier administration. This suggestion was implemented.

The expert panel suggested removing the term "Licensed Professional Counselor" from item 7 since not all participants may reside in states that issue this particular license. However, this suggestion was not implemented because "other" is a choice that participants could select and type their title into the optional provided text box.

A suggestion was made to expand the amount of space allotted to the qualitative question that requested participants respond with their personal opinion of the definition of caregiver engagement. This change was implemented with an increase of 100 characters.

Minor changes were suggested to standardize the item format, including adding instructions above each question and providing "other" as an option on several questions. These suggestions were implemented.

Pilot Study

I conducted a pilot study in April 2010 to identify the perceptions of play therapists in Louisiana regarding the main misconceptions and questions about play therapy among caregivers. I developed a qualitative survey (see Appendix C) specifically for the purpose of the pilot study.

To participate in the pilot study, an individual had to be a member of the Louisiana Association for Play Therapy who held current national certification as either a registered play therapist (RPT) or registered play therapist supervisor (RPT-S). Assumptions based on holding certification are that each participant earned at least a master's degree and holds professional

licensure in Louisiana. Therefore, each participant should have at least four years postgraduate experience (at least two years to receive licensure and at least two years to receive RPT certification). It was anticipated that the participant pool would consist of participants of varying race, socioeconomic background, age, sex, and experience level. The survey was sent to 35 people, of whom 17 responded. Last, the University of New Orleans Institutional Review Board (see Appendix D) approved the pilot study on April 6, 2010.

Procedures.

Using criterion sampling, contact information for the 32 registered RTP/RPT-S in Louisiana was obtained from an online directory accessed through the Association for Play Therapy. A letter explaining the purpose of the study (see Appendix E) confidentiality, voluntary participation, and the expected time required to complete the questionnaire was distributed electronically to registered members of the LAPT directory who hold certification as either RPT or RPT-S. A follow up email (see Appendix F) was sent two weeks later to remind participants to complete the survey and to thank those who chose to participate for their cooperation .The qualitative questionnaire was administered through SurveyMonkey,™ an online survey service. The questionnaire contained the following questions in this order:

1. What is the most common question you receive from caregivers about play therapy prior to beginning services with the child?
2. What do you wish caregivers knew about play therapy?
3. What do you consider the biggest misconception caregivers have about play therapy?

Data were analyzed using grounded theory by summarizing commonalities among participants' responses. According to Creswell (2007, p.68), a researcher utilizing grounded theory "needs to recognize that the primary outcome of this study is a theory with specific

components: a central phenomenon, causal conditions, strategies, conditions and context, and consequences." Commonly used words or phrases were identified through a constant comparative method of analysis, open, axial, and selective coding, and themes were developed. Notable themes were: (a) lack of or improper education about play therapy, (b) financial concerns, and (c) perceptions about the value of play (see Table 3). Findings were expected to enhance understanding of the perceptions of play therapy by caregivers and increase the knowledge base of play therapists in Louisiana.

Table 3

Frequency Distribution of Respondents by Theme

Theme	Sample Response	*n*	%
A	What is play therapy? How is it different from "talk therapy" and how will it help my child?	17	38
B	Children can play with toys at home and obtain the same results, so why spend money?	3	7
C	A child must talk about what is bothering them to generate change.	24	55

Procedures

All procedures and protocols related to data collection were reviewed and approved (see Appendix G) by the University of New Orleans Committee for the Protection of Human Subjects in Research (IRB). Data were collected anonymously from members of the Association for Play Therapy online public directory using Qualtrics,™ an on-line survey and data collection service. Participants were contacted directly by means of a mass electronic message (see Appendix H) including an invitation to participate. The electronic message included a brief description of the study, a statement regarding anonymity, and a statement regarding consent to participate. An electronic reminder (see Appendix I) was sent two weeks after the initial electronic invitation to

participate. The end of the study was announced by a mass electronic message (see Appendix J) indicating that data collection has been completed. The final electronic message included a thank you to those who participated. Also included in the final message was a statement notifying participants of the opportunity to request an email copy of the results of the study.

Advantages of Internet-based Research

The use of Internet-based research has grown considerably in the past 15 years (Cantrell & Lupinacci, 2007) and provides researchers with many benefits, including the ability to gain insight into populations otherwise unable to participate due to geography or weather inhibitions (Hill et al. 2006). Ahern (2005) identified the following as additional benefits for researchers: (1) cost effectiveness, (2) larger and more diverse participant pool, (3) reduced collection time, (4) methodological control, (5) accuracy of data entry and analysis, and (6) easier participant follow-up. In general, the use of Internet-based surveys produces larger sample sizes more quickly, with reduced cost and time spent on data entry. These factors, particularly cost effectiveness and access to a larger participant pool, contributed to my decision to utilize Internet-based research for this study.

Of relevance for this study, Lonsdale, Hodge, and Rose (2006) reported that members of an association might return a higher response rate than a non-homogeneous group due to issue salience. Barry (2001) found that participants who were informed that they could contact the researcher via email with questions about the survey reported a sense of alliance with the researcher that contributed to their decision to complete the survey. The participant pool in this research study was limited to members of APT, hence the assumption was made that they all held a certain level of interest in play therapy. The letter to participants (see Appendix F) included my contact information with a statement welcoming questions from participants.

Anonymity

According to Barry (2001), the Internet can serve as a vehicle for self-disclosure—particularly among cultural groups reluctant to publicly participate—due to its anonymous nature. Internet-based companies facilitating research (such as Qualtrics™) protect participants by ensuring anonymity (Barry). However, return rates may be skewed by the possibility of multiple submissions by the same participant (Barry). I controlled for this in my study by eliminating ballot stuffing using specific procedures with Qualtrics™ software.

Possible Limitations of Internet-based Survey Research

Deliverability

Problems that arise during implementation of Internet-based research can include time-consuming technical problems like locating and checking invalid email addresses (Van Selm & Jankowski, 2006). To minimize this, Lyons, Cude, Lawrence, and Gutter (2005) have suggested requesting the most up-to-date email list from which to recruit, considering the fact that certain target populations, such as students, may have multiple email addresses or change email addresses often. I requested an electronic mailing list of APT membership from C. Guerrero (personal communication, August 09, 2011), credentialing coordinator of APT, to ensure the most current contact information of members.

Representativeness of the Sample

Since a data sample is typically obtained to represent the larger population, researchers utilizing Internet-based surveys have to work to clearly identify the sample (Draugalis, Coons, &Plaza, 2008). Although Internet-based research does have many benefits, Lyons et al. (2005) urged researchers to consider their target population's access to education required to access the Internet, availability of Internet services, willingness to utilize Internet services they may pay for,

and their comfort level with completing an Internet-based survey. Considering the fact that all participants are either pursuing or have earned at least a master's degree, I assumed the majority of them would be acquainted with the Internet and able to complete the survey if they so chose.

Typical Problems and Strategies to Increase Response Rates

Despite the aforementioned advantages to utilizing Internet-based research, Cook, Heath, and Thompson (2000) have found response rates are still lower for than traditional survey methods. Understanding factors that influence response rates is the key to sustaining the value of Internet-based research (Porter, 2003). Research has shown there are ways to increase response rates, including offering participants incentives to participate, minimizing the survey length so that it takes a maximum of 15 minutes to complete (Goritz, 2006), and including an option to pause the survey and resume at a later time (Semler, 2010). While I decided against offering incentives for participation due to cost, consideration was given to the length and ease of completing the survey. Members of the expert panel reported that they were able to complete my survey in approximately 10-15 minutes and the feature in Qualtrics™ that allows participants to take a break from the survey and resume later was used.

Additionally, Dillman (2000) found that personalizing the email used to contact the participant with his or her name generated a higher response rate. Porter and Whitcomb (2003) have suggested that the "sender" of the email should be a person or organization name, rather than an unidentifiable entity that may be viewed as junk email. Although I entered all names into an electronic mailing list that was distributed through Qualtrics™ , my name appeared as the sender of the email. The subject of the email clearly delineated the contents of the email as play therapy research in an attempt to appeal to participants' assumed interest in the topic as members of APT. Lonsdale, Hodge, and Rose (2006) opined that members of an association may return a

higher response rate than a non-homogeneous group due to issue salience. Since this topic is of interest to play therapists, educators, and researchers, I suspect the response rate benefitted from issue salience.

Barry (2001), in a research study on the culture of the Internet found that participants who were informed that they could contact the researcher via email with questions about the survey reported a sense of alliance with the researcher that contributed to their decision to complete of the survey. Participants were provided contact information for myself and my faculty advisor in all electronic messages, and were encouraged to contact us with any questions or concerns regarding the study.

Data Analyses

The study addressed several research questions, beginning with the overall research question, which was, "What are play therapists' perceptions of the factors that influence caregiver engagement in play therapy?" Additional research questions are listed below. Data were analyzed with descriptive statistics, chi-square tests, and Spearman rho and Pearson correlations. To control for the multiple significance tests used in this study a conservative alpha level of .01 was set.

Research Question 1

What are the practice patterns of play therapists when working with a caregiver to achieve caregiver engagement?

Data Analysis

Descriptive survey statistics were calculated on survey responses to items 17, 23, 25, 26, 27, and 29-32.

Research Question 2

What are play therapists' perceptions of various practice patterns as they relate to achieving caregiver engagement?

Data Analysis

Descriptive survey statistics were calculated on survey responses to items 21, 24, 28, and 33.

Research Question 3

What do play therapists identify as the top three strategies for achieving caregiver engagement?

Data Analysis

Descriptive survey statistics were calculated on survey responses to item 22. Results of the data are shown in frequency distributions.

Research Question 4

What training specific to working with caregivers have play therapists received in educational programs, work settings, and continuing education experiences?

Data Analysis

Descriptive survey statistics were calculated on survey responses to items 12(training specific to working with caregivers received in graduate programs) and 14 (training specific to working with caregivers received in workshops and special institutes). Results are shown in frequency distributions.

Research Question 5

Is there a relationship between play therapists' primary worksite and their practice patterns in relation to caregiver engagement?

Data Analysis

A chi square analysis was used to relate item 4 (primary worksite) with items 17, 23, 25, 26, 27, and 29-32.

Research Question 6

Is there a relationship between years practicing as a mental health professional and play therapists' perceptions of the factors that influence caregiver engagement?

Data Analysis

A Spearman rho correlation was used to answer this research question. Item 8 (number of years practicing as a mental health professional) was used to assess the association of items 24 (perceived effectiveness of caregiver engagement strategies) and 33 (perceived effectiveness of educational materials).

Research Question 7

Is there a relationship between perceived ability to facilitate caregiver engagement and use of caregiver engagement strategies?

Data Analysis

A Spearman rho correlation was used to answer this research question. Item 20 (perceived ability to facilitate caregiver engagement) was used to assess the association of items 17, 23, 25, 27, and 29-32.

Research Question 8

What level of formal play therapy training do play therapists receive?

Data Analysis

Descriptive statistics were calculated on survey responses to items 10 and 13.

Research Question 9

Are there differences in number of credentials obtained and use of caregiver engagement strategies by play therapists?

Data Analysis

Item 7 (credential or license obtained) was compared to items 17, 23, 25, 27, and 29-32 (use of caregiver engagement strategies) using chi-square analysis.

Research Question 10

Are there sex differences in play therapists' use of caregiver engagement strategies?

Data Analysis

Item 1 (male and female) was compared to items 17, 23, 25, 27, and 29-32 (use of caregiver engagement strategies) using chi-square analysis.

Research Question 11

Is there a relationship between play therapists' level of education and their use of caregiver engagement strategies?

Data Analysis

Item 6 (highest mental health degree earned) was compared to items 17, 23, 25, 27, and 29-32 (use of caregiver engagement strategies) using a Spearman rho correlation.

Research Question 12

Is there a relationship between play therapists' training status (registered play therapist or registered play therapist supervisor) and their use of caregiver engagement strategies?

Data Analysis

Item 9 (play therapy training status) was compared to items 17, 23, 25, 27, and 29-32 (use of caregiver engagement strategies) using a Spearman rho correlation.

Research Question 13

Is there a relationship between play therapists' formal training in play therapy and their use of caregiver engagement strategies?

Data Analysis

Two spearman rho correlations were used to compare item 10 (number of graduate level play therapy courses) with items 17, 23, 25, 27, and 29-32 (use of caregiver engagement strategies), and item 13 (approximate number of continuing education hours in play therapy) with 17, 23, 25, 27, and 29-32 (use of caregiver engagement strategies).

Research Question 14

Is there a relationship between play therapists having a dedicated room for meeting with caregivers separate from the playroom and their use of caregiver engagement strategies?

Data Analysis

A Spearman rho correlation was used to answer this research question. Item 29 (worksite has a separate room for meeting with caregivers in addition to playroom) was used to assess the association of with items 17, 23, 25, 27, and 29-32.

Research Question 15

Is there a relationship between play therapists having a dedicated waiting room and their use of caregiver engagement strategies?

Data Analysis

A Pearson correlation was used to answer this research question. Item 31 (worksite has a separate waiting room for meeting with caregivers in addition to playroom) was used to assess the association of with items 17, 23, 25, 27, and 29-32.

Research Question 16

What have play therapists identified as the top three barriers to achieving caregiver engagement?

Data Analysis

Descriptive survey statistics were calculated on survey responses to item 34 (top three perceived barriers to achieving caregiver engagement). Results of the data are shown using descriptive statistics.

Research Question 17

What methods have play therapists used to overcome their top three barriers to implementing achieving caregiver engagement?

Data Analysis

Descriptive survey statistics were calculated on survey responses to item 35 (top three ways play therapists' overcome barriers to achieving caregiver engagement). Results of the data are shown using descriptive statistics.

Research Question 18

Is there a relationship between the type of populations served and the use of caregiver engagement strategies?

Data Analysis

A Spearman rho correlation was used to compare item 18 (percentage of client base required by an outside party to seek mental health services) with items 17, 23, 25, 27, and 29-32 (use of caregiver engagement strategies).

Research Question 19

What do play therapists identify as their primary theoretical orientation?

Data Analysis

Descriptive survey statistics were calculated on survey responses to item 16 (primary theoretical orientation). Results of the data are shown using descriptive statistics.

Research Question 20

Does theoretical orientation influence play therapists' approach to achieving caregiver engagement in play therapy?

Data Analysis

Analysis of variance was used to compare item 16 (primary theoretical orientation) with item 17 (influence of theoretical orientation on play therapists' approach to achieving caregiver engagement in play therapy.)

CHAPTER FOUR

RESULTS

The purpose of this study was to identify the practice patterns of play therapists, their perceptions of the factors that influence caregiver engagement, their perceptions of the relationship between caregiver engagement and the therapeutic outcome for the child client, their perceptions of the barriers to achieving caregiver engagement in play therapy and methods they use to overcome such barriers. An additional goal of the study was to learn about play therapists' formal play therapy training, their training in working with caregivers, if there were differences in number of credentials held and the use of caregiver engagement strategies, and if there were sex differences in play therapists' use of caregiver engagement strategies.

Throughout this study, I sought to determine if there was a relationship between play therapists' education levels and their use of caregiver engagement strategies, and if there was a relationship between play therapists' training status (registered play therapist or registered play therapist supervisor) and their use of caregiver engagement strategies. Additionally, I aimed to find if there was a relationship between play therapists' amount of continuing education in play therapy and their use of caregiver engagement strategies. Further, a purpose of the study was to evaluate the relationship between play therapists having a dedicated waiting room or room designated for meeting with caregivers and their use of caregiver engagement strategies. Last, I explored the relationship between the percentage of play therapists' client base mandated to receive services and play therapists' use of caregiver engagement strategies.

Analysis of Research Questions

I addressed several questions, beginning with the overall research question, which was, "What are play therapists' perceptions of the factors that influence caregiver engagement in play therapy?"

Instrumentation

The *Caregiver Engagement Inventory* (CEI) is a 36-item instrument developed by me from a review of play therapy literature and a qualitative pilot study that I conducted on play therapists' perceptions of caregiver misconceptions about play therapy. Items in the CEI were based on relevant literature regarding play therapists' training and their perceptions of such training, their common practice patterns with regard to working with caregivers, their perceptions of effective caregiver engagement, their perceptions of the impact of caregiver engagement on the therapeutic outcome for the child client, and their perceived barriers to achieving caregiver engagement in play therapy. The CEI includes both quantitative and qualitative items and is divided into five sections: Personal Information, Training and Preparedness, Practice Patterns and Perceptions, Perceived Barriers, and Additional Information.

Research Question 1

The first research question asked the practice patterns of play therapists when working with a caregiver to achieve caregiver engagement. Descriptive survey statistics were calculated on survey responses to CEI item 17, which asked play therapists to answer the statement "my theoretical orientation influences my approach to working with caregivers in play therapy." The possible responses included strongly disagree (1), somewhat disagree (2), disagree (3), neither agree nor disagree (4), somewhat agree (5), agree (6) and strongly agree (7). The results (M=5.84, SD=1.17) indicated that play therapists' "agreed" that their theoretical orientation

influenced their approach to caregiver engagement. Thus, it appears that play therapists consider their theoretical orientation when conceptualizing their work with caregivers of their child clients. Play therapists' responses are represented in Table 4.

Table 4
Participants' Theoretical Orientation Practice Patterns by Frequency, Means, and Standard Deviations

Item	*n*	*M*	*SD*
Practice Patterns of Play Therapists			
17. My theoretical orientation influences my approach to working with caregivers in play therapy.	430	5.84	1.17

Note. Likert scale included 1=Strongly disagree, 4=Neither agree or disagree, 7=Strongly agree

Descriptive survey statistics were also calculated on item 23, which asked play therapists to identify the frequency in which they utilize various forms of communication (face to-face communication, telephone consultation, email, video conference, and structured feedback form) with a caregiver. Participants were asked to select never (1), less than once a month (2), once a month (3), 2-3 times a month (4), once a week (5), 2-3 times a week (6) or daily (7) for each form of communication with a caregiver. Overall, play therapists' reported that the most frequently utilized form of communication was face-to-face consultation (*M*=4.36, *SD*=1.26) 2-3 times per month. It seems participants used telephone consultation ((*M*=3.50, *SD*=1.33), e-mail (*M*=2.63, *SD*=1.58), video conferencing (*M*=1.11, *SD*=.55) and a structured feedback form (*M*=2.24, *SD*=1.51) less frequently. Therefore, play therapists seem to favor communicating with caregivers in person rather than by other methods. Results are shown in Table 5.

Table 5
Play Therapists' Communication Practice Patterns by Frequency or Means and Standard Deviations

Item	*n*	*M*	*SD*
Practice Patterns of Play Therapists			
23. Please indicate the frequency in which you utilize the following forms of communication with a caregiver.			
Face-to-face consultation	430	4.36	1.26
Telephone consultation	430	3.50	1.33
E-mail contact	430	2.60	1.58
Video Conference	430	1.11	0.55
Structured feedback form	429	2.24	1.51

Note. Likert scale included 1=Never, 4=2-3 times a month, 7=Daily. The number of frequencies exceeds the number of respondents because participants were asked to report the frequency in which they use all five strategies listed above.

Item 25 asked play therapists about the frequency with which they use play therapy specific educational materials with caregivers of their clients. Participants were asked to select never (1), less than once a month (2), once a month (3), 2-3 times a month (4), once a week (5), 2-3 times per week (6) or daily (7). Data were analyzed two ways to examine frequency of use. First, participants' responses were collapsed into "never used" and "used at one point." An overwhelming majority, 393 (95%), of participants reported that they had used educational materials with caregivers at one point, and 18 (5%) responded that they had never used educational materials with caregivers. The largest number of respondents, 111 (27%) play therapists, reported that they used play therapy specific materials with caregivers once a month (*M*=3.48, *SD*=1.55). Fewer participants, 83 (19%) reported that they used educational materials with caregivers roughly 2-3 times per month. Descriptive statistics for item 25 are shown in Table 6.

Table 6
Play Therapists' Utilization of Educational Materials by Frequency, Mean and Standard Deviation

Item	*n*	*M*	*SD*
Practice Patterns of Play Therapists			
25. How frequently do you use play therapy specific educational materials with caregivers of your clients?	411	3.48	1.55

Note. Likert scale included 1=Never, 4=2-3 times a month, 7=Daily

Descriptive survey statistics were calculated for item 26, which asked play therapists about how they provide play therapy specific educational materials to caregivers. Participants were asked to select from the following options: available in the waiting room, standard packet of information provided to all caregivers prior to beginning services with the child client, face-to-face exchange of information, or other. Of the 421 participants who answered item 26, 306 (73%) indicated that they use face to face exchange of information most often, while the least utilized way to provide play therapy specific educational materials was email exchange, selected by 7 (2%) participants. Few participants (5%) reported that they use their waiting rooms to distribute educational materials to caregivers. More used face-to-face exchange to provide educational materials than all of the other strategies combined. Results of item 26 are presented in Table 7.

Table 7
Play Therapists' Distribution of Educational Materials by Frequency (n=421)

Item	*n*	%
Practice Patterns of Play Therapists		
26. The majority of my play therapy specific educational materials are provided to caregivers via		
Available in waiting room	22	5%
Standard packet of information	65	15%
Email exchange of information	7	1%
Face to face exchange of information	306	73%
Other	21	6%
Total	421	100%

Item 27 asked play therapists to select the strategies they utilize for caregiver engagement from a list that included psychosocial assessment, information about caregiver's family of origin, structured consultation format, collateral communication with others involved in the child client's treatment, caregiver support groups within the play therapist's worksite, child parent relationship therapy (CPRT), or other. The top three most utilized strategies were collateral communication (358 participants), information about caregiver's family of origin (344 participants), and psychosocial assessment (340 participants). The least utilized techniques were collateral communication (58 participants) and CPRT groups (71 participants). Because the respondents were asked to check all that apply, the totals for the frequencies of responses exceed the total number of respondents. Participants could have each selected between 1-8 strategies, and they were not asked to indicate the frequency with which they used each item, so it may be difficult to discern which strategy was actually most utilized. A free form field was provided for "other" and 87 participants responded. Sample responses found in other included:

dyadic play therapy

filial therapy

family play therapy

love and logic parenting resources

Marshack Interaction Method

bibliotherapy

Descriptive statistics for item 27 are shown in Table 8.

Table 8
Play Therapists' Utilization of Caregiver Engagement Strategies by Frequency (n=423)

Item	*n*	%
Practice Patterns of Play Therapists		
27. Please select all the strategies below that you utilize for caregiver engagement.		
Psychosocial assessment	340	80%
Information about caregiver's family of origin	344	81%
Structured consultation format	240	57%
Tour of your playroom	328	78%
Collateral communication	358	85%
Caregiver support groups	58	14%
CPRT groups	71	17%
Other	87	21%

Note. The number of frequencies exceeds the number of respondents because participants were asked to select all that apply.

Item 29 asked, "do you have a separate room for meeting with caregivers in addition to their playroom?" Play therapists were asked to select either "yes" or "no" to item 29. The results are shown in frequency distributions in Table 9. Of the 414 participants who answered item 29, 258 (62%) reported yes, and 156 (38%) reported no. The majority of respondents had a room separate from their playroom that was used for meeting with caregivers. Results are reported in Table 9.

Table 9
Play Therapists' Utilization of Caregiver Room by Frequency (n=414)

Item	n	%
Practice Patterns of Play Therapists		
29. Do you have a separate room for meeting with caregivers in addition to your playroom?		
Yes	258	62%
No	156	38%
Total	414	100%

Play therapists who answered item 30 were asked to indicate the frequency with which they utilize the following items in the room they meet with caregivers: Why Play Therapy? brochure, Play Therapy Works! YouTube video, play therapy educational videos, play therapy magazine articles, play therapy specific books, computer with internet access, computer with multimedia capabilities, television with DVD/VCR, culturally sensitive items, and other. Likert scale descriptors for item 29 included never (1), less than once a month (2), once a month (3), 2-3 times a month (4), once a week (5), 2-3 times per week (6) or daily (7). The most frequently used item by play therapists in the room they meet with caregivers was the Why Play Therapy? brochure (M=3.11, SD=2.03) and the item used least often was play therapy educational videos (M=1.77, SD=1.34). Participants used the brochure about once a month (M=*3.11, SD=2.03)* and almost never *(*M=1.77, SD=1.34) used play therapy educational videos. Other items fell somewhere in between, including other. Participants' responses to other (n=14) were entered into a free form field, and included some of the following:

confidential collateral progress meetings

one-on-one education and demonstration

parenting books and hands on application

NMT brain maps and genograms

Filial therapy workshops

explanation of toys and purposes of plat (sic)

educational documents created by the therapist

handouts downloaded from APT's website.

Descriptive statistics were calculated for item 30 and are shown in Table 10.

Table 10
Play Therapists' Utilization of Educational Materials in Caregiver Room by Frequency, Means, and Standard Deviations

Item	*n*	*M*	*SD*
30. Please indicate the frequency with which you use the following items in the room you meet with caregivers.			
Why Play Therapy brochure	253	3.11	2.03
Play Therapy Works! You Tube video	236	1.45	1.13
Play Therapy educational videos	238	1.77	1.34
Play Therapy magazine articles	243	2.45	1.67
Play Therapy specific books	245	3.07	1.87
Computer with internet access	235	2.33	1.92
Computer with multimedia capabilities	234	1.80	1.67
Television with DVD/VCR	236	2.16	1.68
Culturally sensitive materials	241	2.93	2.20
Other	27	2.81	2.30

Note. Likert scale included 1=Never, 4=2-3 times a month, 7=Daily

Item 31 asked play therapists if they have a designated waiting room separate from the room they meet with caregivers. An overwhelming majority of participants had a waiting room at their worksite. Of the 416 participants who responded, 350 (84%) said they do have a waiting room, and 66 (16%) reported that they do not have one. Results are presented in Table 11.

Table 11
Play Therapists' Utilization of Waiting Room by Frequency (n=416)

Item	n	%
Practice Patterns of Play Therapists		
31. Do you have a designated waiting room separate from the room in which you meet with parents?		
Yes	350	84%
No	66	16%
Total	416	100%

Descriptive statistics were calculated for item 32, which asked play therapists to indicate the frequency with which they use the following items in their waiting room: Why Play Therapy? brochure, Play Therapy Works! YouTube video, play therapy educational videos, play therapy magazine articles, play therapy specific books, computer with internet access, computer with multimedia capabilities, television with DVD/VCR, culturally sensitive items, and other. Likert scale descriptors for item 32 included never (1), less than once a month (2), once a month (3), 2-3 times a month (4), once a week (5), 2-3 times a week (6) or daily (7). Again, the most frequently used item in the waiting room was the Why Play Therapy? brochure (M=3.47, SD=2.63), which participants used once a month. Culturally sensitive items (M=3.20, SD=2.62) were used about once a month, as well as Play Therapy magazine articles and play therapy specific books. Computers with either multimedia capabilities (M=1.21, SD=1.25) or the Internet (M=1.32, SD=1.10) were used in waiting rooms almost never by play therapists, which made them the least utilized items in play therapists' waiting rooms. Similarly, the Play Therapy Works! YouTube video (M=1.29, SD=1.07) was used very rarely in play therapists' waiting rooms, which makes sense considering the fact that a computer with Internet access was required to play it. The results of item 32 are shown in Table 12.

Table 12
Play Therapists' Utilization of Educational Materials in Waiting Room by Frequency, Means, and Standard Deviations

Item	*n*	*M*	*SD*
32. Please indicate the frequency with which you use the following items in your waiting room.			
Why Play Therapy brochure	335	3.47	2.63
Play Therapy Works! You Tube video	310	1.29	1.07
Play Therapy educational videos	314	1.45	1.25
Play Therapy magazine articles	331	2.79	2.34
Play Therapy specific books	321	2.50	2.20
Computer with internet access	308	1.32	1.10
Computer with multimedia capabilities	307	1.21	0.88
Television with DVD/VCR	313	1.93	1.96
Culturally sensitive materials	319	3.20	2.62
Other	64	1.94	2.05

Note. Likert scale included 1=Never, 4=2-3 times per month, 7=Daily

Research Question 2

The second research question asked play therapists' perceptions of various practice patterns as they relate to achieving caregiver engagement. Descriptive statistics were calculated on survey responses to item 21, which asked play therapists to indicate their opinion about whether or not caregiver engagement is related to the therapeutic outcome for the child client. Likert scale descriptors for item 21 included strongly disagree (1), disagree (2), somewhat disagree (3), neither agree nor disagree (4), somewhat agree (5), agree (6), and strongly agree (7). Of the 424 respondents who answered item 21, the majority (69%) "strongly agreed" with the statement "I believe caregiver engagement is related to the therapeutic outcome for the child client," while very few chose strongly disagree (0%), disagree (0%), somewhat agree (5%), or

neither agree or disagree (1%). Overall, play therapists' reports indicated that they strongly agree that a child's therapeutic outcome is related (*M*=6.61, *SD*=.69) to the caregiver's engagement in the play therapy process. Frequency distributions are shown for item 21 in Table 13.

Table 13
Play Therapists' Perceptions of the Relationship Between Caregiver Engagement and the Therapeutic Outcome for Child Client by Frequency

Item	*n*	%
Play Therapists' Perceptions		
21. I believe caregiver engagement is related to the therapeutic outcome for the child client.		
Strongly Disagree	1	0%
Disagree	1	0%
Somewhat Disagree	0	0%
Neither Agree or Disagree	2	1%
Somewhat Agree	20	5%
Agree	107	25%
Strongly Agree	293	69%
Total	424	100%

Item 24 asked play therapists to indicate their perception of the effectiveness of various strategies (face-to-face consultation between caregiver and play therapist, telephone consultation between caregiver and play therapist, email contact between caregiver and play therapist, video conference between caregiver and play therapist, and a structured feedback form completed by caregiver about their child's progress and continued challenges in play therapy) as they relate to caregiver engagement. Play therapists were asked to rate their perception by choosing very ineffective (1), ineffective (2), somewhat ineffective (3), neither effective nor ineffective (4), somewhat effective (5), effective (6) or very effective (7). Overall, play therapists found face-to-face consultation to be very effective (*M*=6.52, *SD*=.75) and telephone consultation (*M*=5.49, *SD*=.93) and email contact (*M*=4.54, *SD*=1.39) to be somewhat effective. Participants found

video conferencing neither effective nor ineffective (*M*=4.16, *SD*=1.39). Of the 431 participants, the majority perceived communicating with parents in person to be more effective than through email, telephone, or video conferencing. Descriptive statistics were calculated for item 24 and the results are shown in Table 14.

Table 14
Play Therapists' Perceptions of the Effectiveness of Communication Strategies by Frequency, Means, and Standard Deviations

Item	*n*	*M*	*SD*
Practice Patterns of Play Therapists 24. Please indicate your perception of the effectiveness of the following forms of communication with a caregiver.			
Face-to-face consultation	428	6.52	0.75
Telephone consultation	426	5.49	0.93
E-mail contact	405	4.54	1.39
Video Conference	363	4.16	1.39
Structured feedback form	393	5.13	1.38

Note. Likert scale included 1=very ineffective, 4= neither effective nor ineffective, 7= very effective.

Item 28 asked play therapists to select their top three caregiver engagement strategies from a list of eight options including psychosocial assessment, information about caregiver's family of origin, tour of playroom, collateral communication, caregiver support groups, child-parent relationship therapy groups within their worksite, and a free form field for other. In response to the request to select their top three caregiver engagement strategies, the majority of play therapists selected psychosocial assessment (63%), the second highest number of play therapists selected information about caregiver's family of origin (52%), and the third most selected caregiver engagement strategy was collateral communication (49%). Therefore, it appeared that play therapists utilized these strategies more frequently than structured consultation format, tour of playroom, caregiver support groups, CPRT groups, or other strategies. Participants were allowed to enter their responses to other in a free form field, and 95 responded.

A few participants' comments included:

parent education sessions

family unity meetings

inviting the caregiver into the room during child's play session

telephone calls to caregiver

combination of consult and survey monthly feedback form from caregiver

video tape modified strange situation between parent and child

during tour discuss how materials are used and supportively discuss parents' concern and their role in the therapeutic process.

Results are detailed in Table 15.

Table 15

Play Therapists' Top Three Caregiver Engagement Strategies by Frequency (n=418)

Item	*n*	%
28. Please select your top three most effective caregiver engagement strategies.		
Psychosocial assessment	265	63%
Information about caregiver's family of origin	217	52%
Structured consultation format	185	44%
Tour of your playroom	120	29%
Collateral communication	206	49%
Caregiver support groups	36	86%
Child Parent Relationship Therapy (CPRT) groups	64	15%
Other*	95	23%

Note. *=Missing 4 participants. The number of frequencies exceeds the number of respondents because participants were asked to select three strategies.

Item 33 asked play therapists to rate the following items based on their experience using them in the room they meet with caregivers: Why Play Therapy? brochure, Play Therapy Works! YouTube video, play therapy educational videos, play therapy magazine articles, play therapy specific books, computer with internet access, computer with multimedia capabilities, television with DVD/VCR, culturally sensitive items, and a free form field for other. Respondents were asked to rate their perception by choosing very ineffective (1), ineffective (2), somewhat

ineffective (3), neither effective nor ineffective (4), somewhat effective (5), effective (6) or very effective (7). Higher means indicate a greater perception of effectiveness, while a lower mean suggests participants perceived the item to be less effective. Play therapists reported that the most effective item used in the room they meet with caregivers was the Why Play Therapy? brochure (M=5.27, SD=1.31), while the item perceived least effective was a computer with multimedia capabilities (M=1.37, SD=1.36). Participants perceived the Play Therapy Works! YouTube video, play therapy educational videos, Play Therapy magazine articles, play therapy books, a television with DVD/VCR capabilities, and other to be somewhat effective. Thus, participants in this study appeared to find the Why Play Therapy? brochure more effective in their work with caregivers than the other aforementioned educational items. In response to other, 26 participants completed a free form field, and responses included:

face-to-face education

child centered magazines

NMT brain maps

toys and play materials

Adlerian brain maps

The results are shown by frequencies, means, and standard deviations in Table 16.

Table 16
Play Therapists' Perceptions of the Effectiveness of Educational Materials in Caregiver Room by Frequency or Means and Standard Deviations

Item	*n*	*M*	*SD*
33. Please indicate your perception of the effectiveness of the following items in the room you meet with caregivers.			
Why Play Therapy? brochure	372	5.27	1.31
Play Therapy Works! You Tube video	302	4.64	1.42
Play Therapy educational videos	319	4.86	1.27
Play Therapy magazine articles	342	4.95	1.24
Play Therapy specific books	329	5.20	1.33
Computer with internet access	308	4.48	1.40
Computer with multimedia capabilities	304	1.37	1.36
Television with DVD/VCR	316	4.69	1.34
Culturally sensitive materials	317	5.17	1.39
Other	78	4.65	1.70

Note. Likert scale included 1=very ineffective, 4= neither effective nor ineffective, 7= very effective.

Research Question 3

The third research question asked what play therapists identify as the top three strategies for achieving caregiver engagement. For item 22, play therapists were asked to list their top three caregiver engagement strategies in a free form field. Rank order was not used, so all responses were collapsed, and themes were developed according to Creswell's (2007) recommendations. Play therapists' responses were used to develop the following themes: provide education, exercise communication, utilize counseling skills, and link to resources. Several responses that were shared by play therapists and reflect the themes are below.

Play therapists identified the following strategies used to achieve caregiver engagement through educating caregivers on play therapy:

Inform caregiver about play therapy

Assignments outside of session

Video training

Play therapists' responses indicated that communication is important when working with a caregiver:

Provide feedback to caregiver

Discussion of how sessions will go and what to expect

Frequent communication via phone or face-to-face contact

Give them permission to call with questions

Daily check-ins

An additional strategy to achieving caregiver engagement identified by play therapists was to utilize basic counseling skills with caregivers:

Rapport building

Relationship building

Listening

Support and empathy

Last, participants identified linking caregivers to resources as a way to achieve caregiver engagement:

Collaborating with others involved in the case

Provide suggestions to parents for additional support

Provide link to other services

Resources in the waiting room

In response to the request to identify their top 3 strategies to achieve caregiver engagement, participants shared the opinion that providing education, exercising communication, utilizing counseling skills, and linking caregivers to additional resources is vital to successful

caregiver engagement. Many specific strategies were identified by participants, with a total of 404 separate entries to item 22.

Research Question 4

The fourth research question asked what type of training specific to working with caregivers play therapists have received in educational programs, work settings, and continuing education experiences. Descriptive statistics were calculated on survey responses to items 12 (training specific to working with caregivers received in graduate programs) and 14 (training specific to working with caregivers received in workshops and special institutes). Descriptive statistics were calculated for responses to item 12, which asked play therapists to respond to the statement "I received training specific to working with caregivers in my graduate program" by selecting strongly agree, disagree, somewhat disagree, neither agree or disagree, somewhat agree, agree, or strongly agree. A lower mean indicates a disagreement with the statement regarding training specific to working with caregivers in graduate programs. The mean response to item 12 from the 425 participants who responded was "neither agree nor disagree" (M=3.86, SD=2.00). This indicates that participants had a neutral opinion about the training they received in their graduate programs specific to working with caregivers. Descriptive statistics were also calculated for responses to item 14, which asked play therapists to respond to the statement "I received training specific to working with caregivers during play therapy specific workshops or institutes" by selecting strongly disagree, disagree, somewhat disagree, neither agree or disagree, somewhat agree, agree, or strongly agree. A higher mean indicates stronger agreement with the statement "I received training specific to working with caregivers during play therapy specific workshops or institutes." Participants (n=437) responded that they somewhat agreed (M=4.94, SD=1.76).

The results indicated that play therapists reported receiving more training specific to working with caregivers in play therapy workshops or special institutes than in their graduate programs. Even so, participants only somewhat agreed with the statement "I received training specific to working with caregivers during play therapy specific workshops or institutes," suggesting that play therapists who took this survey did not believe that they received adequate education for working with caregivers in their graduate programs or workshops/ institutes. Descriptive statistics for items 12 and 14 are presented in Table 17.

Table 17
Play Therapists' Education and Training for Working with Caregivers by Frequency, Means, and Standard Deviations

Item	*n*	*M*	*SD*
Please respond to the following statements regarding educational preparation for working with caregivers.			
12. I received training specific to working with caregivers in my graduate program.	425	3.86	2.00
14. I received training specific to working with caregivers during play therapy specific workshops or institutes.	437	4.94	1.76

Note. Likert scale included 1=Strongly disagree, 4-Neither agree or disagree, 7=Strongly agree

Research Question 5

Research question 5 asked about the relationship between play therapists' primary worksite and their practice patterns in relation to caregiver engagement. A chi-square analysis was used to answer this research question. Item 4 (primary worksite) was used to assess the association of item 17, which asked play therapists to respond to the statement "my theoretical orientation influences my approach to working with caregivers in play therapy" by selecting one of the following options, including strongly agree, disagree, somewhat disagree, neither agree or disagree, somewhat agree, agree, or strongly agree.

Using a conservative *p* level of .01, no statistical significance was found between play therapists' primary worksite and their use of theoretical orientation in their approach to working

with caregivers. Worksite did not appear to impact play therapists' use of theoretical orientation in their work with caregivers of their child clients. Results are shown in Table 18.

Table 18

Chi-square Analyses of Primary Worksite Between Practice Patterns of Play Therapists

	Influence of Theoretical Approach on Caregiver Engagement Strategies									
Variables	Strongly disagree	Disagree	Somewhat disagree	Neither agree or disagree	Somewhat agree	Agree	Strongly agree	*n*	x^2	ρ
Worksite									24.83	0.92
School	0	2	1	3	8	16	8	45		
Community agency	1	1	4	9	16	49	28	108		
Private practice	1	3	6	10	0.5	89	79	223		
Psychiatric hospital	0	0	0	0	0	1	1	2		
Medical hospital	0	0	0	0	1	1	0	2		
University	0	1	2	1	8	6	11	29		
Other	0	1	0	1	7	9	8	23		

A chi-square analysis was used to assess the association between item 4, primary worksite, and item 23, which asked play therapists about the frequency with which they use various forms of communication with caregivers. Using a conservative *p* level of .01, no statistical significance was found between the use of face-to-face consultation between caregiver and play therapist, telephone consultation between caregiver and play therapist, video conference between caregiver and play therapist, and structured feedback form completed by caregiver about their child's progress and continued challenges in play therapy and worksites. Statistical significance was found only in the use of email (=38.99, *n*=427, <0.00) between worksites. Thus, play therapists' use of email appeared higher in private practice than in all other worksites combined. Results are presented in Table 19.

Table 19
Chi-square Analyses of the Perceived Effectiveness of Email Communication Between Worksites

	Use Email Communication				
Variables	Never Used	Used	*n*	□²	*p*
Worksite				38.96	<0.00
School	14	23	37		
Community agency	53	55	108		
Private practice	46	177	223		
Psychiatric hospital	2	0	2		
Medical hospital	0	2	2		
University	9	20	29		
Other	14	12	26		
Total	138	289	427		

Using a chi-square analysis, item 4 (primary worksite) was used to assess the association of item 25, which asked play therapists about the frequency with which they use play therapy specific educational materials with caregivers of their clients. Participants were asked to select one of the following options: never, less than once a month, 2-3 times a month, once a week, 2-3 times a week, or daily. Responses were collapsed into "never used" or "used at one point." Using a conservative *p* level of .01, no statistical significance was found between play therapists' reported use of play therapy specific educational materials and their worksite.

A chi-square analysis was used to relate item 4 (primary worksite) with item 26, which asked play therapists to respond to the statement "the majority of my play therapy specific educational materials are provided to caregivers via" by selecting either standard packet of information I provide prior to beginning services with all child clients, email exchange of information selected for each individual client, face to face exchange of information selected for each individual client, or other. Participants were allowed to share their responses to "other" in a free form field, and 13 responded. One participant said the question did not apply to him or her by saying "not currently using educational materials." Another participant reported telling the caregiver to use "books and resources I tell them to get and read." Using a conservative *p* level of .01, no statistical significance was found between play therapists' reported method of distribution of play therapy specific educational materials and their worksite. There appears to be no difference in play therapists' method of distribution of play therapy specific materials among various worksites.

Using a chi-square analysis, item 4 (primary worksite) was used to assess the association of item 27, which asked play therapists to select all the strategies they utilize from a list that included: psychosocial assessment, information about caregiver's family of origin, structured

consultation format, tour of your playroom, collateral communication with others involved in child client's treatment plan, caregiver support groups within your worksite, child parent relationship therapy (CPRT) groups within your worksite, and other. Using a conservative *p* level of .01, no statistical significance was found between worksite and psychosocial assessment, information about caregiver's family of origin, structured consultation format, collateral communication with others involved in child client's treatment plan, and other. Statistical significance was found in the use of playroom tour (x^2=32.34, n=420, ρ<0.00) and worksite.

Play therapists' reported differences in the use of playroom tours among worksites; the highest number of participants who indicated they use a playroom tour were play therapists in private practice (46%). Play therapists who were least likely to provide playroom tours were employed at either psychiatric (0%) or medical (0%) hospitals. Results are shown in Table 20.

Worksite appeared to influence the utilization of support groups for caregivers (x^2=20.75, n=420, ρ<0.00). Not many (n=58) play therapists reported that they provided support groups for caregivers at their worksite, regardless of the setting. A low percentage of play therapists that worked in private practice (4%) reported offering caregiver support groups, while a slightly higher number (6%) reported that caregiver support groups were offered at their worksites, community agencies. However, the 25 (6%) participants who worked at community agencies represented the largest positive response in reference to providing support groups to caregivers. Results are shown in Table 21.

Last, statistical significance was found in the use of CPRT groups at worksite (x^2=26.81, n=420, ρ<0.00). Similarly to caregiver support groups, CPRT groups were not frequently offered at the various worksites. Play therapists who worked in community agencies (6%) and private practice (6%) were more likely to offer CPRT groups at their worksite than those who

worked in schools (8%), psychiatric (0%) or medical (0%) hospitals, universities (4%), or other worksites (5%). Results are presented in Table 22.

Table 20
Chi-square Analyses of the Perceived Effectiveness Playroom Tours Between Worksites

	Tour of Playroom				
Variables	No	Yes	*n*	x^2	ρ
Worksite				32.34	<0.00
School	16	21	37		
Community agency	35	70	105		
Private practice	27	193	220		
Psychiatric hospital	1	1	2		
Medical hospital	1	1	2		
University	7	22	29		
Other	8	17	25		
Total	95	325	420		

Table 21
Chi-square Analyses of Utilization of Support Groups Between Worksites

	Support Groups Offered at Worksite				
Variables	No	Yes	*n*	x^2	ρ
Worksite				20.75	0.002
School	30	7	37		
Community agency	80	25	105		
Private practice	202	18	220		
Psychiatric hospital	2	0	2		
Medical hospital	2	0	2		
University	22	7	29		
Other	24	1	25		
Total	362	58	420		

Table 22

Chi-square Analyses of CPRT Groups Between Worksites

	CPRT Groups Offered at Worksite				
Variables	No	Yes	*n*	x^2	p
Worksite				26.82	<0.00
School	34	3	37		
Community agency	81	24	105		
Private practice	194	26	220		
Psychiatric hospital	2	0	2		
Medical hospital	1	1	2		
University	16	13	29		
Other	21	4	25		
Total	349	71	420		

Item 29 asked play therapists if they have a separate room for meeting with caregivers in addition to their playroom. Of the 414 participants who responded, 258 (62%) indicated "yes" and 156 (38%) reported "no." Thus, the majority participants in this study had a room for meeting with caregivers separate from their playroom. Frequency distributions for item 29 for research question 5 are reported in Table 9.

Item 30 asked play therapists to indicate the frequency with which they utilize specific items in the room they meet with caregivers. Item 30 included the Why Play Therapy? brochure, Play Therapy Works! YouTube video, play therapy educational videos, play therapy magazine articles, play therapy specific books, computer with internet access, computer with multimedia capabilities, television with DVD/VCR, culturally sensitive items, and a free form field for other. Likert scale descriptors included never, less than once a month, once a month, once a week, 2-3 times a week, or daily. A chi-square analysis was used to relate item 4 (primary worksite) with item 30 (frequency of play therapists' use of Why Play Therapy? brochure, Play Therapy Works!

YouTube video, play therapy educational videos, play therapy magazine articles, play therapy specific books, computer with internet access, computer with multimedia capabilities, television with DVD/VCR, culturally sensitive items, or other in the room play therapists meet with caregivers.) Using a conservative *p* level of .01, no statistical significance was found between worksite and the use of Why Play Therapy? brochure, Play Therapy Works! YouTube video, play therapy educational videos, play therapy magazine articles, play therapy specific books, computer with internet access, computer with multimedia capabilities, television with DVD/VCR, culturally sensitive items, or other in the room play therapists meet with caregivers. Therefore, there are no notable differences between worksite and play therapists' use of Why Play Therapy? brochure, Play Therapy Works! YouTube video, play therapy educational videos, play therapy magazine articles, play therapy specific books, computer with internet access, computer with multimedia capabilities, television with DVD/VCR, culturally sensitive items, or other in the room they meet with caregivers.

A chi-square analysis was used to examine the association of item 4 (primary worksite) with item 31, which asked play therapists if they have a designated waiting room separate from the room they meet with caregivers. Using a conservative *p* level of <.01, statistical significance was found (x^2=40.74, *n*=413, ρ<0.00) between primary worksite and play therapists' having a waiting room. Play therapists who work in private practice (47%), community agencies (21%), and universities (6%) are more likely to have a waiting room separate from the playroom than those who work in schools (4%), psychiatric hospitals (0%), medical hospitals (0 %), or other worksites (5%).

The results are shown in Table 23.

Table 23

Chi-square Analyses of Separate Waiting Room Between Worksites

		Waiting Room Separate from Playroom				
Variables		Yes	No	*n*	x^2	ρ
Worksite					40.74	<0.00
	School	18	18	36		
	Community agency	88	15	103		
	Private practice	195	22	217		
	Psychiatric hospital	1	1	2		
	Medical hospital	2	0	2		
	University	24	3	27		
	Other	20	6	26		
	Total	348	65	413		

Item 32 asked play therapists to indicate the frequency with which they utilize specific items in their waiting room. Item 32 included the "Why Play Therapy? brochure, Play Therapy Works! YouTube video, play therapy educational videos, play therapy magazine articles, play therapy specific books, computer with internet access, computer with multimedia capabilities, television with DVD/VCR, culturally sensitive items, and a free form field for other. Likert scale descriptors included never, less than once a month, once a month, once a week, 2-3 times a week, or daily. Using a conservative *p* level of .01, no statistical significance was found between worksite and the use of Why Play Therapy? brochure, Play Therapy Works! YouTube video, play therapy educational videos, play therapy magazine articles, play therapy specific books, computer with internet access, computer with multimedia capabilities, television with DVD/VCR, culturally sensitive items, or other in the waiting room.

Research Question 6

Research question 6 asked "is there a relationship between years practicing as a mental health professional and play therapists' perceptions of the factors that influence caregiver

engagement?" A Spearman rho correlation was used to measure the relationships between number of years practicing as a mental health professional and perceived effectiveness of caregiver engagement strategies (Likert scale 1-7) and perceived effectiveness of educational materials (Likert scale 1-7). Because of the multiple correlations, a conservative *p* level of .01 was used as the alpha level. The results indicated a statistically significant, positive relationship between the number of years practicing as a mental health professional and perceived effectiveness of face-to-face communication with caregivers (r=0.16, p<.01). Thus, the more years spent as a mental health professional, the more effective participants perceived face-to-face consultation to be. However, the effect size was small, which may indicate little practical significance. No significant relationships were identified between the perceived effectiveness of telephone, email, video, or a feedback form and the number of years as a mental health professional. Results are presented in Table 24.

No statistically significant relationships were found between years as a mental health professional and play therapists' perceived effectiveness of Why Play Therapy? brochure, Play Therapy Works! YouTube video, play therapy educational videos, play therapy magazine articles, play therapy specific books, computer with internet access, computer with multimedia capabilities, television with DVD/VCR, culturally sensitive items, or other as caregiver engagement strategies. Regardless of experience level, no notable differences were found in participants' perceptions of the effectiveness of various educational items. Results are shown in Table 24.

Table 24

Spearman Rho Correlation Between Years Practicing as a Mental Health Professional and Play Therapists' Perceptions of Caregiver Engagement Strategies

	Years as Mental Health Professional	
Items	*rs*	*p*
24. Indicate your perception of the effectiveness of the following forms of communication		
Face-to-face	0.16	0.01
Telephone	0.11	0.03
Email	0.03	0.62
Video	-0.02	0.71
Feedback Form	0.05	0.37
33. Indicate your perception of the effectiveness of the following caregiver engagement strategies		
Why Play Therapy? brochure	0.03	0.58
Play Therapy Works! YouTube Video	-0.01	0.86
Play Therapy Videos	0.03	0.63
Play Therapy Articles	0.09	0.12
Play Therapy Books	0.12	0.03
Internet	-0.07	0.24
Computer	-0.09	0.12
TV	0.04	0.46
Cultural	0.00	0.93
Other	0.06	0.60

*□<.o1

Research Question 7

Research question 7 asked about the relationship between perceived ability to facilitate caregiver engagement and use of caregiver engagement strategies. A Spearman rho correlation was used to answer this research question. Item 20 (perceived ability to facilitate caregiver engagement) was used to assess the association of item 17, which asked play therapists the degree to which their theoretical orientation influences their approach to caregiver engagement, item 23, which asked play therapists to identify the frequency in which they utilize various forms of communication, item 25, which asked play therapists about the frequency with which they use

play therapy specific educational materials with caregivers of their clients, item 27, which asked play therapists to select the strategies they utilize for caregiver engagement from a list including item 29, which asked play therapists if they have a separate room for meeting with caregivers in addition to their play room, item 30, which asked play therapists to indicate the frequency with which they utilize specific items in the room they meet with caregivers, item 31, which asked play therapists if they have a designated waiting room separate from the room they meet with caregivers, and item 32, which asked play therapists to indicate the frequency with which they use specific items in their waiting room. The results indicated a statistically significant, positive relationship between play therapists' perceived ability to facilitate caregiver engagement and their theoretical orientation (r=0.22, p<.01), their use of telephone communication(r=0.13, p<.01), email communication(r=0.15, p<.01) and other (r=0.17, p<.01) strategies. Therefore, the more effective a participant perceived himself/herself at facilitating caregiver engagement, the more likely the participant was to be influenced by his or her theoretical orientation in their work with caregivers, and the more likely to communicate with caregivers through telephone or email consultation. All of these effect sizes are rather small, which may signify few practical implications. Results are detailed in Table 25.

Table 25

Correlations between Perceptions, Education, Worksite and Strategies Implementation

Item	Perceived Ability to Facilitate Caregiver Engagement	Mental Health Degree	Number of Credentials	RPT/ RPT-S	Graduate Level Play Therapy Class	Continuing Education Hours in Play Therapy	Caregiver Room	Waiting Room	Mandated Clients
Theoretical Orientation	0.22*	0.02	0.01	0.12	0.1	0.08	-0.15*	-0.05	0.01
Face-to-Face	0.11	0.16*	-0.03	0.04	0.02	0.13*	0.01	-0.16*	-0.01
Telephone	0.13*	0.07	-0.01	-0.01	-0.03	0.07	-0.1	-0.01	-0.03
Email	0.15*	0.01	-0.06	-0.01	0.03	0.01	0.03	-0.02	-0.04
Video Conference	0.05	0.12	0.11	-0.05	0.03	0.09	0.01	0.03	0.03
Feedback Form	-0.01	0.03	0.09	-0.03	0.03	-0.04	-0.06	-0.03	0.1
Play Therapy Educational Materials	0.07	0.13*	0.07	0.10	0.14*	0.12	-0.04	-0.01	0.03
Psychosocial Assessment	0.06	-0.05	-0.05	0.04	-0.05	0.07	-0.03	-0.12	0.06
Information About Caregiver's Family	0.06	-0.05	0.02	0.10	0.07	0.03	-0.10	-0.05	0
Structured Consultation	0.02	0.06	-0.01	0.08	0.02	0.08	-0.08	-0.08	0.05
Playroom Tour	0.09	0.07	0.05	0.09	-0.05	0.16*	-0.12	-0.19*	-0.17
Collateral Contacts	0.12	0.06	0.1	0.09	-0.04	0.14	-0.04	-0.01	0.09

Table 25 continued

Correlations between Perceptions, Education, Worksite and Strategies Implementation

Item	Perceived Ability to Facilitate Caregiver Engagement	Mental Health Degree	Number of Credentials	RPT/ RPT-S	Graduate Level Play Therapy Class	Continuing Education Hours in Play Therapy	Caregiver Room	Waiting Room	Mandated Clients
Caregiver Support Groups	0.03	0.07	0.02	0.04	0.08	-0.09	-0.05	-0.03	0.16*
CPRT Groups	0.07	0.08	0.04	0.02	0.07	0.09	-0.17	-0.1	-0.03
Other Strategy	0.17	0.08	0.02	0.03	0.01	-0.11	-0.05	-0.01	-0.04
Worksite Has CG Room	0.00	-0.06	-0.03	-0.07	-0.01	-0.12		0.22	0.01
Brochure in CG Room	-0.06	-0.01	0.02	0.1	0.13	0.21		0.01	-0.02
YouTube Video in CG Room	0.08	0.08	0.01	0.11	0.01	0.11		-0.12	-0.04
Play Therapy Video in CG Room	0.03	0.06	0.12	0.18	0.15	0.13		-0.13	-0.02
Play Therapy Articles in CG Room	0.02	-0.05	0.05	-0.06	0.11	0.05		-0.08	-0.03
Play Therapy Books in CG Room	0.07	0.03	0.08	-0.01	0.13	0.04		-0.13	-0.03
Internet in CG Room	0.04	-0.02	-0.04	-0.05	0.08	0		-0.12	-0.03

Table 25 continued

Correlations between Perceptions, Education, Worksite and Strategies Implementation

Item	Perceived Ability to Facilitate Caregiver Engagement	Mental Health Degree	Number of Credentials	RPT/ RPT-S	Graduate Level Play Therapy Class	Continuing Education Hours in Play Therapy	Caregiver Room	Waiting Room	Mandated Clients
Computer in CG Room	0.05	0.00	-0.06	0.01	0.02	0.07		-0.19	-0.01
TV/DVD in CG Room	0.09	0.07	0.1	0.06	0.17	0.1		-0.17	0.08
Culturally Sensitive Items in CG Room	0.03	-0.02	-0.04 .	0.05	0	0.04		-0.15	0.01
Other in CG Room	-0.02	0.02	0.24	-0.14	0.01	0.38		0.06	0.43
Worksite Has WR	-0.10	0.07	0.04	-0.1	0	-0.06	0.22		0.1
Brochure in WR	0.05	0.10	-0.02	0.12	0.04	0.19	-0.01		-0.02
YouTube Video in WR	0.03	0.04	-0.06	0.08	0.14	-0.03	0.01		0.07
Play Therapy Video in WR	-0.04	0.06	0.12	0.15	0.14	0.08	-0.09		0.04
Play Therapy Articles in WR	-0.04	0.06	-0.03	0.04	0.12	0.03	-0.01		-0.02

Table 25 continued

Correlations between Perceptions, Education, Worksite and Strategies Implementation

Item	Perceived Ability to Facilitate Caregiver Engagement	Mental Health Degree	Number of Credentials	RPT/ RPT-S	Graduate Level Play Therapy Class	Continuing Education Hours in Play Therapy	Caregiver Room	Waiting Room	Mandated Clients
Play Therapy Books in WR	0.03	0.12	-0.05	0.02	0.07	0.02	0.05		0.01
Internet in WR	-0.07	-0.05	-0.08	-0.01	0.05	0.01	0.18		-0.03
Computer in WR	-0.10	-0.07	-0.03	-0.05	0.02	-0.05	0.15		-0.03
TV/DVD in WR	0.00	0.01	0.03	0.08	0.09	-0.01	-0.12		-0.01
Culturally Sensitive Items in WR	0.10	0.07	-0.05	0.02	0.12	0	0.14		0.08
Other in WR	0.11	0.21	-0.07	-0.12	-0.19	0.04	0.23		0.06

Note. CG=caregiver; WR=waiting room; * □< .01

Research Question 8

The eighth research question asked participants about the level of formal play therapy training they received. Descriptive statistics were calculated on 417 survey responses to item 10, number of graduate level courses taken in play therapy (3 credit hours or 67.5 play therapy specific hours). Play therapists who responded to item 10 were asked to select either 0, 1, 2, 3, 4, 5 or more than 5 courses. Responses were collapsed into two categories, "has taken at least one play therapy course" and "has not taken a play therapy course." The majority of respondents (65%) had taken at least one graduate level play therapy course, while 35% reported that they had taken no graduate level play therapy courses. Item 13, which asked the number of continuing education hours obtained through play therapy workshops or special institutes, included zero- 100 as choices. Answers ranged from 1-100 (n=417, M=33.76, SD=25.75). Thus, the average participant received roughly 34 hours of play therapy education in workshops or special institutes in the past two years. It appears that play therapists received more training in workshops or special institutes than in graduate training programs. Responses are shown in Table 26.

Table 26
Participant Play Therapy Training by Frequency or Means and Standard Deviations

Item	Variable	n	%	*M*	*SD*
10. Number of Play Therapy Graduate Level Courses					
	None	145	35%		
	At Least One	272	65%		
	Totals	417	100%		
13. Number of continuing education hours attended in the past two years.				33.76	25.75

Research Question 9

Research question 9 asked about the differences in number of credentials obtained and use of caregiver engagement strategies by play therapists. Item 7 (number of credentials obtained) was compared using a chi-square analysis to items item 17, which asked play therapists the degree to which their theoretical orientation influences their approach to caregiver engagement, item 23, which asked play therapists to identify the frequency in which they utilize various forms of communication, item 25, which asked play therapists about the frequency with which they use play therapy specific educational materials with caregivers of their clients, item 27,which asked play therapists to select the strategies they utilize for caregiver engagement from a list, item 29, which asked play therapists if they have a separate room for meeting with caregivers in addition to their play room, item 30, which asked play therapists to indicate the frequency with which they utilize specific items in the room they meet with caregivers, item 31, which asked play therapists if they have a designated waiting room separate from the room they meet with caregivers, and item 32, which asked play therapists to indicate the frequency with which they use specific items in their waiting room.

No statistical significance was found between play therapists' number of credentials and their use of caregiver engagement strategies. Thus, play therapists who had multiple credentials did not appear to utilize different caregiver engagement strategies than those who just had one credential. A conservative alpha level of .01 was used, and results are illustrated in Table 25.

Research Question 10

The tenth research question asked about the relationship between play therapists' sex and use of caregiver engagement strategies. Males comprised only 6% of the sample. Due to the preponderance of female respondents (94%), no statistical significance was expected between

sex and the use of caregiver engagement strategies. No statistical tests were calculated for research question ten.

Research Question 11

Research question 11 asked about the relationship between play therapists' level of education and their use of caregiver engagement strategies. Using a Spearman rho correlation, item 6 (highest mental health degree earned) was compared to item 17, which asked play therapists the degree to which their theoretical orientation influences their approach to caregiver engagement, item 23, which asked play therapists to identify the frequency in which they utilize various forms of communication, item 25, which asked play therapists about the frequency with which they use play therapy specific educational materials with caregivers of their clients, item 27,which asked play therapists to select the strategies they utilize for caregiver engagement from a list, item 29, which asked play therapists if they have a separate room for meeting with caregivers in addition to their play room, item 30, which asked play therapists to indicate the frequency with which they utilize specific items in the room they meet with caregivers, item 31, which asked play therapists if they have a designated waiting room separate from the room they meet with caregivers, and item 32, which asked play therapists to indicate the frequency with which they use specific items in their waiting room. The results indicated a statistically significant, positive relationship between play therapists' highest mental health degree earned and their use of face-to-face consultation (r=0.16, p<.01), and their use of play therapy educational materials (r=0.13, p<.01). Therefore, the more education play therapists had, the more likely they were to use face-to-face consultation and play therapy specific educational materials. Again, these effect sizes are small, which may suggest low practical significance. Results are detailed in Table 25.

Research Question 12

Research question 12 asked about the relationship between play therapists' training status (had achieved status as either registered play therapist or registered play therapist supervisor) and their use of caregiver engagement strategies. A Spearman rho correlation was used to compare item 9 (play therapy training status) with item 17, which asked play therapists the degree to which their theoretical orientation influences their approach to caregiver engagement, item 23, which asked play therapists to identify the frequency in which they utilize various forms of communication, item 25, which asked play therapists about the frequency with which they use play therapy specific educational materials with caregivers of their clients, item 27, which asked play therapists to select the strategies they utilize for caregiver engagement from a list, item 29, which asked play therapists if they have a separate room for meeting with caregivers in addition to their play room, item 30, which asked play therapists to indicate the frequency with which they utilize specific items in the room they meet with caregivers, item 31, which asked play therapists if they have a designated waiting room separate from the room they meet with caregivers, and item 32, which asked play therapists to indicate the frequency with which they use specific items in their waiting room.

The results indicated a statistically significant, positive relationship between play therapists who hold certification as either a RPT or RPT-S and their use of play therapy specific videos in the room they meet with caregivers (r=0.18, p<.01), and their use of play therapy specific videos in their waiting room (r=0.15, p<.01). Thus, play therapists who had achieved status as either RPT or RPT-S were more likely to use play therapy videos to promote caregiver engagement. However, both of these effect sizes are low, which may point to low practical significance. Results are presented in Table 25.

Research Question 13

Research question 13 asked about the relationship between play therapists' formal training in play therapy and their use of caregiver engagement strategies. Spearman rho correlations were used to compare item 10 (has taken at least one graduate level play therapy course) with item 17, which asked play therapists the degree to which their theoretical orientation influences their approach to caregiver engagement, item 23, which asked play therapists to identify the frequency in which they utilize various forms of communication, item 25, which asked play therapists about the frequency with which they use play therapy specific educational materials with caregivers of their clients, item 27,which asked play therapists to select the strategies they utilize for caregiver engagement from a list, item 29, which asked play therapists if they have a separate room for meeting with caregivers in addition to their play room, item 30, which asked play therapists to indicate the frequency with which they utilize specific items in the room they meet with caregivers, item 31, which asked play therapists if they have a designated waiting room separate from the room they meet with caregivers, and item 32, which asked play therapists to indicate the frequency with which they use specific items in their waiting room.

The results indicated a statistically significant, positive relationship between play therapists who have taken at least one graduate level play therapy course and the use of play therapy educational materials (r=0.14, p<.01). Although the effect size is low, the findings suggest that play therapists who have taken at least one graduate level play therapy course use more play therapy specific educational materials than those who have not taken a play therapy graduate level course. No statistical significance was found between taking a graduate level play therapy course and primary theoretical orientation, the frequency in which play therapists utilize

various forms of communication, the frequency with which play therapists use play therapy specific educational materials with caregivers of their clients, the strategies play therapists utilize for caregiver engagement, if play therapists have a separate room for meeting with caregivers in addition to their play room, the frequency with which play therapists utilize specific items in the room they meet with caregivers, if play therapists have a designated waiting room separate from the room they meet with caregivers, or the frequency with which play therapists use specific items in their waiting room. Thus, taking a graduate level play therapy course did not appear to affect play therapists' practice patterns in a statistically significant way. Results are found in Table 25.

Another Spearman rho correlation was used to compare item 13 (approximate number of continuing education hours in play therapy) was compared with item 17, which asked play therapists the degree to which their theoretical orientation influences their approach to caregiver engagement, item 23, which asked play therapists to identify the frequency in which they utilized various forms of communication, item 25, which asked play therapists about the frequency with which they use play therapy specific educational materials with caregivers of their clients, item 27,which asked play therapists to select the strategies they utilize for caregiver engagement from a list, item 29, which asked play therapists if they have a separate room for meeting with caregivers in addition to their play room, item 30, which asked play therapists to indicate the frequency with which they utilize specific items in the room they meet with caregivers, item 31, which asked play therapists if they have a designated waiting room separate from the room they meet with caregivers, and item 32, which asked play therapists to indicate the frequency with which they use specific items in their waiting room. Statistical significance at the .01 level was found between the number of continuing education hours in play therapy and the use of face-to-

face consultation with caregivers (r=0.13, p<.01), playroom tours(r=0.16, p<.01), collateral contacts(r=0.14, p<.01), and the Why Play Therapy? brochure (r=0.21, p<.01) in the room play therapists meet with caregivers and the waiting room (r=0.19, p<.01). Participants who reported higher numbers of continuing education hours in play therapy were more likely to use face-to-face consultation, utilized collateral contacts more often, provided playroom tours more, and were more likely to use the Why Play Therapy? brochure in the room they met with caregivers and their waiting room. All of these effect sizes are small, which likely indicates low practical significance. Results are detailed in Table 25.

Research Question 14

Research question 14 asked about the relationship between play therapists having a dedicated room for meeting with caregivers separate from the playroom and their use of caregiver engagement strategies. A Spearman rho correlation was used to answer this research question. Item 29 (worksite has a separate room for meeting with caregivers in addition to playroom) was used to assess the association of item 17, which asked play therapists the degree to which their theoretical orientation influences their approach to caregiver engagement, item 23, which asked play therapists to identify the frequency in which they utilize various forms of communication, item 25, which asked play therapists about the frequency with which they use play therapy specific educational materials with caregivers of their clients, item 27,which asked play therapists to select the strategies they utilize for caregiver engagement from a list, item 29, which asked play therapists if they had a separate room for meeting with caregivers in addition to their play room, item 30, which asked play therapists to indicate the frequency with which they utilize specific items in the room they meet with caregivers, item 31, which asked play therapists if they have a designated waiting room separate from the room they meet with caregivers, and item 32,

which asked play therapists to indicate the frequency with which they use specific items in their waiting room. Using a conservative alpha level of .01, statistical significance was found between play therapists who had a caregiver meeting room and play therapists who believed their theoretical orientation influenced their approach to caregiver engagement (r=-.15, p<.01), provide CPRT groups at their worksite(r=-.17, p<.01) , and utilize the internet in their waiting room(r=.18, p<.01) . Play therapists who had a caregiver room were less likely to believe their theoretical orientation influences their approach to working with caregivers, less likely to provide CPRT groups, but more likely to utilize the internet for education in their waiting room. However, these are small effect sizes, which may suggest little practical significance considering the weak relationship. Results are found in Table 27.

Table 27

Correlations between Practice Patterns and Caregiver Meeting Room at Worksite

Item	Caregiver Meeting Room at Worksite	
Theoretical Orientation	-0.15	*
Face-to-Face	0.01	
Telephone	-0.10	
Email	0.03	
Video Conference	0.01	
Feedback Form	-0.06	
Play Therapy Educational Materials	-0.04	
Psychosocial Assessment	-0.03	
Information About Caregiver's Family	-0.10	
Structured Consultation	-0.08	
Playroom Tour	-0.12	
Collateral Contacts	-0.04	
Caregiver Support Groups	-0.05	
CPRT Groups	-0.17	*
Other Strategy	-0.05	

Table 27 continued

Correlations between Practice Patterns and Caregiver Meeting Room at Worksite

Item	Caregiver Meeting Room at Worksite	
Worksite Has Waiting Room	0.22	
Brochure in Waiting Room	-0.01	
YouTube Video in Waiting Room	0.01	
Play Therapy Video in Waiting Room	-0.09	
Play Therapy Articles in Waiting Room	-0.01	
Play Therapy Books in Waiting Room	0.05	
Internet in Waiting Room	0.18	*
Computer in in Waiting Room	0.15	
TV/DVD in Waiting Room	-0.12	
Culturally Sensitive Items in Waiting Room	0.14	
Other in in Waiting Room	0.23	

* □< .01

Research Question 15

Research question 15 asked about the relationship between play therapists having a dedicated waiting room and their use of caregiver engagement strategies. A Pearson correlation was used to answer this research question. Item 31 (worksite has a separate waiting room for meeting with caregivers in addition to playroom) was used to assess the association of item 17, which asked play therapists the degree to which their theoretical orientation influences their approach to caregiver engagement, item 23, which asked play therapists to identify the frequency in which they utilize various forms of communication, item 25, which asked play therapists about the frequency with which they use play therapy specific educational materials with caregivers of their clients, item 27,which asked play therapists to select the strategies they utilize for caregiver engagement from a list, item 29, which asked play therapists if they have a separate room for meeting with caregivers in addition to their play room, item 30, which asked play

therapists to indicate the frequency with which they utilize specific items in the room they meet with caregivers, item 31, which asked play therapists if they had a designated waiting room separate from the room they meet with caregivers, and item 32, which asked play therapists to indicate the frequency with which they used specific items in their waiting room.

A significant, negative relationship was found between play therapists who had a waiting room at their worksite, the use of face-to-face consultation with a caregiver (r=-.16, p<.01) and play therapists who provided caregivers with a playroom tour (r=-.19, p<.01). Therefore, play therapists who had a waiting room at their worksite were less likely to use face-to-face consultation or provide caregivers with a playroom tour. The effect sizes are small, so the weak relationship may indicate low practical significance.

A positively significant relationship was found between play therapists who had a waiting room at their worksite and also had a separate room other than their playroom for meeting with caregivers (r=.22, p<.01). Thus, play therapists who had a waiting room at their worksite were more likely to have a separate room for meeting with caregivers as well. These are all small effect sizes suggesting a weak relationship between these three play therapist practice patterns and the existence of a waiting room at the worksite. Results are presented in Table 28.

Table 28

Correlations between Practice Patterns and Waiting Room at Worksite

Item	Waiting Room	
Theoretical Orientation	-0.05	
Face-to-Face	-0.16	*
Telephone	-0.01	
Email	-0.02	
Video Conference	0.03	
Feedback Form	-0.03	
Play Therapy Educational Materials	-0.01	

Table 28 continued

Correlations between Practice Patterns and Waiting Room at Worksite

Item	Waiting Room	
Psychosocial Assessment	-0.12	
Information About Caregiver's Family	-0.05	
Structured Consultation	-0.08	
Playroom Tour	-0.19	*
Collateral Contacts	-0.01	
Caregiver Support Groups	-0.03	
CPRT Groups	-0.10	
Other Strategy	-0.01	
Worksite Has Caregiver Room	0.22	*
Brochure in Caregiver Room	0.01	
YouTube Video in Caregiver Room	-0.12	
Play Therapy Video in Caregiver Room	-0.13	
Play Therapy Articles in Caregiver Room	-0.08	
Play Therapy Books in Caregiver Room	-0.13	
Internet in Caregiver Room	-0.12	
Computer in Caregiver Room	-0.19	*
TV/DVD in Caregiver Room	-0.17	
Culturally Sensitive Items in Caregiver Room	-0.15	
Other in Caregiver Room	0.06	

* □< .01

Research Question 16

Research question 16 asked play therapists to identify their top three barriers to achieving caregiver engagement. Descriptive survey statistics were calculated on survey responses to item 34 (top three perceived barriers to achieving caregiver engagement). Play therapists' responses identified financial concerns (51%), caregiver's lack of education about play therapy (54%), and clients who are mandated by an outside party to receive services (40%) as the top three barriers to achieving caregiver engagement. Barriers of less concern were lack of rapport (27%) and

multicultural competence of the play therapist (6%). Participants were invited to share their responses to "other" in a free form field, and 31% of participants responded. Many responses appeared to be related to the barriers identified in item 34, but were just more specific. For example, one participant said "limited insurance or EAP," which could fit into the barrier of caregiver's financial concerns. However, several participants commented that their largest barrier was the caregiver's motivation to engage, attitude toward play therapy, or time constraints, which were not choices given in item 34. Specific responses included:

resistance of caregiver to implement change

caregiver's own mental health issues or ability to trust

lack of motivation by parent

early disengagement when the primary symptoms are extinguished

caregiver apathy

work load/job of caregiver; busyness of child/family; "advice" from friends, family, culture

caregiver claims they've no time, no energy, verbally agreeing to do something but did not follow through

caregiver's excessive deference to therapist as "expert"

Results of the data are shown in frequency distributions in Table 29.

Table 29
Participants' Perceived Barriers to Caregiver Engagement by Frequency

Item 34	n	%
Barriers		
Financial concerns	219	51
Lack of education about play therapy	230	54
Transportation	153	36
Lack of rapport	118	27
Mandated client	173	40
Multicultural competence of play therapist	27	6
Other	135	31

Note. Because respondents were asked to mark their top three barriers, totals for the frequencies exceed the total number of respondents.

Research Question 17

Research question 17 asked "what methods have play therapists used to overcome their top three barriers to implementing achieving caregiver engagement?" Participants listed their top three perceived barriers to achieving caregiver engagement in a free form field. All responses were collapsed because participants were not asked to rank order their responses. Play therapists' responses were used to develop the following themes: provide education, exercise communication, utilize counseling skills, offer financial assistance, and link to resources.

Participants shared responses regarding using education as a means to overcome their identified barriers to achieving caregiver engagement:

> *Give them the brochure on play therapy to educate them while also explaining how play therapy works in the intake session*
>
> *Watching instructional videos*

Role play

Participants suggested that they were able to overcome barriers to caregiver education by educating caregivers about play therapy through the use of brochures, videos, and role play. Play therapists also identified using communication to overcome barriers to caregiver engagement, and their responses included:

Clear and open communication

Phone calls when caregiver is not able to attend

Direct discussion of need for their participation

Provide many ways of communication

In this study, participants believed communication was effective in overcoming barriers to caregiver engagement, and suggested that being open to many forms of communication, including the telephone, was helpful. An additional way to overcome barriers that was identified by play therapists was to utilize basic counseling skills with caregivers, and responses included:

Empathy

Focus on rapport with parent

Be non-judgmental

Unconditional positive regard

Play therapists in this study reported that relying on their basic counseling skills (empathy, rapport building, being non-judgmental, and demonstrating unconditional positive regard) led to more success with caregiver engagement, and was especially helpful in overcoming barriers. Additionally, participants noted financial assistance as a way to overcome perceived barriers to caregiver engagement:

Find financial assistance

Work with them on reduced payments (reduced fees/payment plans)

Reduce fees

Offer bus tokens

Participants stated that financial assistance in the form of bus tokens, flexible payment plans, and linkage to outside financial resources was helpful in overcoming barriers to caregiver engagement. Finally, participants identified linking caregivers to resources as a way to overcome perceived barriers to caregiver engagement:

Help parent connect to community resources

Team approach

Link for other services

Make resources available in the waiting room

Play therapists were asked to list their top three methods for overcoming barriers to achieving caregiver engagement in a free form field. Communication, utilization of basic counseling skills, provision of financial assistance, and linkage to resources were themes that emerged from participants' responses.

Research Question 18

Research question 18 asked, "is there a relationship between the type of population served and the use of caregiver engagement strategies?" A Spearman rho correlation was used to compare item 18, percentage of client base required by an outside party to seek mental health services, with item 17, which asked play therapists the degree to which their theoretical orientation influences their approach to caregiver engagement, item 23, which asked play therapists to identify the frequency in which they utilize various forms of communication, item 25, which asked play therapists about the frequency with which they used play therapy

specific educational materials with caregivers of their clients, item 27, which asked play therapists to select the strategies they utilized for caregiver engagement from a list, item 29, which asked play therapists if they had a separate room for meeting with caregivers in addition to their play room, item 30, which asked play therapists to indicate the frequency with which they utilized specific items in the room they meet with caregivers, item 31, which asked play therapists if they had a designated waiting room separate from the room they meet with caregivers, and item 32, which asked play therapists to indicate the frequency with which they used specific items in their waiting room. Only one positively significant relationship was found between percentage of mandated clients and the use of caregiver support groups at play therapists' worksites. (r=.16, p<.01). Thus, play therapists who reported a higher percentage of mandated clients were more likely to offer caregiver support groups at their worksite. However, this is a small effect size, thereby suggesting a weak relationship between the two variables. No significant relationships were discovered between the other caregiver engagement strategies and the percentage of play therapists' client population that were mandated for services.

Research Question 19

The nineteenth research question asked, "what do play therapists identify as their primary theoretical orientation?" Descriptive survey statistics were calculated on survey responses to item 16 (primary theoretical orientation). Of the 404 respondents, the majority (58%) indicated child-centered play therapy as their theoretical orientation. Very few play therapists indicated psychoanalytic play therapy (3%) or ecosystemic play therapy (2%) as their theoretical orientation. Thus, more child-centered play therapists responded to this survey than play therapists who identified with other theoretical orientations. Results of the data are shown in frequency distributions in Table 30.

Table 30

Frequency Distribution of Participant Theoretical Orientation

Item	*n*	%
16. Primary Theoretical Orientation		
Child Centered Play Therapy	269	58
Cognitive Behavioral Play Therapy	42	9
Gestalt Play Therapy	14	3
Ecosystemic Play Therapy	8	2
Psychoanalytic Play Therapy	12	3
Adlerian Play Therapy	41	9
Jungian Play Therapy	18	4
Totals	404	88

Research Question 20

Research question 20 asked, "does theoretical orientation influence play therapists' approach to achieving caregiver engagement in play therapy?" Analysis of variance was used to compare item 16 (primary theoretical orientation) with item 17 (influence of theoretical orientation on approach to achieving caregiver engagement in play therapy.) Table 30 reflects the results of the comparisons. Using a conservative alpha level of $p<.01$, statistical significance was found ($F=5.03$, $p<.001$) between theoretical orientation and play therapists' perceptions of the influence of their theoretical orientation on their approach to caregiver engagement. Thus, there were differences between various theoretical orientations and the influence of theoretical orientation on play therapists' work with caregivers. Specifically, ecosystemic play therapists ($M=6.88$, $SD=.35$) and play therapists who identified with "other" theoretical orientations ($M=6.43$, $SD=.95$) reported that they believed their theoretical orientation influenced their approach with caregivers more than cognitive behavioral play therapists ($M=5.80$, $SD=1.11$), child centered play therapists ($M=5.76$, $SD=1.12$), gestalt play therapists ($M=5.50$, $SD=1.09$),

psychoanalytic play therapists (*M*=5.33, *SD*=1.50), Adlerian play therapists (*M*=5.86, *SD*=1.23), and Jungian play therapists (*M*=5.12, *SD*=1.73). Results are shown in Table 31.

Table 31
Analysis of Variance for Play Therapists' Therapeutic Orientation and Approach to Caregiver Engagement

Source	*SS*	*df*	*MS*	*F*
Between groups	45.57	7	2.192	5.03*
Within Groups	544.97	421	1006.54	
Total	590.54	428	1003.92	

**=p<.001*

Summary of the Findings

The results of the data gathered through the *CEI* are summarized below. Included in the discussion are survey responses to items 1-36, which were used to answer the twenty research questions posed in this exploratory study.

The first research question asked the practice patterns of play therapists when working with a caregiver to achieve caregiver engagement. The results (*M*=5.84, *SD*=1.17) indicated that play therapists agree that their theoretical orientation influences their approach to caregiver engagement. Overall, play therapists reported that the most frequently utilized form of communication was face-to-face consultation (*M*=4.36, *SD*=1.26) 2-3 times per month. In this study, 111 (27%) play therapists reported they use play therapy specific materials with caregivers 2-3 times a month. Most participants 306 (73%) indicated that they distributed those materials through face to face exchange of information, while the least utilized way to provide play therapy specific educational materials was email exchange, selected by 7 (2%) participants.

The top three most utilized strategies identified by participants were collateral communication (358 participants), information about caregiver's family of origin (344 participants), and psychosocial assessment (340 participants). The least utilized techniques were caregiver support groups (58 participants) and Child Parent Relationship (CPRT) groups (71 participants).

Of the 414 participants who answered item 29 , which asked whether participants had a room for meeting with caregivers separate from their caregiver room, 258 (62%) reported yes, and 156 (38%) reported no. The most frequently used item by play therapists in the room they meet with caregivers was the Why Play Therapy? brochure (M=3.11, SD=2.03) and the item used least often was play therapy educational materials (M=1.77, SD=1.34).

Question 31 asked if play therapists have a designated waiting room at their worksite. Of the 416 participants who responded, 350 (84%) selected yes, and 66 (16%) selected no. Again, the most frequently used item in the waiting room was the Why Play Therapy? brochure (M=3.47, SD=2.63). The item used the least by play therapists in their waiting room was a computer with multimedia capabilities (M=1.21, SD=1.25).

The second research question asked play therapists' perceptions of various practice patterns as they relate to achieving caregiver engagement. Descriptive survey statistics were calculated on survey responses to item 21, which asked play therapists to indicate their opinion about whether or not caregiver engagement is related to the therapeutic outcome for the child client. Of the 424 respondents who answered, the majority (69%) "strongly agreed" with the statement "I believe caregiver engagement is related to the therapeutic outcome for the child client."

Item 24 asked play therapists to indicate their perception of the effectiveness of various communication strategies as they relate to caregiver engagement. Overall, play therapists found face-to-face consultation to be very effective (*M*=6.52, *SD*=.75) and telephone consultation (*M*=6.5.49, *SD*=.93) and email contact (*M*=4.54, *SD*=1.39) to be somewhat effective.

In response to the request to select their top three caregiver engagement strategies, the majority of play therapists selected psychosocial assessment (63%), the second highest number of play therapists selected information about caregiver's family of origin (52%), and the third most selected caregiver engagement strategy was collateral communication (49%).

Item 33 asked play therapists to rate items based on their experience using them in the room they meet with caregivers. Play therapists reported that the most effective item used in the room they meet with caregivers was the Why Play Therapy? brochure (*M*=5.27, *SD*=1.31), while the item perceived least effective was a computer with multimedia capabilities (*M*=1.37, *SD*=1.36).

The third research question asked what play therapists identify as the top three strategies for achieving caregiver engagement. Play therapists were asked to list their top three caregiver engagement strategies in a free form field. Rank order was not used, so all responses were collapsed, and themes were developed. Play therapists' responses were used to develop the following themes: provide education, exercise communication, utilize counseling skills, offer financial assistance, and link to resources.

The fourth research question asked what type of training specific to working with caregivers play therapists have received in educational programs, work settings, and continuing education experiences. For item 12, which asked participants to rate the degree they agreed with the statement "I received training specific to working with caregivers in my graduate program,"

90% of the 418 respondents said they did not receive training as a student specific to working with caregivers. Descriptive statistics were also calculated for responses to item 14, which asked play therapists to respond to the statement "I received training specific to working with caregivers during play therapy specific workshops or institutes." The results showed that a larger number of play therapists received training specific to working with caregivers in play therapy workshops than in their graduate program (M=4.94, SD=1.76). Thus, more education and training specific to working with caregivers was acquired through play therapy workshops and special institutes than formal training programs.

Research question 5 asked about the relationship between play therapists' primary worksite and their practice patterns in relation to caregiver engagement. A chi-square analysis was used to answer this research question. Using a conservative p level of .01, no statistical significance was found between play therapists' primary worksite and their use of theoretical orientation in their work with caregivers. Therefore, participants' worksites did not appear to affect their utilization of their theoretical orientation in their work caregivers. No statistical significance was found between face-to-face consultation between caregiver and play therapist, telephone consultation between caregiver and play therapist, video conference between caregiver and play therapist, and structured feedback form completed by caregiver about their child's progress and continued challenges in play therapy. Statistical significance was found only in the use of email (x^2=38.99, n=427, ρ<0.00) between worksites. Thus, there appeared to be a difference in the amount of email communication used by play therapists among various worksites. No statistical significance was found between play therapists' reported use of play therapy specific educational materials and their worksite. Therefore, no difference was found in the use of play therapy specific educational materials between worksites. Likewise, no difference was found between

play therapists' reported method of distribution of play therapy specific educational materials and their worksite. Similarly, no statistical significance was found between worksite and the use of psychosocial assessment, information about caregiver's family of origin, structured consultation format, collateral communication with others involved in child client's treatment plan, or other. Statistical significance was found in the use of playroom tour (x^2=32.34, n=420, ρ<0.00) and in the use of caregiver support groups at worksite (x^2=20.75, n=420, ρ<0.00). Last, statistical significance was found in the use of CPRT groups at worksite (x^2=26.81, n=420, ρ<0.00). Participants reported differences in the use of playroom tours, CPRT groups, and caregiver support groups among worksites.

Of the 414 participants who indicated whether or not they had a separate room for meeting with caregivers, 258 (62%) indicated "yes" and 156 (38%) reported "no." Item 30 asked play therapists to indicate the frequency with which they utilize specific items in the room they meet with caregivers. Using chi-square analysis and a conservative p level of .01, no statistical significance was found between worksite and the use of Why Play Therapy? brochure, Play Therapy Works! YouTube video, play therapy educational videos, play therapy magazine articles, play therapy specific books, computer with internet access, computer with multimedia capabilities, television with DVD/VCR, culturally sensitive items, or other in the room play therapists meet with caregivers at various worksites. There appeared to be no difference in the use of the aforementioned educational items in the room play therapists met with caregivers among worksites.

In this study, 350 (84%) of participants reported that they had a waiting room at their worksite. A chi-square analysis was used to correlate item 4 with item 31. Using a conservative p level of <.01, statistical significance was found (x^2=40.74, n=413, ρ<0.00) between primary

worksite and play therapists' having a waiting room. Thus, differences were found in the existence of a waiting room among between worksites. Item 32 asked play therapists to indicate the frequency with which they utilize specific items in their waiting room. Using a conservative *p* level of .01, no statistical significance was found between worksite and the use of Why Play Therapy? brochure, Play Therapy Works! YouTube video, play therapy educational videos, play therapy magazine articles, play therapy specific books, computer with internet access, computer with multimedia capabilities, television with DVD/VCR, culturally sensitive items, or other in the waiting room. Thus, there were no differences found in play therapists' use of the educational items above between worksites.

Research question 6 asked, "is there a relationship between play therapists' primary worksite and their practice patterns in relation to caregiver engagement?" A Spearman rho correlation was used to measure the relationships between number of years practicing as a mental health professional and perceived effectiveness of caregiver engagement strategies and perceived effectiveness of educational materials. A conservative *p* level of .01 was used as the alpha level. The results indicate a statistically significant, positive relationship between the number of years practicing as a mental health professional and the use of face-to-face communication with caregivers (r=0.16, p<.01). The more years spent as a mental health professional, the more effective they perceived face-to-face consultation to be. There were no significant relationships identified between telephone, email, video, and a feedback form and the number of years as a mental health professional. No statistically significant relationships were found between years as a mental health professional and perceived effectiveness of Why Play Therapy? brochure, Play Therapy Works! YouTube video, play therapy educational videos, play therapy magazine articles, play therapy specific books, computer with internet access, computer with multimedia

capabilities, television with DVD/VCR, culturally sensitive items, or other as caregiver engagement strategies.

Research question 7 asked about the relationship between perceived ability to facilitate caregiver engagement and use of caregiver engagement strategies. A Spearman rho correlation was used to answer this research question. The results indicated a statistically significant, positive relationship between play therapists' perceived ability to facilitate caregiver engagement and their theoretical orientation (r=0.22, p<.01), their use of telephone communication(r=0.13, p<.01), email communication(r=0.15, p<.01) and other (r=0.17, p<.01) strategies. Play therapists' perceptions of their ability to facilitate caregiver engagement was related to theoretical orientation, their use of the telephone or email to communicate with caregivers, and other strategies.

Next, the eighth research question asked about the level of formal play therapy training that play therapists receive. Descriptive statistics were calculated on 417 survey responses to item 10, and the results showed that the majority of respondents (65%) had taken at least one graduate level play therapy course, while 35% reported that they had taken no graduate level play therapy courses.

Research question 9 asked about the differences in number of credentials obtained and use of caregiver engagement strategies by play therapists. Using a chi-square analysis, no relationship was found between play therapists' number of credentials and their use of caregiver engagement strategies. The number of credentials held by participants did not appear to affect their use of caregiver engagement strategies.

The tenth research question asked about the relationship between play therapists' sex and use of caregiver engagement strategies. Males comprised only 6% of the sample. Due to the

overwhelming majority of female respondents (94%), no statistical significance was expected between sex and the use of caregiver engagement strategies.

Research question 11 asked about the relationship between play therapists' level of education and their use of caregiver engagement strategies. Using a Spearman rho correlation, a statistically significant, positive relationship was found between play therapists' highest mental health degree earned and their use of face-to-face consultation (r=0.16, p<.01), and their use of play therapy educational materials (r=0.13, p<.01). Thus, the more education participants had, the more likely they appeared to be to use face-to-face consultation and play therapy educational materials with caregivers.

Research question 12 asked about the relationship between play therapists' training status and their use of caregiver engagement strategies. Using a Spearman rho correlation, a statistically significant, positive relationship was revealed between play therapists who hold certification as either a RPT or RPT-S and their use of play therapy specific videos in the room they meet with caregivers (r=0.18, p<.01), and their use of play therapy specific videos in their waiting room (r=0.15, p<.01). Therefore, participants who held certification as either an RPT or RPT-S were more likely to use play therapy specific videos with caregivers than those participants who had not earned the credentials.

Spearman rho correlations were used to compare the relationship between play therapists' formal training in play therapy and their use of caregiver engagement strategies. The results indicated a statistically significant, positive relationship between play therapists who had taken at least one graduate level play therapy course and the use of play therapy educational materials (r=0.14, p<.01). Thus, participants in this study who had taken at least one formal graduate level

course in play therapy were more likely to use play therapy specific educational materials than those participants who had not taken any courses.

Another Spearman rho correlation was used to reveal a statistically significant relationship between the number of continuing education hours in play therapy and the use of face-to-face consultation with caregivers (r=0.13, p<.01), playroom tours(r=0.16, p<.01), collateral contacts(r=0.14, p<.01), and the Why Play Therapy? brochure in the room play therapists meet with caregivers (r=0.21, p<.01) and the waiting room (r=0.19, p<.01). It appeared that the more continuing education participants had earned, the more likely they were to use face-to-face consultation and the Why Play Therapy? brochure.

Research question 14 asked about the relationship between play therapists having a dedicated room for meeting with caregivers separate from the playroom and their use of caregiver engagement strategies. A Spearman rho correlation was used, and the existence of a caregiver meeting room at play therapists' worksite was found to be negatively associated with the belief that theoretical orientation influences their approach to caregiver engagement (r=-.15, p<.01), the provision of CPRT groups at play therapists' worksites (r=-.17, p<.01), and the utilization of the internet in play therapists' waiting rooms (r=.18, p<.01). Thus, participants who had a separate room for meeting with caregivers appeared less likely to believe their theoretical orientation influenced their work with caregivers, less likely to provide CPRT groups, and less likely to use the internet in their waiting rooms.

Next, research question 15 asked about the relationship between play therapists having a dedicated waiting room and their use of caregiver engagement strategies. A Pearson correlation was used to answer this research question. A significant, negative relationship was found between play therapists who have a waiting room at their worksite and the use of face-to-face

consultation with a caregiver (r=-.16, p<.01) and play therapists who provide caregivers with a playroom tour (r=-.19, p<.01). Therefore, play therapists who have a waiting room at their worksite were less likely to use face-to-face consultation or provide caregivers with a playroom tour. A positively significant relationship was found between play therapists who have a waiting room at their worksite and also have a separate room other than their playroom for meeting with caregivers (r=.22, p<.01). Thus, play therapists who have a waiting room at their worksite are more likely to have a separate room for meeting with caregivers as well. These are all small effect sizes suggesting a weak relationship between these three play therapist practice patterns and a waiting room at the worksite.

Research question 16 asked play therapists to identify their top three barriers to achieving caregiver engagement. Descriptive survey statistics were calculated on survey responses to item 34 (top three perceived barriers to achieving caregiver engagement). Play therapists' responses identified financial concerns (51%), caregiver's lack of education about play therapy (54%), and clients who are mandated by an outside party to receive services (40%) as the top three barriers to achieving caregiver engagement.

Research question 17 asked "what methods have play therapists used to overcome their top three barriers to implementing achieving caregiver engagement?" Participants listed their top three perceived barriers to achieving caregiver engagement in a free form field. All responses were collapsed because participants were not asked to rank order their responses. Play therapists' responses were used to develop the following themes: provide education, exercise communication, utilize counseling skills, offer financial assistance, and link to resources.

Research question 18 asked, "is there a relationship between the type of population served and the use of caregiver engagement strategies?" A Spearman rho correlation was used to

find a significant, positive relationship between percentage of mandated clients and the use of caregiver support groups at play therapists' worksites (r=.16, p<.01). Play therapists who reported a higher percentage of mandated clients were more likely to offer caregiver support groups at their worksite. This is a small effect size, thereby suggesting a weak relationship between the two variables. No significant relationship was discovered between the other caregiver engagement strategies and the percentage of play therapists' client population that were mandated for services.

The nineteenth research question asked, "what do play therapists identify as their primary theoretical orientation?" Descriptive statistics were calculated on survey responses to item 16. Of the 404 respondents, the majority (58%) indicated child centered play therapy as their theoretical orientation.

Research question 20 asked, "does theoretical orientation influence play therapists' approach to achieving caregiver engagement in play therapy?" Analysis of variance was used to compare item 16 with item 17. Using a conservative alpha level of .01, a significant difference was found between various theoretical orientations and play therapists' reported influence of theoretical orientation when they are working with caregivers in play therapy(F=5.03, p<.001). Thus, there were differences between various theoretical orientations and the influence of theoretical orientation on play therapists' work with caregivers. Specifically, ecosystemic play therapists (M=6.88, SD=.35) and play therapists who identified with "other" theoretical orientations (M=6.43, SD=.95) reported that they believed their theoretical orientation influenced their approach with caregivers more than cognitive behavioral play therapists, child centered play therapists, gestalt play therapists, psychoanalytic play therapists, Adlerian play therapists, and Jungian play therapists.

The results detailed in this chapter are discussed further in Chapter 5. Chapter 5 also includes recommendations for play therapists and educators of mental health professionals, implications for future research, and limitations of the current study.

CHAPTER FIVE

DISCUSSION

Chapter Five includes a summary and discussion of the findings from this study, as well as recommendations for future research. Limitations of the study and implications for play therapists and educators are also provided.

Overview of the Study

The purpose of this study was to examine the perceptions of play therapists who are members of the Association for Play Therapy (APT) as they relate to the factors that influence caregiver engagement in play therapy. Additional purposes of this study were to examine the practice patterns of play therapists and their perceptions of the impact of caregiver engagement on the therapeutic outcome for the child client. This study also sought to determine differences among play therapists based on sex, age, number of credentials held, worksite, theoretical orientation, education, play therapy specific training, and training specific to working with caregivers of child clients. The *Caregiver Engagement Inventory* (CEI), a 36 item, structured and semi-structured instrument developed by me for this research, was electronically distributed to 4854 registered members of APT. Responses were received from 539 participants; 431 were deemed appropriate for inclusion in the study.

This study was based on Haslam and Harris' (2011) study of 295 play therapists regarding their attitudes toward integrating traditional family therapy and play therapy, along with the methods chosen and frequency of involving families in their child's play therapy treatment. Also, the study was influenced by the qualitative pilot study conducted by me (2010) to explore the perceptions of play therapists in Louisiana regarding the main misconceptions and questions caregivers had about play therapy prior to beginning services. Although research has found

caregiver engagement to be a predictor of successful therapeutic outcomes in play therapy, recommendations for practice remain vague (LeBlanc & Ritchie, 1999; Ray et al., 2001). My study was different from existing studies because it explored play therapists' perceptions regarding the factors that influence caregiver engagement and their practice patterns when working to achieve engagement with a caregiver in play therapy. No previous studies have examined the specific interventions clinicians utilize to achieve caregiver engagement in play therapy or their perceptions as to how the identified interventions relate to the outcome for the child client; therefore, no appropriate survey existed for this study. As such, I created the *Caregiver Engagement Inventory* (CEI), specifically for this study to determine the following: (a) the frequency of the use of caregiver engagement strategies by counselors who conduct play therapy; (b) play therapists' formal training in play therapy; (c) play therapists' formal training in working with caregivers of child clients; (d) play therapists' beliefs regarding caregiver engagement strategies; (e) play therapists' incorporation of their theoretical orientation when utilizing caregiver engagement strategies; (f) play therapists' identified barriers to achieving caregiver engagement in play therapy; (g) methods play therapists used to overcome barriers to achieving caregiver engagement in play therapy; (h) the practice patterns utilized by play therapists at their worksite; (i) sex differences in play therapists' practice patterns related to caregiver engagement; (j) the relationship between play therapists' level of education and their practice patterns related to caregiver engagement; (k) the relationship between play therapists' formal training in play therapy and use of play therapy; (l) the relationship between the play therapists' status as a play therapist and practice patterns related to caregiver engagement; (m) the differences in play therapists' number of credentials held as compared to practice patterns for caregiver engagement; (n) the differences in having a designated room for meeting with

caregivers and practice patterns related to caregiver engagement; (o) the differences in having a designated waiting room and practice patterns related to caregiver engagement (p) the relationship between years as a mental health professional and practice patterns related to caregiver engagement; and (q) the relationship between years practicing as a registered play therapist and the practice patterns related to caregiver engagement. Overall, the purpose of this quantitative study was to identify the factors that play therapists believe influence caregiver engagement in play therapy, the utilization of those factors in clinical practice, play therapists' perceptions of how those factors influence caregiver engagement, and play therapists' perceptions of how successful caregiver engagement influences therapeutic outcomes for the child client. In an effort to discover any statistically significant differences in practice patterns or perceptions held, relationships were explored between several variables, including participants' theoretical orientation, level of education, type of worksite they were employed in and play therapy training status. Due to the high number of correlations calculated in this study, a conservative *p* value of .01 was used for all statistical tests to minimize the potential of a Type I error.

Discussion of the Findings

Participants' Practice Patterns and Perceptions

Theoretical orientation.

One of the main objectives of this study was to examine the practice patterns of play therapists, including their incorporation of theoretical orientation into their work with caregivers. Similar to the findings of Lambert et al. (2005), who found that the majority of play therapists who responded to their survey of APT's membership base (67%) reported child centered play therapy as their theoretical orientation, 58% of participants in this study indicated

the same. In like fashion, the majority of respondents (56%) in Ryan, Gomery, and Lacasse's (2002) survey of APT's members said that if they were exposed to play therapy in their graduate coursework or practicum, the model taught was child-centered play therapy. Until now, no studies have further examined the relationship between play therapists' theoretical orientation and their approach to caregiver engagement. Participants were asked to respond to the statement "my theoretical orientation influences my approach to working with caregivers in play therapy." The results (M=5.84, SD=1.17) indicated that play therapists' "agree" that their theoretical orientation influences their approach to caregiver engagement. To illustrate, a participant in this study believed an approach grounded in theory is critical, as evidenced by commenting "essential: training in systems theory, conceptual understanding/ability to structure family therapy, competence skills working w/ adults/parents" in the free form field for item 36, which welcomed additional comments from participants. A statistically significant, positive relationship was found between play therapists' belief that their theoretical orientation influences their approach to caregiver engagement and their perceived ability to facilitate caregiver engagement (r=0.22, p<.01). The more strongly participants agreed that their theoretical orientation guided their work with caregivers, the more prepared they felt to engage caregivers in the process. This finding provides implications for educators who seek to integrate play therapy into their theories courses, and for clinicians who have doubts about their ability to facilitate caregiver engagement. Perhaps a stronger understanding of theory could lead to greater feelings of preparedness for working with caregivers.

Another intent of this study was to examine the differences between play therapists' identified theoretical orientation and their perceptions of the influence of their theoretical orientations on their approaches to working with caregivers. Analysis of variance was used and

a significant difference at the .01 level was found between various theoretical orientations and play therapists' reported influence of theoretical orientation when they are working with caregivers in play therapy (F=5.03, p<.001). For instance, most child-centered play therapists (M=5.76, SD=1.12) agreed with the statement "my theoretical orientation influences my approach to working with caregivers in play therapy," while Jungian (M=5.12, SD=1.73) and psychoanalytic (M=5.3, SD=1.50) play therapists only somewhat agreed. This finding may be influenced by the existence of child parent relationship therapy (CPRT) and filial therapy, both of which are rooted in the foundations of child centered play therapy and are approaches that are well known and widely utilized within the play therapy community. Current literature on other theoretical approaches lacks a comparable strategy for working with caregivers in play therapy, thereby suggesting a need for additional techniques and strategies specific to various theoretical orientations. In spite of this, Cates, Paone, Packman, and Margolis (2006) have acknowledged that approaches to working with caregivers will vary in time spent in therapy, desired involvement of caregivers, and therapeutic goals in relation to the play therapists' theoretical orientation.

Communication strategies.

Moreover, communication between play therapists and caregivers was studied to evaluate the frequency with which play therapists utilized face to-face communication, telephone consultation, email, video conference, and a structured feedback form with a caregiver. Overall, play therapists reported that the most frequently used form of communication was face-to-face consultation (M=4.36, SD=1.26) 2-3 times per month. The results also indicated a statistically significant, positive relationship between the number of years practicing as a mental health professional and play therapists' perceptions of the effectiveness of face-to-face communication

with caregivers (r=0.16, p<.01). The more years spent as a mental health professional, the more effective the participants perceived face-to-face consultation to be. Generally, play therapists found face-to-face consultation to be very effective (M=6.52, SD=.75) and telephone consultation (M=6.5.49, SD=.93) and email contact (M=4.54, SD=1.39) to be somewhat effective. Related to this finding is Haslam and Harris' (2011) study of APT's membership that found 66% of play therapists surveyed regarding their attitudes toward integrating family and play therapy reported feeling very comfortable working with parents independently of their child's play therapy session. An additional 24% of respondents in their study said they were comfortable meeting with caregivers alone, thus supporting the finding in this study--face-to-face consultation is the communication strategy used the most. According to participants in this study, communicating with caregivers through video conference was the least utilized strategy, and 93% said they had never done it.

In spite of this, Day and Schneider (2011), in their experimental study of the outcomes of mental health services provided through distance technology, found therapists' ratings of client participation were higher for video than for face-to-face or audio sessions. Possible reasons given by the researchers were that participants felt a greater sense of safety due to the distance, or that the participants may have simply talked louder or were more physically animated to compensate for perceived technological challenges. Because scheduling conflicts were indicated as barriers in the current study, perhaps the use of video conferencing with caregivers could be a way to overcome these challenges. The mean use of video conference in this study was 1.11 on a 7-point scale, or the equivalent of never; yet, participants reported their perceived effectiveness of the technique with parents as neither effective nor ineffective. One participant said the greatest barrier to caregiver engagement was "caregiver's lack of availability (i.e., other children

with caregiver or someone else transports child to appointments)." Video conferencing could provide play therapists the ability to give and receive feedback from caregivers who are at home or work instead of relying on meeting at the therapists' office. As with any means of electronic communication, however, consideration should be given to limits to confidentiality.

Participants in this study identified their top three caregiver engagement strategies as conducting a psychosocial assessment (63%), obtaining information about the caregiver's family of origin (52%), and engaging in collateral communication (49%). This finding is supported by Ryan, Gomery and Lacasse's (2002) report that 88.5% of participants who responded to their survey of APT's membership reported that their clinical work focuses on family issues, thus obtaining information from a child's caregiver appears to be a critical part of the therapeutic process that play therapists value.

I was surprised by the low number of respondents (29%) who selected playroom tour as one of the top three most effective caregiver engagement strategies as compared the number of participants (78%) who reported that they provide playroom tours at their worksite. It appears that although play therapists in this study provided playroom tours, they did not perceive the practice to make much difference. In my own practice as a play therapist at three separate worksites, my experience was that caregivers requested playroom tours more often than not, so I adjusted my practices accordingly. One participant advised, "give a playroom tour and explain what child is likely to do, what I do, and how that's designed to help them." The reason play therapists in this study chose to provide playroom tours is unknown. Possible hesitations toward providing playroom tours may include time limitations on the part of either caregiver or play therapist, or perhaps the play therapy room is a shared space that is not always available for tours.

Educational materials.

On average, play therapists reported they use play therapy specific educational materials with caregivers of their clients once a week. Of the 421 participants who reported how they distribute such educational items, 306 (73%) indicated that they use face-to-face exchange of information most often, while the least utilized way to provide play therapy specific educational materials was email exchange, selected by 7 (2%) participants. No previous research examined play therapists' practice patterns in relation to educational materials; however, I did not expect that so few participants would report utilization of email to distribute educational materials. The mean age of participants in this study was 48 (M=30.16, SD=12.38) and the range was 23-77, which is similar to Lambert et al.'s (2005) study in which the average participant was 44 years old. While electronic resources are readily available and easily disseminated, access and prevalence of the Internet is a relatively new phenomenon, so perhaps age explains some of the preference for face-to-face communication. Additionally, participants may have had concerns regarding confidentiality of electronic exchange of communication, or their Internet use may have been restricted by their employer.

Participants were asked the frequency with which they used various educational items in both their waiting rooms and the room they met with caregivers. Of the 414 participants who answered, 258 (62%) reported they had a room for meeting with caregivers separate from the playroom. Similarly, of the 416 participants who responded, 350 (84%) reported they had a waiting room. No previous research has examined play therapists' practice patterns in relation to their room for meeting with caregivers or their waiting room. Ray (2011), however, made recommendations for the waiting room regarding size, availability of entertainment appropriate for children, and minimal breakable items such as lamps.

The item used most often in both rooms was the Why Play Therapy? brochure. One participant advised, "give them the brochure on play therapy to educate them while also explaining how play therapy works in the intake session." A 50-pack of full-color brochures is available for $13.00 (APT, 2011) on APT's website, which provides a way to market services and inform caregivers for a modest fee, thus potentially appealing to play therapists more than other items like books or educational videos. Of relevance to the current study, Shuman and Shapiro (2002) conducted an experimental study on the effects of preparing parents for child psychotherapy with a video, video and brochure, or nothing, and they found that the use of a combination approach (informational brochure and video) increased the accuracy of parents' expectations of their child's therapy, but did not ultimately lead to an increase in attendance. In other words, videos appeared to have a greater impact on caregivers' understanding, but that did not necessarily mean they were more likely to continue services. Participants in this study reported very low utilization of multimedia educational strategies; only 35% who stated they used videos in the caregiver room and 18 % used them in the waiting room. The Internet (45%), computers (24%) and televisions (48%) were used by about half of the participants in their caregiver room.

A particularly disappointing finding is the lack of use of the new Play Therapy Works! YouTube video (APT, 2010). A mere 20% of participants reported that they use the YouTube video in their caregiver room, and even fewer (10%) use it in their waiting rooms. Because the video requires Internet access and a computer, perhaps participants were hindered by lack of resources required to use it. Participants' reasons for utilization of particular educational items and methods of distributions were not explored in this study, but insight into play therapists'

decision-making process regarding educational materials may be of interest to APT and its members.

Worksite.

A goal of this study was to explore the relationship between play therapists' primary worksite and their practice patterns in relation to caregiver engagement. Parallels were found between this study's findings of the most common worksites (private practice, 52%; community agency, 25%) and Lambert et al.'s (2005) survey of play therapists; their participants mostly worked in private practice or a community mental health setting.

In particular, an objective of this study was to examine the relationship between play therapists' worksites and their practice patterns in relation to either a caregiver meeting room or waiting room. When asked if they have a separate room for meeting with caregivers in addition to their playroom, 414 participants responded, and 258 (62%) indicated "yes." This number was higher than I expected due to the assumption that space would be an issue for most respondents. No significant relationship was found between play therapists who have a separate room for meeting with caregivers and their practice patterns at various worksites. No statistical significance was found between worksite and the frequency with which play therapists use Why Play Therapy? brochure, Play Therapy Works! YouTube video, play therapy educational videos, play therapy magazine articles, play therapy specific books, computer with internet access, computer with multimedia capabilities, television with DVD/VCR, culturally sensitive items, or other in the room play therapists meet with caregivers. There appears to be no difference among play therapists who work in schools, community agencies, private practices, psychiatric or medical hospitals, or universities in terms of their use of the strategies listed above. Based on the presumed dissimilarity between environments (e.g., private practice vs. psychiatric hospital)

typical of the various worksites, I was surprised that no significant difference was found in play therapists' use of caregiver engagement strategies at various worksites. No previous research has explored the relationship between practice patterns and a separate room for meeting with caregivers.

A chi-square analysis was used to examine the relationship between primary worksite and play therapists having a waiting room. Using a conservative p level of <.01, statistical significance was found (x^2=40.74, n=413, ρ<0.00) between primary worksite and play therapists' having a waiting room. Participants who worked in community agencies (85%) and private practices (90%) were the most likely to have waiting rooms at their worksite. Considering the fact that respondents to this survey were assumed to provide play therapy services to children, an adult would be required to transport them to and from appointments. Therefore, it makes sense that most play therapists had a waiting room available for the next client or for caregivers waiting for their child. No differences were found between worksite and the use of Why Play Therapy? brochure, Play Therapy Works! YouTube video, play therapy educational videos, play therapy magazine articles, play therapy specific books, computer with internet access, computer with multimedia capabilities, television with DVD/VCR, culturally sensitive items, or other in the waiting room. Historically, waiting rooms have been utilized for similar purposes across disciplines; therefore, the fact that there are no differences in the use of caregiver engagement strategies among worksites is not unexpected. No previous research, however, has examined the relationship between play therapists' worksite and their practice patterns in their waiting room. Participants in this study made the following comments regarding their waiting rooms:

Waiting room is shared by other types of offices and is not conducive to children.

Technology in session and waiting room (YouTube vidoes, email, internet) is restricted agency policy.

Waiting rooms seem to be an untapped resource in the quest to increase caregivers' knowledge about play therapy. Depending on availability of resources and worksite acquiescence, videos, books, articles, and brochures could be displayed in the waiting room. Additionally, the time spent in the waiting room could be used to obtain written feedback from caregivers about progress and continued challenges while their children are in their play therapy sessions.

A small, negative relationship was found between the existence of a caregiver meeting room at play therapists' worksite and the belief that theoretical orientation influences their approach to caregiver engagement (r=-.15, p<.01). This is a small effect size, therefore probably does not have many practical implications. In addition, there was a relationship between a caregiver meeting room and the provision of CPRT groups at play therapists' worksites (r=-.17, p<.01). This finding may suggest that play therapists who do not provide CPRT groups at their worksite may not have adequate space to do so. Likewise, a small, negative relationship was found between the existence of a caregiver meeting room at play therapists' worksite and the utilization of the internet in play therapists' waiting rooms (r=.18, p<.01). No previous research has examined the relationship between the existence of a caregiver meeting room at play therapists' worksite with the belief that theoretical orientation influences their approach to caregiver engagement, the provision of CPRT groups at play therapists' worksites, or the utilization of the internet in play therapists' waiting rooms.

A significant, negative relationship was found between play therapists who have a waiting room at their worksite, the use of face-to-face consultation with a caregiver (r=-.16, p<.01) and play therapists who provide caregivers with a playroom tour (r=-.19, p<.01). A positively

significant relationship was found between play therapists who also have a separate room other than their playroom for meeting with caregivers (r=.22, p<.01). These are all small effect sizes suggesting a weak relationship between these three play therapist practice patterns and a waiting room at the worksite.

In the current study, statistical significance was found in the use of playroom tour (x^2=32.34, n=420, ρ<0.00). The majority of participants who worked at community agencies (67%) and private practices (87%) reported that they provide playroom tours. Statistical significance was also found in the use of caregiver support groups at worksite (x^2=20.75, n=420, ρ<0.00). Play therapists in university settings were most likely (24%) to provide caregiver support groups, and those who worked in medical hospitals (0%) were least likely. This finding was surprising as participants who worked in university settings only accounted for 7% of the sample. Last, statistical significance was found in the use of CPRT groups at worksite (x^2=26.81, n=420, ρ<0.00). Play therapists who worked in community agencies (23%) were the most likely to provide CPRT groups. As community agencies typically employ more employees than private practices, and also sometimes have more space, it makes sense that availability to provide CPRT groups would be greater than at other worksites. Group therapy sessions may also cost less than individual caregiver consultations, and clientele at community agencies may have more limited resources than those clients who choose to use private pay or third party payment for their sessions.

Another question posed by this study was "is there a relationship between the type of population served and the use of caregiver engagement strategies?" A significant, positive relationship was found only between percentage of mandated clients and the use of caregiver support groups at play therapists' worksites (r=.16, p<.01). Play therapists who reported a higher

percentage of mandated clients were more likely to offer caregiver support groups at their worksite. This is a small effect size, thereby suggesting a weak relationship between the two variables. No significant relationship was discovered between the other caregiver engagement strategies and the percentage of play therapists' client population that were mandated for services.

Education and training.

In reference to education, the majority of respondents (65%) had taken at least one graduate level play therapy course, while 35% reported that they had taken none. These findings are slightly higher than those of Ryan, Gomery, and Lacasse (2002) who reported that 40% of participants in their survey of APT's members reported being exposed to play therapy content in their graduate coursework. In addition, Ryan, Gomery, and Lacasse found that 29% of their respondents had taken over 150 hours of play therapy continuing education in their lifetimes. Participants in this study reported a mean of 34 (M=33.76, SD=25.75) hours of continuing education in the past two years. Both studies suggest that more play therapy education is obtained through continuing education or workshops/special institutes than in graduate programs. Availability of training is important because, to receive certification as a Registered Play Therapist (RPT), one must satisfy the requirements set forth by APT, including 150 hours of play therapy instruction. Only 56% of the respondents to this survey reported that they held certification as either an RPT or a Registered Play Therapist-Supervisor (RPT-S), which may be attributed to the fact that currently there are only 18 approved centers of play therapy education in the United States (APT, 2011). Educational hours could, however, be attained through approved providers of play therapy education, although access to approved providers is limited. For example, there are only six approved providers of play therapy education in Louisiana.

These findings indicate a need for an increase in play therapy education in graduate training programs, and more access to continuing education. The association appears to have responded to the growing demand by establishing its e-learning center, available through www.a4pt.org.

Education and training appeared to play a role in differences between participants' practice patterns and perceptions of effective caregiver engagement strategies in this study. To illustrate, there was a positive, but small relationship between play therapists' highest mental health degree earned and their use of face-to-face consultation (r=0.16, p<.01), and their use of play therapy educational materials (r=0.13, p<.01). Participants who had earned higher mental health degrees were more likely to use face-to-face consultation and educational materials in their work with caregivers. The majority of participants in this study reported their highest degree earned as a master's (54%), which is lower than Ryan, Gomery, and Lacasse (2002) found (77%). However, 20% of participants in this study reported their highest degree earned as a doctorate, which is similar to the 18% found by Ryan, Gomery, and Lacasse. The differences may be explained by the fact that participants in this study could choose from six options, (currently in master's program, currently in PhD program, master's, master's +30, Doctorate, or other) and Ryan, Gomery, and Lacasse allowed for only three options (master's, Doctorate, or other). Additionally, most participants worked in private practices (52%) or community agencies (25%), which are settings typically conducive to the use of face-to-face meetings and the use of educational strategies with parents.

Relationships were also found between the number of years practicing as a mental health professional and play therapists' perceptions of the effectiveness of caregiver engagement strategies and play therapy educational materials. There was a statistically significant, positive relationship between the number of years practicing as a mental health professional and play

therapists' perceptions of the effectiveness of face-to-face communication (r=0.16, p<.01) and educational materials with caregivers (r=0.13, p<.01). The more years spent as a mental health professional, the more effective they perceived face-to-face consultation and educational materials to be. It may be true that the more time spent as a mental health professional, the more selective play therapists are regarding the practice patterns they believe work, as they have experience to influence their decisions. Moreover, perhaps the longer participants had been mental health professionals, the more confident they were meeting face-to-face with caregivers. On the contrary, there were no significant relationships between participants' perceived effectiveness of telephone, email, video, or a feedback form and the number of years spent as a mental health professional. Likewise, there were no statistically significant relationships between years spent as a mental health professional and participants' perceived effectiveness of the Why Play Therapy? brochure, Play Therapy Works! YouTube video, play therapy educational videos, play therapy magazine articles, play therapy specific books, computer with internet access, computer with multimedia capabilities, television with DVD/VCR, culturally sensitive items, or other as caregiver engagement strategies. This may suggest that the longer participants spent in the mental health field, the more experience they gathered, therefore contributing to greater discernment. Simply put, the longer participants have worked, the more time they have had to make determinations about the strategies they believe work. No previous research has examined the relationship between years as a mental health professional and perceived effectiveness of play therapy specific educational materials. Equally important, play therapists who held certification as either a RPT or RPT-S were more likely to use play therapy specific videos in the room they met with caregivers (r=0.18, p<.01), and in their waiting room (r=0.15, p<.01). Perhaps participants who committed the time and expense toward securing the RPT/S

credentials were exposed to larger amounts of training and more resources that they in turn use in their own practices.

There was a small, but positive relationship between play therapists who had taken at least one graduate level play therapy course and their use of play therapy educational materials (r=0.14, p<.01). This suggests that formal education influences the utilization of tangible items such as brochures, books, and videos for educational purposes. Statistical significance at the .01 level was found between the number of continuing education hours in play therapy and the use of face-to-face consultation with caregivers (r=0.13, p<.01), playroom tours (r=0.16, p<.01), and collateral contacts (r=0.14, p<.01).

Finally, there was a relationship between the number of continuing education hours and the use of the Why Play Therapy? brochure in the room play therapists meet with caregivers (r=0.21, p<.01) and the waiting room (r=0.19, p<.01). Although all of these effect sizes are small, so most likely indicate low practical significance, it is assumed that the more continuing education in play therapy participants had, the greater their knowledge base of helpful strategies. No previous studies have explored the relationship between play therapists' education and training in play therapy and their use of caregiver engagement strategies.

Participants in this study selected all that applied to them from a list of eleven professional licenses and credentials. Respondents held anywhere from one to four credentials, so data analysis was done on the number of credentials held by each participant rather than each individual credential. There was no statistical significance between play therapists' number of credentials and their use of caregiver engagement strategies. Nevertheless, it is notable that most participants (34%) identified themselves as licensed professional counselors (LPC) or licensed clinical social workers (LCSW; 26%). These numbers are slightly lower than those of Lambert,

et al. (2005), who reported that 45% of participants who completed their survey of APT's membership selected professional counseling and 21% selected social work as their primary professional affiliation. This may indicate that APT's membership has become more diversified in terms of the disciplines represented. It could, however, be attributed to the fact that this study provided more choices than Lambert et al.'s and that participants were not limited to indicating one credential.

In terms of what type of training specific to working with caregivers play therapists have received in educational programs and continuing education experiences, respondents said they neither agreed or disagreed with the statement "I received training specific to working with caregivers in my graduate program." In the same way, participants were asked to respond to the statement "I received training specific to working with caregivers during play therapy specific workshops or institutes," and the results showed that a larger number of play therapists received training specific to working with caregivers in play therapy workshops than in their graduate program (M=4.94, SD=1.76). These findings may be skewed by the fact that most participants received more play therapy education in workshops or special institutes than in graduate programs anyway, so it is difficult to extrapolate participants' experiences with training specific to working with caregivers. No known research has been conducted on play therapists' educational preparation for working with caregivers, but practical suggestions have been made for necessary skills and techniques to utilize with caregivers (Cates, Paone, Packman, & Margolis, 2006; Kottman & Ashby, 1996).

In examining the participants' demographics, males were found to comprise only 6% of the sample. Likewise, Lambert et al. (2005) surveyed the membership of APT, and the majority of respondents were female (92%). Due to the large number of female respondents (94%) in this

study, no statistical significance was expected between sex and the use of caregiver engagement strategies. This information would have been interesting to examine in order to shed light on any differences between males and females and their approaches to caregiver engagement, including differences in perceptions of effectiveness. Additional research on the differences between male and female play therapists is warranted in order to draw any meaningful conclusions.

Participants' Perceptions

In addition to practice patterns, another interest of this study was play therapists' perceptions of the effectiveness of each strategy in relation to achieving caregiver engagement.

Of the 424 respondents who indicated their opinion about whether or not caregiver engagement is related to the therapeutic outcome for the child client, the majority (69%) "strongly agreed" with the statement "I believe caregiver engagement is related to the therapeutic outcome for the child client." While much literature (e.g. Guernsey & Stover, 1971; LeBlanc, 1998) exists to support the belief that caregiver involvement is related to the outcome for the child client, no research has been conducted specifically on play therapists' perceptions of the relationship between caregiver engagement and play therapy outcomes of children.

The study also explored the relationship between play therapists' perceived ability to facilitate caregiver engagement and their use of caregiver engagement strategies. The results indicated a statistically significant, positive relationship between play therapists' perceived ability to facilitate caregiver engagement and their theoretical orientation (r=0.22, p<.01), their use of telephone communication (r=0.13, p<.01), email communication(r=0.15, p<.01) and other (r=0.17, p<.01) strategies.

In response to a request to denote their top three most effective caregiver engagement strategies, play therapists identified collateral communication (358 participants), obtaining

information about caregiver's family of origin (344 participants), and completing a psychosocial assessment (340 participants). The techniques perceived less effective were caregiver support groups (58 participants) and child parent relationship (CPRT) groups (71 participants). While practical recommendations have been made for effective caregiver consultation and other forms of communication (Cates, Paone, Packman, & Margolis, 2006; Kottman & Ashby, 1996), no previous research has focused on play therapists' perceptions of the effectiveness of various communication strategies with caregivers. This implies a need for additional research into play therapists' perceptions of effective communication with caregivers.

Perceived Barriers and Methods Used to Overcome Barriers

Another intention of this study was to identify play therapists' perceptions of barriers to achieving caregiver engagement, and the methods they employ to overcome the barriers. Potential barriers to working with caregivers were in literature as either attitudinal (e.g., beliefs and perceptions of the clinician or mental health service) or structural (e.g., transportation, scheduling conflicts, and childcare needs) (Mendez, Carpenter, LaForett, & Cohen, 2009). To examine their perceptions of barriers, participants in my study were asked to select three barriers from a list of seven, including (a) caregiver's financial concerns, (b) caregiver's lack of education about play therapy, (c) caregiver's lack of transportation, (d) lack of rapport between clinician and caregiver, (e) mandated by an outside party to receive mental health services, (f) multicultural competence of clinician, and (g) other. Play therapists identified financial concerns (51%), caregiver's lack of education about play therapy (54%), and working with clients who are mandated by an outside party to receive services (40%) as the top three barriers to achieving caregiver engagement. One participant commented that "expectations for a 'quick fix' by parents / parents seeking fast resolution via medication management" were barriers for him/her.

Another respondent identified "limited insurance or EAP" as a financial barrier to caregiver engagement, and another said caregivers are "not able to afford additional sessions without child sometimes to specifically address parenting issues."

According to Kazdin and Mazurick (1994), early termination in child therapy could be attributed to the caregiver's age and marital status, which may support the findings of the current study in terms of the fact that single caregivers may have more limited funds than homes supported by two incomes. Participants in this study noted that providing financial assistance was a way they overcame barriers to caregiver engagement, and specific suggestions provided were (a) work with them on reduced payments (reduced fees/payment plans), (b) offer reduced fees, and (c) offer bus tokens. Although these suggestions seem like they may contribute to caregivers' abilities to afford sessions, offering financial assistance may not be a practical solution for all play therapists because the decision to offer flexible fees or provide assistance may be an agency decision, or simply may not be something all play therapists can afford.

Nevas and Farber (2001) stated that previous studies of parental influence on outcomes for children suggest that parents who receive preparation prior to beginning services have more realistic expectations of the process, which may positively influence their level of engagement. Participants in this study believed that education could be used as a way to overcome barriers to caregiver engagement, and suggested (a) give them the brochure on play therapy to educate them, (b) show play therapy educational videos during caregiver training, and (c) provide caregivers with education about therapy process for children and child's challenges (at times I give caregivers books to read while their child is in a session with me). Although 54% of participants reported caregivers' lack of education about play therapy as a barrier to caregiver engagement, respondents said they use play therapy specific educational materials only an

average of once a month. It is important to understand why play therapists do not use play therapy educational materials more often, but this study did not examine participants' decisions surrounding utilization of educational materials with caregivers. Possible reasons could be lack of financial resources to purchase materials, lack of space to store materials, or lack of space to display materials.

Participants in this study reported that about 20% of their clients are mandated for services by an outside party. Considering the fact that this number seems fairly low, I was surprised that working with caregivers who are mandated to receive services was identified by 40% of respondents as a top barrier. A participant shared his/her perspective by stating "I have the hardest time with mandated clients and clients who feel the child is to blame for the problem and the one who needs to be "fixed." Suggestions were given for ways to address this barrier, and include:

invite caregiver to establish their own goals for mandated services

communication with team members about other treatment for mandated parties

engage caregiver to find value in services beyond referral or mandated treatment

Working with mandated clients is a reality for some play therapists; therefore, strategies for meeting the unique needs should be examined in further research. Information regarding successful approaches to working with caregivers mandated to receive services may be of interest to educators, court systems, and clinicians alike.

Although only 7% of participants said their own multicultural competence was a barrier to caregiver engagement, this finding is important as it may suggest that play therapists generally perceive themselves to be multiculturally competent. One participant felt it was important to "identify multicultural perspectives and invite dialogue from first interview." Overall,

participants felt the use of culturally sensitive items with caregivers was somewhat effective (M=5.17, SD=1.39). Considering this perception, sensitivity should be given to multicultural populations in every aspect of treatment, including toys and office décor, and educational materials should be available in various languages (Cates, Paone, Packman, & Margolis, 2006). Additionally, play therapists should take care to gain understanding of the child's and family's perception of play therapy services, the child's ethnic identity, and the cultural experiences of the child (Hinman, 2003).

Gaining additional insight into existing barriers to caregiver engagement and ways to overcome them is paramount considering the fact that alignment between play therapist and caregiver has been shown to improve caregivers' compliance levels (Cates, Paone, Packman, & Margolis, 2006). It seems that those participants who were faced with barriers were determined to move beyond the challenges. Some responses that were particularly notable in response to overcoming barriers included:

> *I try to grasp a vision from the caregiver's story about their childhood experiences so that I can link this to their children's presenting issues.*
>
> *I'm constantly thinking of ways I can increase the caretaker's knowledge of play therapy.*

Limitations and Delimitations

Limitations of this study include instrument design, data collection, and sampling bias. The first limitation noted is construction of the *Caregiver Engagement Inventory* (CEI). Although I designed the survey specifically for use in this study and received feedback from an expert panel of six mental health professionals, design flaws may have existed. The CEI may not have accurately measured the practice patterns or perceptions of play therapists as they relate to caregiver engagement, nor does it account for changes in opinions over time. Participants' responses reflected their opinions at the time they answered the CEI. Additionally, the survey

was designed as such that participants could not return to a question once they submitted their response, which may have created frustration and subsequent quitting of respondents.

A second limitation of the study was the sample. The data were collected from members of the Association for Play Therapy (APT). Whereas Lonsdale, Hodge, and Rose (2006) reported that members of an association may return a higher response rate than a non-homogeneous group due to issue salience, participants were not required to respond or complete the survey, therefore respondents may not comprise a representative sample of most play therapists in the field. Of the 4854 surveys distributed, 431 returned were deemed appropriate for inclusion, which represents a response rate of 9%.

Last, the use of electronic distribution and survey completion may have been a limitation of the study. I chose electronic distribution because Ahern (2005) identified many benefits to electronic research including cost effectiveness, access to a larger and more diverse participant pool, reduced collection time, methodological control, accuracy of data entry and analysis, and easier participant follow-up. Despite the noted benefits, limitations to electronic survey distribution may have included lack of access to members of APT who do not have access to the Internet, distrust electronic communication, or lack education necessary for utilization of required technology for completing an electronic survey.

The fact that the CEI was distributed to only members of APT can be considered a delimitation of the study. To generalize the results to all play therapists, a high response rate was needed (Creswell, 2005). Of the 4854 surveys electronically distributed, 539 were returned, and 431 were deemed appropriate for inclusion in the study. This represents a response rate of 9%. As a result, the findings are generalizable only to APT's membership population.

Implications of the Study

This study sought to increase understanding about play therapists' perceptions of the factors that influence caregiver engagement, the practice patterns and specific strategies utilized by play therapists practicing in the mental health field, and the barriers encountered by play therapists when attempting to achieve caregiver engagement.

As a result of this study, play therapists may gain an appreciation for strategies that are used and perceived effective by other play therapists in the field. Additionally, play therapists may increase their awareness regarding barriers encountered by other play therapists when attempting to achieve caregiver engagement at their respective worksites. Clinicians and educators may also find value in learning about strategies utilized and recommended by practicing play therapists to overcome such barriers.

Last, educators of mental health professionals may view the additional comments given in this survey as an indicator of topics of interest to students who wish to obtain knowledge about play therapy in graduate level courses or continuing education forums. A sample of participant feedback is found below.

> *…your survey has given me some ideas of how I can improve in this area and some resources I should make available to caregivers.*
>
> *I work primarily with autistic children and learning disabled children, two populations left behind in the play therapy movement, research and lit."*
>
> *I don't practice in a traditional setting. I meet with families in client homes. Much of this survey is just wishful thinking to me!!!*
>
> *This is probably my most frustrating issue in my practice. I work with some foster children…where adults want the therapist to simply "fix the child."*
>
> *We talk about CE, but we don't ACT like we want caregivers involved. Until we value them AND have training in working with them it will be lip service.*

Recommendations for topics of focus for educators and current play therapists who seek to disseminate play therapy knowledge and skills include attention to effective strategies for

working with caregivers of child clients, specialized populations, and appropriate skills for consistently striving for caregiver engagement.

Significance of the Study

Existing play therapy research shows a positive relationship between caregivers' involvement in play therapy and successful outcomes (Bratton, Ray, Rhine, & Jones, 2005; LeBlanc & Ritchie, 1999). Little research exists, however, to document specific practice patterns and perceptions of play therapists in relation to achieving caregiver engagement. This study sought to identify the practice patterns of play therapists, their perceptions of the factors that influence caregiver engagement, their perceptions of the relationship between caregiver engagement and the therapeutic outcome for the child client, and their perceptions of the barriers to achieving caregiver engagement in play therapy. The results of this study could inform educators, clinicians, and the Association for Play Therapy about how play therapists are currently working with caregivers, and what they identify as beneficial or lacking in their educational preparation, continuing education, or benefits of their national association. The association currently provides recommendations for educational materials appropriate for caregivers of diverse backgrounds, and also provides free access to educational videos and play therapy educational articles for their members. Information obtained from this study could guide APT's national and state branches in their provisions of necessary resources for their members. Additionally, administration and staff in particular worksites can benefit from increasing their knowledge in terms of the practice patterns and perceived barriers of play therapists at specific worksites (e.g. schools, private practices).

Implications for Future Research

Because of the limited amount of empirical research on play therapists' practice patterns and perceptions of effective caregiver engagement strategies, along with lack of information about perceived barriers and methods for overcoming them, this study offers new information that adds to the knowledge base relevant for play therapists, educators, and caregivers. Future research is needed, however, to further this topic. The study was mostly quantitatively structured, but qualitative adjuncts were present throughout. The large amount of qualitative data submitted suggests that participants had much to say about their experiences working with caregivers, and were eager for a medium to express their voice. Additionally, participants expressed agreement with the need for more insight into what practicing play therapists do to achieve successful caregiver engagement. For example, one participant stated "After taking this survey, I realize I am missing opportunities to continually educate caregivers like lobby time, articles on play or videos on play." Therefore, a more in-depth qualitative study might provide richer information and a greater understanding of play therapists' experiences with success and challenges when working with the caregivers of their child clients in play therapy. General and brief responses could be expanded upon and clarified during an interview, thereby providing more understanding and clearer implications for practical application of the information.

Additionally, a more in-depth study examining barriers to caregiver engagement is needed to fully understand play therapists' challenges. For example, the second highest barrier indicated in this study was financial concerns. The qualitative comments, however, revealed inconsistencies in play therapists' interpretation of the question. Some participants' responses were centered on their own lack of adequate funds to purchase educational materials (e.g. brochures, computers, or books), while others were clearly referencing the caregivers' financial

situation being a barrier to consistent attendance in consultations or leading to early termination for their child.

Another qualitative study could focus on the experiences of caregivers in play therapy. In order to effectively engage and educate caregivers, play therapists must possess insight into caregivers' perceptions of the process. This information could also influence educators of mental health professionals and play therapists who provide workshops or special institutes in play therapy as they work to structure educational experiences for play therapists seeking new knowledge.

Conclusions

The current study adds to the literature concerning play therapists' preparation for working with caregivers, practice patterns when working with caregivers, perceptions of effective caregiver engagement strategies, barriers to caregiver engagement encountered by play therapists, and methods used to overcome such barriers.

Of the 423 participants who responded, 292 (69%) strongly agreed and 107 (25%) agreed that caregiver engagement is related to a child's therapeutic outcome in play therapy. Fifty-three percent (n=228) of respondents strongly agreed that they are prepared to facilitate caregiver engagement in play therapy, and 35% (n=151) agreed. These results suggested that while 94% of play therapists who responded believed caregiver engagement was a large factor in successful play therapy outcomes, only 88% of the participants felt prepared to accomplish the task with caregivers of their child clients.

The results indicated a relationship between training and play therapists' practice patterns related to caregiver engagement, but participants reported minimal exposure (Likert scale 1-7) to training specific to working with caregivers in both their graduate programs (M=3.86, SD=2.00)

and workshops (M=4.94, SD=1.76). The findings point to a belief that work with caregivers is vital to success for children in play therapy, thereby suggesting the desire for an increase in education, training, and resources devoted to working with caregivers in play therapy.

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APPENDIX A

MAILING LIST REQUEST

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 5-10 days prior to date needed.

1.Requestor Information:
Name, Address, Affiliation, Institution or Dept. sponsoring research.

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

3. Short discussion of each of the following proposal (1 page total):
a) description of target population: number of subjects, selection criteria (e.g., specialty area, employment setting, demographic variables, etc.),

b) methodology/procedures, including: by mail, phone, or in-person interviews, scheduled date of first mailing/contact and any follow-ups, anonymity or confidentiality of responses (justify need for identifiers, if any),

c)
purpose of the research (who benefits/importance to the field),

d)
risk to the respondent,

e)
plans for analyses, dissemination (e.g., publication, presentation),

f) any funding to help support the research.

4. Evidence of approval by an Human Subjects Review/IRB Committee at outside institution.
If you are not requesting a complete set, please indicate so on the Mailing List Rental Form and/or special instructions. Your request will be reviewed by the APT Research Committee. Please allow at least 5-10 days for review and mailing of labels.

3198 Willow Avenue, Suite 110, Clovis, CA 93612 * (559) 294-2128 * www.a4pt.org

APPENDIX B

CAREGIVER ENGAGEMENT INVENTORY

1. Please provide the following personal information.

Sex
Male

Female

2. What is your age?

18-99

3. Ethnicity

African American

Asian American

Caucasian

Hispanic

Native American

Pacific Islander

Other (please specify) _____

4. Please select the choice below that best defines your primary worksite.

School

Community agency

Private practice or group

Psychiatric hospital

Medical hospital

University

Other _____

5. In which state do you currently reside?

Alabama

Alaska

Arizona

Arkansas

California

Colorado

Connecticut

Delaware

District of Columbia

Florida

Georgia

Hawaii

Idaho

Illinois

Indiana

Iowa

Kansas

Kentucky

Louisiana

Maine

Maryland

Massachusetts

Michigan

Minnesota

Mississippi

Missouri

Montana

Nebraska

Nevada

New Hampshire

New Jersey

New Mexico

New York

North Carolina

North Dakota

Ohio

Oklahoma

Oregon

Pennsylvania

Rhode Island

South Carolina

South Dakota

Tennessee

Texas

Utah

Vermont

Virginia

Washington

West Virginia

Wisconsin

Wyoming

I do not live in the United States

6. Highest Mental Health Degree earned

Currently in a master's program

Currently in a PhD program

Master's

Master's + 30

Doctorate

Other _____

7. Mental Health Credential/License(s) Please check all that apply.

Licensed Marriage and Family Therapist (LMFT)

Post master's intern pursuing status as Licensed Professional Counselor (CI)

Licensed Professional Counselor (LPC)

Licensed Clinical Social Worker (LCSW)

Licensed School Psychologist

Licensed Psychologist

Licensed Professional Counselor-Supervisor (LPC-S)

Nurse Practitioner

Psychiatrist

Post master's intern pursuing status as Graduate Social Worker (GSW) or Licensed Clinical Social Worker (LCSW)

Other _____

8. Total number of years practicing as a mental health professional

< 1 - 50

9. Play therapy training status. Please check all that apply.

Student

Currently receiving supervision for registered play therapist (RPT) credential

Registered play therapist (RPT)

Registered play therapist- supervisor (RPT-S)

Other _____

10. Number of graduate level courses that you have taken in play therapy (3 credit hours or 67.5 play therapy specific hours) from an accredited university or college.

0- >5

11. Total number of years practicing as a registered play therapist (RPT)

<1-50

12 .Please read the statement below and select the best choice.

	Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Agree	Strongly Agree
I received training specific to working with caregivers in my graduate program.	❍	❍	❍	❍	❍	❍	❍

13. Number of continuing education hours obtained through play therapy workshops or special institutes you have attended in the past two years.

0-100

14. Please read the statement below and select the best choice.

	Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Agree	Strongly Agree
I received training specific to working with caregivers during play therapy specific workshops or institutes.	❍	❍	❍	❍	❍	❍	❍

15. Do you have a room designated for exclusive use of play therapy at your worksite?

Yes

No

16. Please select your primary theoretical orientation below. Your choice should reflect your primary theoretical orientation when providing play therapy services.

Child Centered Play Therapy

Cognitive Behavioral Play Therapy

Gestalt Play Therapy

Ecosystemic Play Therapy

Psychoanalytic Play Therapy

Adlerian Play Therapy

Jungian Play Therapy

Other _____

17. Please read the statement below and select the best choice.

	Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Agree	Strongly Agree
My primary theoretical orientation influences my approach to working with caregivers in play therapy.	❍	❍	❍	❍	❍	❍	❍

18. **What percentage of your typical client base is required by an outside party (e.g. court mandated, custody evaluation, adoption evaluation, school) to receive mental health services for their child, self or family?**

0-100

19. A review of recent literature suggests a lack of a universally accepted definition of caregiver engagement. Please define caregiver engagement. Your response should reflect your own personal opinion.

Free form field.

20. For the purpose of this survey, caregiver engagement will refer to caregivers' investment and involvement in their child's play therapy process as demonstrated by frequency of attending scheduled appointments with their play therapist for both themselves and the child client, reported frequency of implementing suggested interventions outside of their child's play therapy session, and reported frequency of following through with their play therapist's recommendations for additional services outside of play therapy. Please read the statement below and select the best choice based on this definition of caregiver engagement.

	Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Agree	Strongly Agree
I am prepared to facilitate caregiver engagement with the caregivers of my child clients.	❍	❍	❍	❍	❍	❍	❍

21. Please read the statement below and select the best choice.

	Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Agree	Strongly Agree
I believe caregiver engagement is related to the therapeutic outcome for the child client.	❍	❍	❍	❍	❍	❍	❍

22. Please list the top three caregiver engagement strategies that positively impact the therapeutic outcome for the child. The term "caregiver engagement strategies" refers to actions taken by the play therapist to achieve caregiver engagement with the primary caregiver(s) of your child clients. Your response should reflect your own personal opinion.

1.
2.
3

23. Please indicate below the frequency in which you utilize the following forms of communication with a caregiver.

	Never	Less than Once a Month	Once a Month	2-3 Times a Month	Once a Week	2-3 Times a Week	Daily
Face-to-face consultation between caregiver and play therapist	❍	❍	❍	❍	❍	❍	❍
Telephone consultation between caregiver and play therapist	❍	❍	❍	❍	❍	❍	❍
Email contact between caregiver and play therapist	❍	❍	❍	❍	❍	❍	❍
Video conference between caregiver and play therapist	❍	❍	❍	❍	❍	❍	❍
Structured feedback form completed by caregiver about their child's progress and continued challenges in play therapy	❍	❍	❍	❍	❍	❍	❍

24. Please indicate below your perception of the effectiveness of each strategy as it relates to achieving caregiver engagement.

	Very Ineffective	Ineffective	Somewhat Ineffective	Neither Effective nor Ineffective	Somewhat Effective	Effective	Very Effective
Face-to-face consultation between caregiver and play therapist	❍	❍	❍	❍	❍	❍	❍
Telephone consultation between caregiver and play therapist	❍	❍	❍	❍	❍	❍	❍
Email contact between caregiver and play therapist	❍	❍	❍	❍	❍	❍	❍
Video conference between caregiver and play therapist	❍	❍	❍	❍	❍	❍	❍
Structured feedback form completed by caregiver about their child's progress and continued challenges in play therapy	❍	❍	❍	❍	❍	❍	❍

25. Please read the statement below and select the best choice. How frequently do you use play therapy specific educational materials with caregivers of your clients?

Never

Less than Once a Month

Once a Month

2-3 Times a Month

Once a Week

2-3 Times a Week

Daily

26. The majority of my play therapy specific educational materials are provided to caregivers via

Available in waiting room for caregiver's own selection

Standard packet of information I provide prior to beginning services with all child clients

Email exchange of information selected for each individual client

Face to face exchange of information selected for each individual client

Other _____

27. Please select the strategies below that you utilize for caregiver engagement. Please check all that apply.

Psychosocial assessment

Information about caregiver's family of origin

Structured consultation format

Tour of your playroom

Collateral communication with others involved in child client's treatment plan, e.g. teachers, psychiatrists

Caregiver support groups within your worksite

Child Parent Relationship Therapy (CPRT) groups within your worksite

Other _____

28. Please select your top three most effective caregiver engagement strategies below:

Psychosocial assessment

Information about caregiver's family of origin

Structured consultation format

Tour of your playroom

Collateral communication with others involved in child client's treatment plan, e.g. teachers, psychiatrists

Caregiver support groups within your worksite

Child Parent Relationship Therapy (CPRT) groups within your worksite

Other _____

29. Do you have a separate room for meeting with caregivers in addition to your playroom?

Yes

No

30. Please indicate the frequency with which you use the following items in the room you meet with caregivers.

	Never	Less than Once a Month	Once a Month	2-3 Times a Month	Once a Week	2-3 Times a Week	Daily
Why Play Therapy brochure	❍	❍	❍	❍	❍	❍	❍
Play Therapy Works! You Tube video	❍	❍	❍	❍	❍	❍	❍
Play Therapy educational videos	❍	❍	❍	❍	❍	❍	❍
Play Therapy magazine articles	❍	❍	❍	❍	❍	❍	❍
Play Therapy specific books	❍	❍	❍	❍	❍	❍	❍
Computer with internet access	❍	❍	❍	❍	❍	❍	❍
Computer with multimedia capabilities	❍	❍	❍	❍	❍	❍	❍
Television with DVD/VCR	❍	❍	❍	❍	❍	❍	❍
Culturally sensitive materials (materials in various languages, decor, etc)	❍	❍	❍	❍	❍	❍	❍
Other	❍	❍	❍	❍	❍	❍	❍

31. Do you have a designated waiting room separate from the room in which you meet with parents?

Yes

No

32. Please indicate the frequency with which you use the following items in your waiting room.

	Never	Less than Once a Month	Once a Month	2-3 Times a Month	Once a Week	2-3 Times a Week	Daily
Why Play Therapy brochure	❍	❍	❍	❍	❍	❍	❍
Play Therapy Works! You Tube video	❍	❍	❍	❍	❍	❍	❍
Play Therapy educational videos	❍	❍	❍	❍	❍	❍	❍
Play Therapy magazine articles	❍	❍	❍	❍	❍	❍	❍
Play Therapy specific books	❍	❍	❍	❍	❍	❍	❍
Computer with internet access	❍	❍	❍	❍	❍	❍	❍
Computer with multimedia capabilities	❍	❍	❍	❍	❍	❍	❍
Television with DVD/VCR	❍	❍	❍	❍	❍	❍	❍
Culturally sensitive items (materials in various	❍	❍	❍	❍	❍	❍	❍

languages, decor, etc)							
Other	❍	❍	❍	❍	❍	❍	❍

33. Please rate the items below in terms of your perceived effectiveness with regard to achieving caregiver engagement.

	Very Ineffective	Ineffective	Somewhat Ineffective	Neither Effective nor Ineffective	Somewhat Effective	Effective	Very Effective
Why Play Therapy brochure	❍	❍	❍	❍	❍	❍	❍
Play Therapy Works! You Tube video	❍	❍	❍	❍	❍	❍	❍
Play Therapy educational videos	❍	❍	❍	❍	❍	❍	❍
Play Therapy magazine articles	❍	❍	❍	❍	❍	❍	❍
Play Therapy specific books	❍	❍	❍	❍	❍	❍	❍
Computer with internet access	❍	❍	❍	❍	❍	❍	❍
Computer with multimedia capabilities	❍	❍	❍	❍	❍	❍	❍
Television with DVD/VCR	❍	❍	❍	❍	❍	❍	❍
Culturally sensitive items (materials in various languages, decor, etc)	❍	❍	❍	❍	❍	❍	❍
Other	❍	❍	❍	❍	❍	❍	❍

34. Please select your top three perceived barriers to achieving caregiver engagement.

Caregiver's financial concerns

Caregiver's lack of education about play therapy

Caregiver's lack of transportation

Lack of rapport between clinician and caregiver

Mandated by outside party to receive mental health services

Multicultural competence of clinician

Other _____

35. Please list the top three ways that you overcome barriers to achieving caregiver engagement.

1.
2.
3

36. Please comment on anything additional that you think is important for me to know about achieving caregiver engagement in play therapy.

Free form field.

APPENDIX C

PILOT STUDY SURVEY

1. What is the most common question you receive from caregivers about play therapy prior to beginning services with the client?

2. What do you wish caregivers knew about play therapy?

3. What do you consider to be the biggest misconception caregivers have about play therapy?

APPENDIX D

IRB APPROVAL LETTER FOR PILOT STUDY

University Committee for the Protection of Human Subjects in Research

University of New Orleans

Campus Correspondence

Principal Investigator: Louis V. Paradise

Co-Investigator:

Date: April 6, 2010

Protocol Title: "Misconceptions about Play Therapy among Caregivers"

IRB#: 06Apr10

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 this research will involve the use of interview procedures. Although information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects, any disclosure of the human subjects' responses outside the research wouldn't reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

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, Chair
UNO Committee for the Protection of Human Subjects in Research

APPENDIX E

INFORMED CONSENT INITIAL EMAIL FOR PILOT STUDY

Hello fellow LAPT member,

My name is Adrianne Lolan and I am a doctoral student in Counselor Education at the University of New Orleans. I am conducting a research project, which will explore common questions posed to play therapists by caregivers. I am distributing an online questionnaire to mental health professionals who work as play therapists in Louisiana. The purpose of the study is to identify misconceptions and beliefs associated with play therapy. Results are expected to enhance understanding of the perceptions of play therapy in Louisiana and increase the knowledge base of play therapists in Louisiana.

I obtained your contact information via the Louisiana Association for Play Therapy and hope you are willing to participate. Please use the link below to complete the survey by April 27, 2010.

http://www.surveymonkey.com/s.aspx?sm=foLe54_2f_2bAiFkGCvOVqfXEg_3d_3d

You may contact me via this email address. Also, I can send more specific information about the project if you are interested. You may also contact my faculty advisor, Dr. Louis V. Paradise, by email at LParadis@uno.edu for more information regarding this study.

Thanks in advance for your participation.

Adrianne

Adrianne Lolan, LPC, CRC
Doctoral Student
University of New Orleans
College of Education & Human Development
Department of Educational Leadership,
Counseling, & Foundations
alolan@uno.edu

APPENDIX F

INFORMED CONSENT FINAL EMAIL FOR PILOT STUDY

Hello fellow LAPT member,

If you have not done so already, please complete my survey by April 27 using the link in this email. Thanks to all who have completed it already!

My name is Adrianne Lolan and I am a doctoral student in Counselor Education at the University of New Orleans. I am conducting a research project, which will explore common questions posed to play therapists by caregivers. I am distributing an online questionnaire to mental health professionals who work as play therapists in Louisiana. The purpose of the study is to identify misconceptions and beliefs associated with play therapy. Results are expected to enhance understanding of the perceptions of play therapy in Louisiana and increase the knowledge base of play therapists in Louisiana.

I obtained your contact information via the Louisiana Association for Play Therapy and hope you are willing to participate. Please use the link below to complete the survey by April 27, 2010.

http://www.surveymonkey.com/s.aspx?sm=foLe54_2f_2bAiFkGCvOVqfXEg_3d_3d

You may contact me via this email address. Also, I can send more specific information about the project if you are interested. You may also contact my faculty advisor, Dr. Louis V. Paradise, by email at LParadis@uno.edufor more information regarding this study.

Thanks in advance for your participation.

Adrianne

Adrianne Lolan, LPC, CRC
Doctoral Student
University of New Orleans
College of Education & Human Development
Department of Educational Leadership,
Counseling, & Foundations
alolan@uno.edu
337-380-4339

APPENDIX G

IRB APPROVAL LETTER

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

Campus Correspondence

Principal Investigator: Louis V. Paradise

Co-Investigator: Adrianne Lolan

Date: August 9, 2011

Protocol Title: "Play Therapists' Practice Patterns and Perceptions of the Factors that Influence Caregiver Engagement in Play Therapy"

IRB#: 01Aug11

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

FIRST ELECTRONIC MESSAGE TO PARTICIPANTS

Hello APT member,

My name is Adrianne Lolan and I am a doctoral candidate in Counselor Education at the University of New Orleans. I am writing to request your assistance with my dissertation study titled *Play Therapists' Practice Patterns and Perceptions of the Factors that Influence Caregiver Engagement in Play Therapy*. I developed a survey (*Caregiver Engagement Inventory or CEI)* specifically for the purpose of my dissertation that asks play therapists to respond to questions about their use of caregiver engagement strategies, their beliefs regarding the relationship between caregiver engagement and outcomes for the child client, their perceived barriers to achieving caregiver engagement, and their definition of caregiver engagement. My hope is that the information obtained from this survey will provide valuable information regarding successful caregiver engagement in play therapy for use by play therapy students, educators, and clinicians.

All information you provide is anonymous, and there will be no way to identify you after you submit your answers. The survey will take approximately 10 minutes to complete. Completion and electronic submission of the CEI indicates your consent for participation. The results of the research study may be published, but no identifying information will be used.

If you are willing to participate, please follow the link below to find the Qualtrics™ survey. Please be as honest as possible when answering the questions to ensure proper results.

http://neworleans.qualtrics.com/SE/?SID=SV_eyd413E3gqfpblG

If you are not connected automatically, you can copy and paste the link into your web browser and hit enter.

Possible benefits of your participation are that you may enjoy participating in the study, and you may find the results of the study interesting in regard to your own play therapy practices. The risks involved in taking the survey are minimal, such as you may become tired while answering the questions.

Your participation in this study is completely voluntary, and you may choose to withdraw your consent at any time. If you have any questions regarding this study, please do not hesitate to contact the investigator of this study, Adrianne Lolan, at alolan@my.uno.edu. You may also contact my faculty advisor, Dr. Louis V. Paradise, by email at LParadis@uno.edu for more information regarding this study.

Thank you in advance for your time and willingness to participate.

Sincerely,

Adrianne Lolan, MHS, LPC-S, CRC
Registered Play Therapist
Doctoral Candidate
University of New Orleans

APPENDIX I

SECOND ELECTRONIC MESSAGE TO PARTICIPANTS

Hello APT member,

If you have already completed the *Caregiver Engagement Inventory*, thank you again for your participation in this study. If you have not had the opportunity to participate, please take approximately 10 minutes to complete this brief 36-item survey.

As stated in my previous email, my name is Adrianne Lolan and I am a doctoral candidate in Counselor Education at the University of New Orleans. I am writing to request your assistance with my dissertation study titled *Play Therapists' Practice Patterns and Perceptions of the Factors that Influence Caregiver Engagement in Play Therapy*. I developed a survey (*Caregiver Engagement Inventory or* CEI*)* specifically for the purpose of my dissertation that asks play therapists to respond to questions about their use of caregiver engagement strategies, their beliefs regarding the relationship between caregiver engagement and outcomes for the child client, their perceived barriers to achieving caregiver engagement, and their definition of caregiver engagement. My hope is that the information obtained from this survey will provide valuable information regarding successful caregiver engagement in play therapy for use by play therapy students, educators, and clinicians.

All information you provide is anonymous, and there will be no way to identify you after you submit your answers. The survey will take approximately 10 minutes to complete. Completion and electronic submission of the CEI indicates your consent for participation. The results of the research study may be published, but no identifying information will be used.

If you are willing to participate, please follow the link below to find the Qualtrics™ survey. Please be as honest as possible when answering the questions to ensure proper results.

http://neworleans.qualtrics.com/WRQualtricsSurveyEngine/?SID=SV_eyd413E3gqfpblG&_=1

If you are not connected automatically, you can copy and paste the link into your web browser and hit enter.

Possible benefits of your participation are that you may enjoy participating in the study, and you may find the results of the study interesting in regard to your own play therapy practices. The risks involved in taking the survey are minimal, such as you may become tired while answering the questions.

Your participation in this study is completely voluntary, and you may choose to withdraw your consent at any time. If you have any questions regarding this study, please do not hesitate to contact the investigator of this study, Adrianne Lolan, at alolan@my.uno.edu. You may also contact my faculty advisor, Dr. Louis V. Paradise, by email at LParadis@uno.edu for more information regarding this study.

Thank you in advance for your time and willingness to participate.

Sincerely,

Adrianne Lolan, MHS, LPC-S, CRC
Registered Play Therapist
Doctoral Candidate
University of New Orleans

APPENDIX J

FINAL ELECTRONIC MESSAGE TO PARTICIPANTS

Dear APT member,

Thank you to everyone who participated in my dissertation study titled *Play Therapists' Practice Patterns and Perceptions of the Factors that Influence Caregiver Engagement in Play Therapy by completing the Caregiver Engagement Inventory* (CEI). Data collection, which ran from August 11, 2011 to September 9, 2011, is now complete.

The data from the survey will be used to examine play therapists' use of caregiver engagement strategies, their beliefs regarding the relationship between caregiver engagement and outcomes for the child client, their perceived barriers to achieving caregiver engagement, and their definition of caregiver engagement.

If you wish to receive information regarding the results of this study and have not already informed the investigator, please send an email request to alolan@my.uno.edu.

If you have any questions or comments regarding this study, please do not hesitate to contact the investigator of this study, Adrianne Lolan, at alolan@my.uno.edu.You may also contact the faculty advisor, Dr. Louis V. Paradise, by email at LParadis@uno.edu for more information regarding this study.

Thank you again for your time and willingness to participate.

Sincerely,

Adrianne Lolan, MHS, LPC-S, CRC
Registered Play Therapist
Doctoral Candidate
University of New Orleans

VITA

Adrianne Lolan earned a Bachelor of Science in Psychology from Louisiana State University in 2004 and a master's degree in Rehabilitation Counseling in 2006 from Louisiana State University Health Sciences Center. In 2011, she earned a Doctor of Philosophy degree in Counselor Education from the University of New Orleans.

Adrianne is a Licensed Professional Counselor-Supervisor (LPC-S), a Registered Play Therapist, and a Certified Rehabilitation Counselor (CRC). She is a member of the American Counseling Association (ACA), Louisiana Counseling Association (LCA), American Mental Health Counselors Association (AMHCA), and Association for Play Therapy (APT). Adrianne is a member of the Louisiana Association for Counselor Educators and Supervisors (LACES) and Louisiana Association for Play Therapy (APT), and she has served on the Executive Board of both associations. Adrianne was a member of APT's Leadership Academy (2011) and LCA's Leadership Academy (2011).

Adrianne holds clinical work experience in private practice, community based mental health clinics, and a university play therapy clinic. She is also owner and director of NOLA Play Therapy, L.L.C. Her areas of interest include preventative education, counseling outcome research, and play therapy outcome research.