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# Play Therapist's Perspectives on Culturally Sensitive Play Therapy

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Play Therapists' Perspectives on Culturally Sensitive Play Therapy

A Dissertation

Submitted to the Graduate Faculty of the  
University of New Orleans  
In partial fulfillment of the  
requirements for the degree of

Doctor of Philosophy  
in  
Counselor Education

by

Krystal Vaughn

B.S., Northwestern State University, 2003  
M.S., Louisiana State University Shreveport, 2005

May 2012

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## DEDICATION

I dedicate this dissertation to my son, Zachary, who has taught me the true value of play and the joy that toys bring. I love you and your continued inquires about the “toy paper” allowed me to move forward even when I would rather play “Legos”.

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## TABLE OF CONTENTS

Dedication .....	ii
Acknowledgment .....	iii
List of Tables .....	vii
Abstract .....	ix
CHAPTER ONE .....	1
Introduction.....	1
The Cultural Divide .....	2
Play Therapy Approaches .....	5
Toys in the Playroom .....	5
The Role of the Association of Play Therapy .....	7
Educating Play Therapists on Diverse Populations .....	9
Conceptual Framework.....	11
Significance of the Study .....	12
Purpose of the Study .....	12
Research Questions.....	13
Assumptions of the Study .....	14
Definition of Terms.....	15
CHAPTER TWO .....	16
Review of the Literature .....	16
History of Play Therapy.....	16
Play Therapy Theories and Approaches .....	19
Non-Directive Play Therapy.....	20
Client-centered Play Therapy .....	20
Directive Play Therapy .....	22
Cognitive Behavioral Play Therapy.....	23
Gestalt Play Therapy.....	24
Adlerian Play Therapy .....	25
Jungian Play Therapy.....	26
Psychoanalytic Play Therapy.....	27
Toys in Play Therapy.....	28
Culturally Sensitive Toys in the Playroom .....	29
The Role of the Association for Play Therapy.....	30
Advancing the Field.....	30
Credentialing.....	31
Training and Professional Growth.....	32
Multiculturalism Training.....	33
Multicultural Practices in Play Therapy .....	34
Universal Language .....	35
Guiding the Change .....	36
Cultural Perceptions, Expectations, and Considerations .....	37
Trends, Change, and Culturally Sensitive Play Therapy .....	38

Conclusion .....	40
CHAPTER THREE .....	42
Method .....	42
Purpose of the Study .....	42
General Research Question.....	42
Participants.....	44
Instrument Development.....	49
Expert Panel .....	53
Data Analysis .....	56
Procedures.....	60
CHAPTER FOUR.....	62
Results.....	62
Analysis of Research Questions.....	62
Research Questions.....	62
Instrumentation .....	62
Research Question 1 .....	63
Research Question 2 .....	66
Research Question 3 .....	67
Research Question 4 .....	72
Research Question 5 .....	73
Research Question 6 .....	75
Research Question 7 .....	84
Research Question 8 .....	87
Research Question 9 .....	94
Research Question 10 .....	96
Research Question 11 .....	101
Research Question 12 .....	104
Research Question 13 .....	107
Research Question 14 .....	109
Research Question 15 .....	109
Summary .....	111
CHAPTER FIVE .....	115
Discussion .....	115
Purpose of the Study .....	115
Discussion of Findings.....	115
Arts and Crafts Materials .....	119
Culturally Sensitive Games and Books.....	120
Dramatic Play Materials .....	122
Dress Up Clothing.....	123
Dolls, Dollhouses, and Dollhouse Materials.....	124
Puppets .....	127
Sand Tray Materials .....	129
Musical Instruments.....	131
Overview Summary .....	132
Limitations of the Study.....	134
Implications for Play Therapists .....	136

Implications for Future Research.....	137
Summary .....	138
References.....	141
APPENDICES .....	150
Appendix A.....	151
Appendix B .....	153
Appendix C.....	164
Appendix D.....	166
VITA.....	182



## LIST OF TABLES

Table 1 Frequency Distributions of Participants by Gender.....	45
Table 2 Frequency Distributions of Participants by Ethnicity.....	45
Table 3 Mean and Standard Deviation of Clients by Ethnicity .....	46
Table 4 Frequency Distributions for Participants' Status as a Play Therapist .....	47
Table 5 Frequency Distributions for Participants' Theoretical Orientation .....	48
Table 6 Frequency Distributions for Participants' Level of Education.....	49
Table 7 Instrument Development Culturally Sensitive Play Therapy Survey.....	51
Table 8 Frequency Distributions for Play Therapy Training and Education.....	64
Table 9 Frequency Distributions for Multicultural Education.....	66
Table 10 Frequency Distributions for Respondents Belief about Culturally Sensitive Play Therapy .....	69
Table 11 Means and Standard Deviations Respondents Belief about Culturally Sensitive Play Therapy .....	71
Table 12 Frequency Distributions for Materials Used or Available.....	76
Table 13 Chi square Analyses of Materials Used or Available Between Levels of Education .....	85
Table 14 Chi square Analyses of Materials Used or Available Between Levels of Play Therapy Graduate Courses.....	88
Table 15 Chi square Analyses of Materials Used or Available Between Levels of Multicultural Counseling Graduate Courses.....	90
Table 16 Chi square Analyses of Materials Used or Available Between Attendance at Play Therapy Workshops or Special Institutes .....	92
Table 17 Chi square Analyses of Materials Used or Available Between Levels of Play Therapy Status .....	95
Table 18 Chi Square Analyses of Materials Used or Available Between Ethnicity.....	98
Table 19 Analysis of Variance for Art and Crafts Materials Available or Used and	

Client’s Ethnicity .....	101
Table 20 Analysis of Variance for Books Available or Used and Client’s Ethnicity.....	101
Table 21 Analysis of Variance for Board Games Available or Used and Client’s Ethnicity .....	102
Table 22 Analysis of Variance for Dramatic Play Materials Available or Used and Client’s Ethnicity .....	102
Table 23 Analysis of Variance for Dramatic Play Materials Available or Used and Client’s Ethnicity .....	102
Table 24 Analysis of Variance for Dolls Available or Used and Client’s Ethnicity .....	103
Table 25 Analysis of Variance for Dollhouse and/or Materials Available or Used and Client’s Ethnicity .....	103
Table 26 Analysis of Variance for Puppets Available or Used and Client’s Ethnicity ...	103
Table 27 Analysis of Variance for Sand Tray Materials Available or Used and Client’s Ethnicity .....	104
Table 28 Chi Square Analyses of Materials Used or Available Between Levels of Education .....	105
Table 29 Chi Square Analyses of Materials Used or Available Between Availability of Playroom.....	107

## ABSTRACT

The Association for Play Therapy (2009) promotes play therapists' awareness of personal cultural identity, obtaining continuous cultural knowledge, and displaying culturally appropriate practices. Play therapy research includes studies on working with specific culturally diverse populations. Founding play therapists, such as Virginia Axline, have made suggestions for toys that should be included in the therapist's playroom. This exploratory survey inquired about play therapists' perceptions of culturally sensitive play therapy, materials used, and perceived barriers to implementing culturally sensitive play therapy. Members of the Association of Play Therapy with at least master's degree (n=385) reported on their ability to incorporate culturally sensitive materials into their playroom, most commonly arts and crafts materials. Participants noted less often the use of culturally sensitive board games and culturally sensitive dress up clothes, making them the least commonly used.

Play therapists reported encountering barriers to implementing culturally sensitive materials, such as costs, availability, and space. Having space, specifically a designed play therapy room, was significantly related to the use or availability of culturally sensitive items, such as dramatic play materials, dollhouse and/or materials, and sand tray materials. Additionally, an individual's status as a registered play therapist was related to the use of a dollhouse and/or materials. Some play therapists were able to overcome barriers through education, personally purchasing materials, and networking. Overall, the play therapist's ethnicity, education and licensure type did not relate to their use of culturally sensitive play therapy materials.

Play therapists could benefit from training on how to locate, incorporate, and use costs effective culturally sensitive materials. It was clear that play therapists valued continuing

education and kept current on play therapy recommendations, indicating that those forums would be the most beneficial avenue to offer information on culturally sensitive material.

Play therapy; culturally sensitive play therapy; toys

## **CHAPTER ONE**

### **INTRODUCTION**

Sigmund Freud's (1909/1955) first documented therapeutic work to focus on a child was the result of his advising a child's father after the father observed his own son playing and then reported his findings to Freud. Play therapy has since evolved from Freud's initial findings into a specialized field with an organized international association of 4,400 members and two levels of professional certification (Landreth, 2002). With the classic case of "Little Hans" in 1909, Freud documented the first therapeutic use of the observation of play and therapeutic work with children, and he opened the gateways for its study among therapists worldwide.

The second major contribution to the field of play therapy was Levy's (1938) release therapy—a therapy in which the child is able to express anxieties through structured play. Levy (1938) described release therapy as a structured therapeutic model wherein the child was allowed free play in session, and then the therapist introduced toys into the session relating to the stress-filled event, thereby allowing the child to release the anxiety surrounding the event.

Anna Freud (1946) building on her father's psychoanalytic work, used play therapy to interpret the unconscious motivation of children while building a therapeutic relationship with them. Around the same time, Melanie Klein (1955) began using play therapy to substitute for free association in psychoanalysis with children under the age of six. Whereas both Klein and Freud practiced psychoanalytic play therapy, Klein believed that the child's play was akin to free association.

Virginia Axline credited as the pioneer of nondirective play therapy, believed that children strove for growth and had the ability for self-direction. Axline theorized that through the therapeutic process and with a secure relationship the child was able to express him or

herself. It is through the therapist's complete acceptance of the child that Axline believed the child was able to accept and cope with his or her feelings. Building on the work of Axline, Landreth (2002) has described play therapy as a relationship between a child and a trained play therapist in which the permission given to the child allows them to express him or herself in the safe relationship, through the natural communication of play.

Over the past century, play therapy has proven to be beneficial in the treatment of children who experience problems related to aggression (e.g., Dogra & Veeraraghaven, 1994; Willock, 1983); adjustment to divorce (e.g., Burroughs, Wagner, & Johnson, 1997; Mendell, 1983); and depression (e.g., Burroughs et al., 1997; Springer, Phillips, Phillips, Cannady, & Kerst-Harris, 1992; Tyndall-Lindet et al., 2001). Cross culturally and multi-culturally, play therapists have noted the benefits of play therapy for children around the world who fall into the following groups: Asian families (Chau & Landreth, 1997; Lee & Landreth, 2003; Yuen, Landreth, & Baggerly, 2002;); Native American families (Glover & Landreth, 2000), German mothers (Grskovic & Goetze 2008); Israeli parents (Kidron & Landreth 2010); Hispanic populations (Constantino, Malgady, & Rogler, 1986; Garza, Kinsworthy, & Watts, 2009; Perez, Ramirez, & Kranz, 2007); and African Americans (Solis, Meyers, & Varjas 2004).

Play therapy has developed and evolved tremendously from its initial founding—from observation in conjunction with psychoanalysis to a field of study unto itself.

### **The Cultural Divide**

U.S. Census Bureau statistics show that the country is ever changing and will continue to become more diverse (2010). Correspondingly, Ryan, Gomory, and Lacasse (2002) have noted that the makeup of the play therapy profession or Association of Play Therapy is 92.1% White/Non-Hispanic. Ryan et al. further observed that it “raises concerns regarding the diversity

and cultural accessibility/sensitivity of APT and play therapy services in general” (p. 28). Ryan et al. found that the majority of the members of the Association of Play Therapy were White, but in the near future, they will be providing services to a population that is far more diverse than the current makeup of the association. They further questioned the preparedness of play therapists to provide culturally sensitive play therapy and whether or not play therapy was perceived to be accessible by diverse populations.

Ritter and Chang (2002) also noted the discrepancy between play therapists’ lack of formal training and their perceived multicultural competency, and thought that future studies would be needed to examine the rationale for the incongruence. Play therapists registered with the Association of Play Therapy responded to the *Multicultural Counseling Competence and Training Survey*; 24% of the members of the association did not have multicultural coursework, but surprisingly the respondents felt competent about cultural awareness (Ritter & Chang, 2002). Additionally, Ritter and Chang’s study suggested that play therapists who took multicultural courses believed that they were poorly trained, but felt more competent with increased multicultural courses. This could suggest that play therapists are not getting the type of multicultural trainings they wished for, but remained confident in their cultural awareness despite their beliefs that their training was poor.

With the predicted change in population diversity, play therapists have the opportunity and the obligation to provide culturally sensitive play therapy (Ryan, Gomory, & Lacasse, 2002). However, the U.S. Census (2010) has provided limited data regarding two acutely important diverse populations: same-sex couples with children, and groups per religious affiliation. Data on same-sex couples with children are not reported by the U.S. Census (2010) based on the census’s definition of family: “A family household is composed of at least two persons related by birth,

marriage, or adoption. A nonfamily household is either a person living alone or a householder who is not related to any of the other persons sharing their home” (U.S. Census, 2010). In 1936, the census stopped collecting data on religious make-up due to Public Law 94-521 that does not allow the government to require individuals to disclose their religious affiliation (U.S. Census, 2011). As awareness grows, so has the importance of meeting the needs of multicultural clients and families, and play therapists need continued awareness in order to prepare for the diversity shifts in their practices (Ryan et al., 2002).

Hinman (2003) and O’Connor (2005) have discussed specific cultures, how to become culturally competent, and how to increase awareness and skills, and made suggestions for working with children and their families in specific population groups. Numerous studies have addressed play therapy with diverse populations:

- Asian families (Chau & Landreth, 1997; Lee & Landreth, 2003; Yuen, Landreth, & Baggerly, 2002).
- Native American families (Glover & Landreth, 2000).
- German mothers (Grskovic & Goetze, 2008).
- Israeli parents (Kidron & Landreth, 2010).
- Hispanic populations (Constantino, Malgady, & Rogler, 1986; Garza, Kinsworthy, & Watts, 2009; Perez, Ramirez, & Kranz 2007).
- African Americans (Solis, Meyers, & Varjas, 2004; Hammer & Weiss, 1999).

These studies support play therapists’ increased knowledge, skills and awareness when working with specific cultures and ethnically diverse clients. These studies also included suggestions for adapting play therapies for specific cultures. Some studies have suggested



modifications to the traditional toy recommendations by Axline (1950) and Landreth (2002) to include toys that would be more familiar to the child and the child's cultural upbringing.

### **Play Therapy Approaches**

Rasmussen and Cunningham (1995) described two types of play therapy: non-directive and focused, citing the therapist's role as the differing factor between non-directive and focused play therapy. Axline (1964) stated that play therapy "may be directive in form—that is, the therapist may assume responsibility for guidance and interpretation, or it may be nondirective; the therapist may leave responsibility and direction to the child" (p. 9).

Jones, Casado, and Robinson (2003) have stated that some structured play therapies subscribe to utilizing less directive approaches to establish rapport and build the relationship, then move toward more direct approaches. Berting (2009) also supported utilizing directive approaches once the child is able to participate in a directive therapy; Berting cautioned therapist not to utilize directive approaches too soon in the relationship. Berting believed that behaviors such as disengaging, hiding and refusing to participate in directive techniques could indicate that a child is not ready for direct play therapy and may signal the need for less directive techniques.

### **Toys in the Playroom**

Toys have provided countless hours of play throughout the centuries, and therapists noted the benefits of play beginning in the early 1900s. The American Academy of Pediatrics (2007) promotes the importance of free play with toys such as dolls and blocks to allow children to use their imagination to develop cognitive, physical, social and emotional wellbeing.

In 1938, therapist David Levy discussed the use of play cabinets, clay, trains, dolls, and an array of possible materials that could be used in the playroom. Levy used free play and toys to initially engage the child and he later more directly used the materials to reenact the event that

preceded the need for therapy. Where as Levy supported the use of toys to directly reenact the event, Axline (1950) described the rationale for the use of toys in a less direct format with young children, believing that children should direct the play and that children used the toys as their natural form of communication. She proposed that play therapy be used as method of delivering therapy that allows children to express emotions through symbolic expression. The offering of toys allows for projection of emotions by children who lack the ability or self-awareness to verbalize feelings and emotions (Axline). In more recent literature, Landreth (2002) has stated, “Toys and materials can, however, determine or structure the kind of degree of expression by the child and their interaction with the therapist, and therefore must receive careful attention as to their selection” (pp. 138-139). Landreth also discussed the use of structured and unstructured items in the playroom by describing water and sand as unstructured materials that allow children to determine the use and representation. Structured materials such as the bop bag, toy soldiers, and alligator puppets may be used to express anger and frustration, according to Landreth (2002). Thus, as Axline (1950) has concluded, play in early childhood allows for overall healthy development; more specifically, the use of toys in a therapeutic playroom allows for symbolic expression as an avenue for healing.

As early as 1938, Levy described the use of dolls to allow for the recreation of an event that preceded the presenting problem. Similarly, Landreth (2002) recommends providing children with dolls, which he believes can represent the members of that child’s family, thereby enabling the therapist to better understand the child’s intended meaning behind familial play. Toys used in the playroom allow non-verbal children to express themselves through the manipulation of the toys (Axline, 1950) as toys are symbolic expressions of emotions in therapy sessions.

Providing the child with real-life miniatures, such as a medical kit, allows children to express themselves, thus promoting healing, according to Landreth (2002). Items that promote feelings of success, such as clay, crayons, and blocks, provide the child with the ability to complete a task independently and promote a positive self-image. The documentation of the symbolic use of toys in the playroom has over many decades demonstrated benefits (Axline, 1950; Landreth, 2002; Levy 1938).

O'Connor (2005) has suggested that with the aim of meeting the needs of diverse populations, playrooms should have culture-neutral items and culture-specific items, such as homes that are representative of all levels of socioeconomic families; dolls of varied ethnicities; healthcare devices to represent disabilities; multiple sets of dolls for use by children from same-sex households in which the caretakers may identify as gay or lesbian; and varied religious symbols.

Religion can be a strong influence for certain clients and should not be avoided, according to Gil and Drewes (2005), but instead should be used as an avenue to learning more about a client and family beliefs. Gil and Drewes have stated that the cultural background of a child and the level of parental involvement in the child's play may dictate how a child plays with the toy—all of which should be considered when observing play in session in order to limit flawed assumptions. They further recommended that therapists visit dollar stores and grocery stores within specific communities, which not only allows therapists to purchase inexpensive items, but also exposes the therapist to a child's cultural experience.

### **The Role of the Association of Play Therapy**

In 1982, the Association of Play Therapy was formed as an interdisciplinary organization to advance the field of play therapy as well as provide professional credentials to therapists

educated in the modality of play therapy. Charles Schaefer and Kevin O'Connor founded the Association for Play Therapy with the mission of advancing the field of play therapy and providing guidelines for practitioners on techniques and theories within the field. Today, the Association for Play Therapy awards credentials to play therapists, educates the public on the value of play, researches and supports play therapy practices, encourages diversity in play, and maintains the professional organization (Association for Play Therapy, 2010). The Association for Play Therapy issued *Play Therapy Best Practices* in 2009 specifically to establish guidelines for practitioners and to formally establish standards for play therapy. This report addressed the therapeutic relationship, parents and family, confidentiality, professional responsibility, relationships with other professionals, evaluation, assessment and interpretation, teaching, training and supervision, research and publication (Association for Play Therapy, 2009).

Continuing Schaefer and O'Connor's original mission to advance the field of play therapy, the Association of Play Therapy introduced and currently credentials registered play therapists. The Association for Play Therapy specifically requires the following courses to obtain certification as a registered play therapist: ethics, child development, theories of personality, principles of psychotherapy, and child/adolescent psychopathology (Association for Play Therapy, 2010). Multicultural counseling coursework is not a prerequisite for becoming a registered play therapist; however, the association did address diversity in *Play Therapy Best Practices* by recommending therapists gain awareness in cultural identity, cultural knowledge, and culturally appropriate practices. The document further acknowledges that play therapists' own cultural identity influences their interventions and therapeutic ideas, and therefore the association encourages play therapists to be mindful and respectful of the client's cultural identity. However, the association acknowledges in *Play Therapy Best Practices* (2009), that

play therapists present with their own personal beliefs and values and promote the discussion of how those values may present in the therapeutic relationship to support an open dialogue and lead to best practices.

The Association for Play Therapy Credentialing Program (2010) offers certifications for registered play therapists (RPT) and registered play therapist supervisors (RPT-S). To become a registered play therapist, an applicant should meet the requirements in five areas:

license/certification, educational degrees, clinical experience, play therapy training, and supervised play therapy experience. To become a registered play therapist supervisor, an applicant should meet the requirements in six areas: license/certification, educational degrees, clinical experience, play therapy training, supervised play therapy experience, and supervisor training.

Further, The Association for Play Therapy Credentialing Program (2010) provides certification to either independent clinical mental health professionals or supervised clinical mental health professionals in the state in which the therapist practices, for example, licensed clinical psychologist (LCP); licensed professional counselor (LPC); licensed clinical social worker (LCSW); licensed marriage and family therapist (LMFT); and limited licensed psychologist (LLP).

### **Educating Play Therapists on Diverse Populations**

In section G.2 of *Play Therapy Association Best Practices*, the Play Therapy Association (2009) recommends awareness of personal cultural identity, obtaining continuous cultural knowledge, and displaying culturally appropriate practices. However, it does not provide directives on how to become culturally competent. To investigate cultural competence training, Ritter and Chang (2002) used a researcher-developed questionnaire, *Multicultural Counseling*

*Competence and Training Survey*, and found that the responding 134 play therapists registered with APT believed that they had poor training in the five subscales assessed (knowledge, awareness, terminology, racial identity development, and skills), rating racial identity development as the lowest. The respondents reportedly felt most competent in the area of multicultural awareness with a mean score of 3.38 on a scale of 1 to 4, with 4 representing “extremely competent.” They reported feeling slightly less competent in the area of terminology with a mean score of 3.37, and least competent in racial identity development with a mean score of 2.07. Ritter and Chang postulated that these findings suggested that participating play therapists believed they had sufficient training in the areas they felt more competent in—multicultural awareness and terminology. They also found that when play therapists perceived their training as more than adequate, they perceived themselves to be more competent in areas of multiculturalism, such as awareness and terminology.

Ritter and Chang (2002) asserted that more research was needed to identify the rationale for play therapists feeling competent but perceiving their training as poor. They did find that play therapists who had more education felt more competent. Play therapists did not perceive themselves as more competent based on years of experience, but did perceive themselves as more competent based on courses taken in multicultural counseling (Ritter & Chang, 2002).

Conversely, Ryan, Gomory, and Lacasse (2002) used a web-based survey administered to the participating members of the Association of Play Therapy and found that 67.1% of respondents read play therapy materials monthly. However, only 16.6% of respondents read play therapy research only every six months or less. They reported no significant relationship between reading play therapy literature and gender or discipline. They concluded that, overall, play therapists are reading play therapy materials, seeking out continuing education, and believed that

with trainings focused on evidenced based interventions the field of play therapy could continue to grow. They also felt that the Association for Play Therapy could use the findings of their study to inform the future plans and strategies for future professional growth of play therapists. They advocated for an increase in awareness and availability of specific topics through continued education arenas. Thus, the association has the opportunity to educate therapists on culturally sensitive play therapy.

### **Conceptual Framework**

The conceptual framework for my study is based on the eight basic principles of non-directive play therapy of Virginia Axline. According to Axline (1947), the guiding principles of nondirective play therapy are: (a) development of the relationship, (b) acceptance of the child, (c) permissiveness for expression, (d) recognition of feelings and reflection of feelings, (e) respecting the child's ability to find solutions to problems and allowing the child space to do so, (f) the child as leader, (g) the therapist as patient, and (h) the establishment of minimal limitations. Axline (1947) believed that play was the natural form of communication for children, stating that children were able to express through play what they were unable to express verbally due to developmental limitations. She discussed the development of rapport early on in the relationship as an essential factor of non-directive play therapy. Also, she believed that the child must be welcomed exactly as he or she is. The child should be given permission within the play therapy room to fully express him or herself (Axline), this may be aided by materials that are culturally sensitive.

Axline (1947) offered that children are able to find solutions to their own problems, given respect and time. Axline further proposed that children should not be hurried or directed in the play therapy room but allowed time to express through play their true emotions. Building on

Axline's guiding principles, the play therapist should have the skills necessary to work with children regardless of their cultural or ethnic backgrounds.

### **Significance of Study**

Although the literature has recommendations on working with specific racial populations including Asian families (Chau & Landreth, 1997; Lee & Landreth, 2003; Yuen, Landreth, & Baggerly, 2002); Native American families (Glover & Landreth, 2000), German mothers (Grskovic & Goetze, 2008); Israeli parents (Kidron & Landreth, 2010); Hispanic populations (Constantino, Malgady, & Rogler, 1986; Garza, Kinsworthy, & Watts, 2009; Perez, Ramirez, & Kranz, 2007); and African Americans (Solis, Meyers, & Varjas, 2004), little information is available in play therapy literature that addresses other cultural variables such as gender, sexual orientation, religion, or socioeconomics. Regarding the use of toys, the current body of play therapy literature has general guidelines on what toys should be made available in a playroom (Axline, 1948; Kottman, 2001; Landreth, 2002). Additionally, the Association of Play Therapy has recommended that play therapists become culturally competent through an increase in knowledge, skills, and awareness of culturally sensitive areas, but does little to direct play therapists on how they should provide services or what materials should be included in a playroom when working with diverse populations.

### **Purpose of the Study**

The purpose of this study was to understand how play therapists defined and provided culturally sensitive play therapy. Additional purposes of this study were to examine the relationship between populations served and materials available in the playroom and to determine differences among registered play therapists based on sex, age, type of licensure, formal multicultural training, and play therapy training.



This study was based on the work of Ritter and Chang (2002), who surveyed members of the Association for Play Therapy with the *Multicultural Counseling Competence and Training Survey*. This study also included two optional open-ended questions following the survey: “What trends, if any, do you see in the play therapy with your culturally diverse clients?” and “What items do you include in your playroom to specifically represent culturally diverse populations?” Not fully addressed in the 2002 article by Ritter and Chang, the responses to the two open-ended questions were later detailed by Chang, Ritter, and Hays (2005). The response to toys used to represent culturally diverse populations in the playroom was limited to respondents willing to complete the *Multicultural Counseling Competence and Training Survey*. The instrument I developed for my study was based on the literature and their work. With this instrument, I surveyed play therapists who were identified by the Association for Play Therapy as members with at least a master’s degree.

### **Research Questions:**

1. What is the relationship between the perceived barriers and the use of culturally sensitive play therapy materials available in the playroom?
2. What is the relationship between beliefs about culturally sensitive play therapy and the use of culturally sensitive play therapy materials?
3. Is there a relationship between the type of ethnic populations served and the use of culturally sensitive play therapy materials?
4. What types of culturally sensitive materials are available in play therapists’ playrooms?

### The following subquestions were addressed:

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

2. What level of formal multicultural training do play therapists receive?
3. Are there differences in licensure obtained and use of culturally sensitive play therapy materials by play therapists?
4. Are there sex differences in play therapists use of culturally sensitive play therapy materials?
5. Is there a relationship between play therapists' level of education and their use of culturally sensitive play therapy materials?
6. Is there a relationship between play therapists' status (registered play therapist or registered play therapist supervisor) and their use of culturally sensitive play therapy materials?
7. Is there a relationship between play therapists' formal training and their use of culturally sensitive play therapy materials?
8. Is there a relationship between play therapists having a dedicated playroom and their use of culturally sensitive play therapy materials?

### **Assumptions of the Study**

It was assumed that persons listed on the Association for Play Therapy mailing list as a registered play therapist (RPT) or registered play therapist supervisor (RPT-S) have met the requirements for certification. It was assumed that individuals have had at least a master's degree when completing the survey. Another assumption was that respondents were honest in their answers to the survey. Further, it was assumed that the survey instrument was valid and precisely measured registered play therapists' use of materials when working with diverse populations.

## **Definition of Terms**

Association for Play Therapy (APT): An interdisciplinary association whose mission is to promote the value of play, promote play therapy, and credential play therapists (Association for Play Therapy, 2006).

Filial Therapy: The training of parents in basic play therapy skills for use at home to improve the parent-child relationship (Landreth, 2002).

Nondirective Play Therapy: A therapeutic process 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).

Play Therapy: A relationship between a child and a trained play therapist wherein the permission given to the child allows him to express himself, in the safe relationship, through the natural communication of play (Landreth, 2002).

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

## CHAPTER TWO

### REVIEW OF THE LITERATURE

#### **History of Play Therapy**

Play therapy has been traced to the pioneering work of Sigmund Freud (1909/1955), who, in the classic case of “Little Hans,” documented the first psychoanalytic therapeutic work that focused on a child. Freud advised Hans’s father, who observed his son’s play and reported it back to Freud. Through the observational reports of the father, including Hans’s play, behaviors, and dreams, Freud was able to explore Little Hans’s phobias. Freud’s psychoanalytic casework on Little Hans opened doors for a number of psychologists in the child therapy field and started the therapeutic work that is now play therapy.

One of the most notable psychologists of her time and an innovator in the field, Melanie Klein (1955) began using play therapy to substitute for the psychoanalytic technique of free association with children under the age of six. Klein believed that children could benefit from psychoanalysis regardless of whether they were developing normally or were disturbed (Klein, 1955). She also (1955) believed that children were best analyzed through actions, not through customary speaking as used in adult psychoanalysis; therefore, Klein allowed for toys in the session, and she interpreted the child’s actions in relation to the play with toys.

Sigmund Freud’s daughter, Anna Freud (1946), followed in her father’s footsteps, but used play in therapy to interpret the unconscious motivation of children while building a therapeutic relationship. Early in her career, Freud (1946) realized that “special modifications and adjustments” (p. 4) were needed in addition to the traditionally prescribed methods of psychoanalysis with adults. She also realized that children, unlike adults, did not choose to enter into psychoanalysis. Children instead were brought without consent; therefore, the beginning

stage of the analytic relationship with children is different than that of the adult relationship in analysis. Further, Anna Freud stated that in psychoanalysis with adults, the therapist is able to depend solely on the information given by the patient; however, when working with children, a working history is needed from the child's caregiver.

Anna Freud found children to be distrustful of the process of psychoanalysis, and she believed that alternative methods were needed to build the therapeutic relationship. She did not think it was possible to practice true psychoanalysis of the child during the beginning stage due to the child's mistrust of the situation. To gain the child's trust and begin the therapeutic relationship, Freud became a friend to the child. To gain the child's trust and begin the therapeutic relationship, Freud became useful and interesting to the child. She described engaging children by allowing them to tell stories, typing their letters, crocheting and knitting doll clothing. Freud stated that the relationship between her and the patient needed to be strong enough to endure analysis. She also thought that dreams and daydream analysis with children could be accompanied by drawings.

It was not until the 1930s that David Levy (1938) introduced the concept of release therapy, marking another major contribution to the field of play therapy. Levy's release therapy was a therapy through which a child was able to express anxieties through structured play. The child was allowed to free play in session, similar to Klein's free association. The therapist then introduced toys into the session that related to the event that necessitated the therapeutic intervention, and thereby allowed the child to release the anxiety surrounding the event.

Around the same time in Europe when Anna Freud developed approaches for play therapy with children, in America, Virginia Axline (1950) created nondirective play therapy. Axline defined this type of 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 this own way and in his own time” (p. 68). Unlike Freud and Klein who focused on psychoanalysis, Axline believed that children would strive to meet their full potential and that the therapeutic relationship fostered that growth.

Today’s guiding principles of nondirective play therapy are based on Axline’s work (1947), because she focused on such a variety of themes: development of the relationship; acceptance of the child; permissiveness for expression; recognition and reflection of feelings; respecting the child’s ability to find solutions to problems and allowing the child space to do so; the child as leader; the therapist as patient; and the establishment of minimal limitations. Axline’s non-directive play therapy with children offered an alternative to the psychoanalytic work of Freud and Klein.

Building and extending the non-directive play therapy approach of Axline, Landreth (2002) proposed that the child-centered play therapy relationship must be different from any other relationship that the child had experienced. He described play therapy as a relationship between a child and a trained play therapist in which the child is given permission to be expressive in the safe relationship, through the natural communication of play. Landreth (2002) believed that the unconditional acceptance of a child would offer a distinctive relational component that was not experienced by children in their day-to-day relationships. He believes that that bond is the foundation for the child-centered therapeutic relationship. Landreth (2002) prescribed that the therapist act as a mirror for the child’s emotion and refrain from seeking out or directing the child’s play, believing that the child guided the work in the playroom, without the therapist’s interpretation of the child’s actions.

## **Play Therapy Theories and Approaches**

“Child-focused,” “client-centered,” and “unstructured” are terms used to define components of non-directive approaches of play therapy. Elements of directive approaches, by contrast, are referred to as “structured,” “directive” and “focused.” Gil (1994) explained numerous directive play therapy approaches—for example behavioral or gestalt—but maintained that nondirective play therapy has a more client-centered approach. Elaborating on the terms chosen to describe play therapy approaches, Gil (1994) stated that non-directive play therapy allows the child to guide the session, whereas in directive or structured play therapy the therapist guides the session in order to move the therapy in a particular direction.

Jones, Casado and Robinson (2003) described structured play therapy as directive in approach and said that planned activities are used in most structured or directive sessions. When considering approaches to building rapport in structured play therapy, they subscribed to utilizing less directive approaches, then moving toward more direct approaches. Rasmussen and Cunningham (1995) also argued for an integrated approach in which the therapist determines which approach to utilize based on: (a) the child’s character, (b) his or her presenting issue(s), and (c) the therapeutic stage. Similarly, Berting (2009) supported the idea of building the therapeutic relationship through the use of less directive approaches prior to more directive activities in the working stages of the play therapy session. Berting also encouraged clinicians to consider the need for the child to be able or willing to join in directive play therapy, stating that behaviors such as disengaging, hiding and refusing to participate in directive techniques may signal decreased readiness to progress and the need for less directive techniques.

## **Non-Directive Play Therapy**

The contributions of Axline, credited as the founder of non-directive play therapy, to the field influenced play therapists' work for over 60 years. Axline (1947) developed non-directive client-centered play therapy. It was Axline's belief that through play the child is allowed to communicate and little interpretation or guidance of that play should be made by the therapist. It is through that relationship that the rudiments of Axline's client-centered play therapy assist the child in experiencing: (a) genuineness, (b) unconditional positive regard, and (c) empathy (Astramovich, 1999).

Similarly, Ray, Blanco, Sullivan, and Holliman (2009) have stated that in the therapeutic relationship built on the therapist's unconditional acceptance of the child, the child learns self-acceptance. Further, Ray et al. (2009) trusted that the child would then progress toward his or her potential. The notion of reaching one's full potential was originally proffered by Axline (1947), who theorized that progression toward full potential occurs because of the therapeutic relationship, not because of prescribed interventions or specific techniques. As play therapists continue to build on the foundations of non-directive approach that is guided by Axline's original work, the field of non-directive play therapy continues to progress more than 60 years later.

### **Client-centered play therapy.**

Landreth (2002) is credited with expanding on the ideas of Axline (1947), Ginott (1959) and Moustakas (1959) to develop what is now known as client-centered play therapy. Axline (1947), who believed in the child's potential for self-actualization, stated the foundations of play therapy were based on the relationship and the acceptance of the children as they are. She also believed that play was the natural form of communication for children, stating that children were



able to express through play what they were unable to express verbally. Moustakas (1959) thought that children needed to feel understood and believed that client-centered play therapy sessions allowed the child to grow in a self-directed manner. Additionally, he thought that client-centered play therapy allowed for an environment of respect and focused on acceptance, as opposed to presenting issues or problems.

More recently, Astramovich (1999) stated that the primary purpose of client-centered play therapy was to concentrate on the child's growth and change through self-directed therapeutic play therapy sessions. Similarly, Gil (1994) advised that the client-centered play therapists should not engage in question-and-answer segments or give instructions, but concentrate instead on providing observations or undivided attention to the child.

Therapists practicing child-centered play therapy continue to dominate the play therapy arena, as shown by Ryan, Gomory, and Lacasse (2002) who surveyed members of the Association for Play Therapy to determine membership characteristics, including demographics, membership status, formal education, continuing education, supervision, work setting, and work distribution. Ryan, Gomory, and Lacasse found participants reported their respective universities taught child-centered play therapy most often, making it one of the top-two most frequently taught graduate-level play therapy models. This was supported by related evidence of Lambert et al. (2005) who surveyed play therapists who were members of both the Association for Play Therapy and the American Counseling Association regarding their training, modalities, theoretical orientation, and work setting. Lambert et al. also found that 66.6% of responding practitioners identified their theoretical orientation as child-centered.

## **Directive Play Therapy**

Jones, Casado and Robinson (2003) described a directive approach to play therapy they termed as “structured” play therapy stating that the therapist uses coordinated and planned activities based on needs or symptoms, giving careful consideration to the benefits of each endeavor. Jones et al. stated that the therapist holds the onus for selecting the topics and activities for each session and must pay attention to the child’s developmental level of functioning, under the assumption that structured activities are best for children ages seven or older. This theory is in keeping with McCalla’s (1994) argument that it is important to consider the chronological age, developmental age, and the cultural environment of the client to properly identify, understand, and respond to the child’s play in session. Additionally, Jones et al. urged directive play therapists to be aware of the progression or intensity of the play therapy. Jones et al. also suggested that therapists begin sessions in a less threatening manner with the child through one issue at a time, which is considered to be the therapeutic rate.

“Focused” or “directive play” therapists may use directive techniques such as cognitive-behavioral techniques, metaphors, bibliotherapy, role-plays, games, or art therapy (Rasmussen & Cunningham, 1995) to guide the play therapy session. Berting (2009) recommended that counselors first determine if the child is able or willing to participate in directive play therapy, and then determine what materials will be beneficial. She stated that behaviors such as disengaging, hiding and refusing to participate in directive techniques may signal decreased readiness to progress and the need for less directive techniques. Furthermore, she detailed in her case presentation that she believed the therapy was successful after the child was allowed permission to control the sessions through non-directive play therapy.

Jones, Casado, and Robinson (2003) alerted therapists to consider the sequence, intensity, and rationale for materials employed in each client's session and listed the following for use in structured play therapy: books, artwork, imaginative play, puppets, dolls, sand, worksheets, and music. Regardless of the theoretical approach chosen by a play therapist, the therapist should be mindful of the child's ability to engage in the session.

### **Cognitive behavioral play therapy.**

Susan Knell (1993a, 1993b, 1994, 1997) was a luminary in the work of cognitive behavioral play therapy with young children. Knell described cognitive behavioral play therapy as an incorporation of developmentally appropriate cognitive behavioral techniques and play therapy principles. In concurrence, Rasmussen and Cunningham (1995) 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) described several of the cognitive behavioral techniques used in play therapy as cognitive restructuring, disputing irrational beliefs, and cognitive distortions, which are used with adults but modified to meet the needs of younger clients in play therapy.

Knell (1998) cautioned therapists to remain flexible in their approaches to cognitive behavioral play therapy and to adjust the therapy to meet the developmental needs of young children. As an example, she cited the use of puppets to model positive statements to counter the young client's unhealthy beliefs. Through the use of cognitive behavioral principles, Knell (1998) stated that a few of the goals of cognitive behavioral play therapy were to teach young children new coping skills and alternative behaviors. This is illustrated by Knell's (1998) statement that the therapist could guide the child through a series of stories, pictures, or puppet play to decrease anxiety and capitalize on the child's strengths, thereby enabling the child to

build coping strategies. Alternatively, Swank (2008) advocated the use of games in cognitive behavioral play therapy, stating that games capitalize on the clinician's ability to educate, challenge, or transform the child's detrimental thoughts or behaviors. After the therapist had successfully assisted the client in altering unhealthy thoughts or behaviors, Knell (1998) proposed that the newly learned coping skills could transfer to the child's outside world.

### **Gestalt play therapy.**

Gestalt play therapy, according to Oaklander (2001), focuses on the complete child, including the body, the emotional states, and the mind. In an interview, Oaklander (1993) described her approach to play therapy as a dance, stating that at times she led (hence more direction), while other times the child led. Oaklander (2001) maintained that the therapeutic relationship was the foundation of gestalt play therapy and noted, similarly to Axline, that the therapist welcomed the child as he or she was in the present moment. Oaklander further stated that gestalt play therapists focused on the essential progression toward homeostasis, which can be problematic for the ever-growing, transforming child. The child's ability to appropriately express emotions is vital to a healthy outlook, thus Oaklander (2001) prescribed the use of multiple modalities, such as music, clay work, puppet play, or artwork. Throughout the healing process, gestalt work focuses less on the "why" and more on "what" and "how," as Oaklander (2001) found.

Understanding child development is essential to working with children in play therapy, regardless of techniques used. Oaklander (2001) postulated that a strong sense of self was essential for a child to heal. She believed that it was the therapist's responsibility to offer the child activities that would foster the child's sense of self, such as storytelling, artwork and offering choices. Oaklander (1993) pinpointed many of the techniques used in gestalt play

therapy that she believed should be altered in accordance with the child's developmental stage and needs. She used the example of working with a client on "the self," whereas with a young child, she may approach this theme through projective means (i.e., artwork, sand, or clay). In the case of an adolescent, the adolescent may have the ability to conceptualize ideas and speak about specific emotions.

However, Botha and Dunn (2009) thought that children attempted to reach homeostasis by fulfilling their needs and adapting to a changing environment. Botha and Dunn (2009) named the stages of gestalt play therapy as: (1) relationship building, (2) observing sense of self, (3) self-nurturing, then (4) termination. True to the foundations of gestalt therapy, the I/Thou relationship is also nurtured in gestalt play therapy: continuing to accept the child as he or she is, thereby building therapeutic alliance (Oaklander, 2001). Through the process of gestalt play therapy, children are able to build a healthy sense of self, accept responsibility for their choices, and progress toward homeostasis (Botha & Dunn, 2009).

#### **Adlerian play therapy.**

Kottman (2001) stated that Adlerian play therapy might link strategies of non-direct and direct play therapy; the goal of both was to help move the client toward a feeling of confidence, connectedness, courage, and capability. Although Kottman and Warlick (1989) acknowledged that children may lack the insight to comprehend the Adlerian use of abstract symbols, they advocated the use of the following Adlerian techniques in play therapy sessions: (a) encouragement, (b) family constellation, (c) early recollections, (d) goal disclosure, and (e) tentative hypotheses. Adlerian play therapists also believe that all behaviors are purposeful acts by the client, and that through the use of Adlerian play therapy, children could gain insight and learn alternative coping strategies, according to Kottman and Warlick (1989).

Sweeney, Minnix, and Homeyer (2003) elaborated on the idea of children being goal-oriented and stated that at times the goals were relationally driven and that the child may find it difficult to verbally express private thoughts. They advocated the idea of blending Adlerian philosophies with play therapy techniques.

Watts and Garza (2008) described the Adlerian play therapy phases as: (a) development of the relationship, (b) exploration of the child's style, behaviors, and maladaptive beliefs, (c) increasing the child's insight, and (d) education on significance and interactions with others.

Later, Morrison (2009) expanded on the description of the interaction with others phase of Adlerian play therapy, stating it was especially important to children. Morrison stated children's sense of belonging was developed typically through early interactions with their families.

Morrison also believed that young children's early interactions formed their decisions. Morrison identified with the four phases of Adlerian play therapy, however, did not believe that the identified phases were chronological or static. This supported Watts and Garza's description of Adlerian play therapy wherein they proposed that the phases of Adlerian play therapy were fluid.

### **Jungian play therapy.**

Green (2008) described Jungian analytical play therapy (JAPT) 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). JAPT, as described by Green, merges methods of play therapy with the theoretical underpinnings of Jungian therapy, focusing on the archetypes and the collective unconscious to promote psychological wellbeing. Green believed that Jungian analytical play therapy was a therapist-directed relationship built on a foundation of trust. Green also believed the child recognized where he or she desired to go, but allowed the therapist to direct the session. For example, Green stated that serial drawings, a

technique in which a child draws in front of the therapist each week and the therapist focuses on the healing aspects of the artwork, may be used in Jungian play therapy. Sand play, a therapeutic tool in which the child is allowed to place objects in the sand, is another tool used in directive play therapy by some Jungian play therapists (Bainum, Schneider & Stone, 2006). Bainum, Schneider and Stone believed that the sand is representative of the Jungian dream state. Bradway (2006) further described sand tray therapy as nonverbal and imaginative therapy, which is the vehicle to the client's unconscious.

Perry (2002) believed that the trained Jungian play therapist was able to identify the archetypal symbols (such as the hero) used in the child's play. Perry further postulated that the archetypal symbols were cross-cultural and that diverse populations could be served through Jungian play therapy. He also believed that trained Jungians could combine their knowledge of the cross-cultural archetypal symbols and knowledge of child development to assist children in working through unresolved problems.

### **Psychoanalytic play therapy.**

Melanie Klein and Anna Freud made the earliest and most significant advancements in play therapy with contributions of psychoanalytic play therapy. Klein (1955) started utilizing therapy to substitute for free association in psychoanalysis with children under the age of six. Similarly, Anna Freud (1946) used play therapy to interpret the unconscious motivation of children while building a therapeutic relationship. More recently, McCalla (1994) stated that the function of the therapist is to guide, interpret, and build an alliance with the child. McCalla also reported that toys should be uncomplicated and should facilitate recreation of the child's world within the playroom. Swank (2009) suggested that psychoanalytic play therapists make use of

therapeutic games as observers within the session to detect the client's drives, defenses, and conflicts.

### **Toys in Play Therapy**

Landreth (2002) recommended a well-stocked, inviting playroom with deliberately chosen, developmentally appropriate toys that the child can use without direction from the therapist. The current body of play therapy literature has general recommendations, regardless of theoretical approach, on toys that should be made available within a playroom (e.g., Axline, 1948; Kottman, 2001; Landreth, 2002).

Toys have provided countless hours of play throughout the centuries, but the discussion of benefits of toys in the therapeutic arena originally appeared in the early 1900s. Anna Freud (1946) first described children's use of toys to represent people in a world that is much larger than they are, in which they are able to manage and determine how to manipulate materials. Around the same time, Axline (1947) believed that toys allowed for the expression of emotions through symbolic play. Children who lacked the ability or self-awareness to verbalize feelings and emotions were offered toys that Axline (1950) suggested be allowed for the projection of emotions. Later, Cassell (1972) stated that toys used for therapeutic needs could be divided into specialized types: (a) psychotherapeutic toys; (b) artistic materials; (c) hand puppets and portable stage; and (d) portable furnished dollhouse. At that point in play therapy history, toys were chosen for the ease with which children could express themselves with them, their price, and their appeal to children, including diverse dolls (Cassell, 1972). More recently Landreth (2002) has recommended that toys are chosen carefully, based on therapeutic and expressive needs of the child.



## **Culturally Sensitive Toys in the Playroom**

O'Connor (2005) suggested that with the aim of meeting the needs of diverse populations, playrooms should have culture-neutral items and culture-specific items, such as homes that are representative of all levels of socioeconomic families; dolls of varied ethnicities; healthcare devices to represent disabilities; multiple sets of dolls for use by children from same-sex households in which the caretakers may identify as gay or lesbian; and varied religious symbols. Gil and Drewes (2005) acknowledged that the cultural background of a child and the level of parental involvement in the child's play may dictate how a child plays with the toy—all of which should be considered when observing play in session in order to limit flawed assumptions. They further recommended that therapists visit dollar stores and grocery stores within specific communities, which not only allows therapists to purchase inexpensive items, but also exposes therapists to client's cultural experience.

Hinman (2003) has suggested that play therapists utilize puppets, dolls, and dramatic play for the development of coping skills among populations who are dealing with identity development. Further, Gil and Drewes (2005) offered specific play materials for working with diverse populations, including but not limited to: books for use with African-American populations, books for use with Hispanic populations, and books for use with multicultural populations. Additionally, Gil and Drewes identified several corporations that supply a wide variety of sand tray miniatures that are reflective of diverse religions and diverse landscaping materials, as well as dolls and puppets with a variety of skin tones. They elaborated on the use of religious symbols, stating that the religious symbols hold a strong influence for certain clients and should not be avoided, but instead used as an avenue through which to learn more about a client and family beliefs.

## **The Role of the Association of Play Therapy**

The Association for Play Therapy, established in 1982 by Charles Schaefer and Kevin O'Connor, promotes play therapy as an effective therapeutic avenue to working with children. Schaefer and O'Connor recognized the need for a professional association which focused on promoting play therapy, promoting professionalism, and educating on the practice of play therapy. The Association made another advancement in the field of play therapy in 1992 with the first issue of *International Journal of Play Therapy*, which allowed for the dissemination of research devoted to play therapy. The following year, 1993, the association began credentialing registered play therapist (RPT) and registered play therapy supervisors (RPT-S). The Association for Play Therapy has since grown into an international professional organization that continues to credentials to play therapists, produces a peer reviewed journal, a magazine dedicated to play therapy, encourages research on play therapy, and educates the public on the value of play (Association for Play Therapy, 2010).

The Association for Play Therapy *Bylaws* (2006) recognize three categories of membership in Article II: professional, international, and affiliate. The Association defines a professional member as a person living in the United States who holds a mental health Master's degree. The professional membership also requires membership in a chartered branch, if applicable. Full-time students, parents, non-mental health professionals, or retired or inactive play therapists may register as affiliate members of the association.

### **Advancing the Field**

The Association for Play Therapy (2011) publishes four types of publications: the *International Journal of Play Therapy*, the *Member Flash*, the *Mining Reports*, and the *Play Therapy Magazine*. The *International Journal of Play Therapy* focuses on research, current

practices, and case studies (Association for Play Therapy, 2011). The *Member Flash* aims to raise awareness about upcoming training opportunities and recognize play therapist accomplishments. It is distributed via email bi-weekly (Association for Play Therapy, 2011). The Association for Play Therapy also produces *Mining Reports*, sent to members via email, to notify play therapists of best practices and trends in the field. Finally, the *Play Therapy Magazine* reports on recent research-based practices and applications, association news, and promotes play therapy materials and providers (Association for Play Therapy, 2011).

The association also issued *Play Therapy Best Practices* in 2009, a policy document that addressed the standards of play therapy. *Play Therapy Best Practices* addressed issues relating to the therapeutic relationship, parents and family, confidentiality, professional responsibility, relationships with other professionals, evaluation, assessment and interpretation, teaching, training and supervision, research and publication. The document is a guide for play therapists in “instruction, supervision, and practice of play therapy” (Association of Play Therapy, 2009, p. 2).

## **Credentialing**

The Association for Play Therapy Credentialing Program (2010) recognizes registered play therapists (RPT) and registered play therapist supervisors (RPT-S). The association requires play therapists to meet criteria in five areas (license/certification, educational degrees, clinical experience, play therapy training, and supervised play therapy experience) before becoming a registered play therapist. The Association specifically requires the following courses to obtain certification as a registered play therapist: ethics, child development, theories of personality, principles of psychotherapy, and child/adolescent psychopathology (Association for Play Therapy, 2010). Currently, multicultural counseling is not a prerequisite for becoming a

registered play therapist; however, the association addresses diversity in *Play Therapy Best Practices* (2009). The association recommends in *Play Therapy Best Practices* (2009) that play therapists gain awareness in cultural identity, cultural knowledge, and culturally appropriate practices, while being mindful and respectful of the client's cultural identity.

### **Training and Professional Growth**

Joiner and Landreth (2005) surveyed professors identified as experts in the play therapy field regarding their beliefs regarding essential components of play therapists' education; they reported a lack of financial resources and lack of adequately equipped playrooms or availability of playrooms at their respective universities as limitations to training. Joiner and Landreth believed that these issues could be addressed through the use of a tote bag playroom and supervision sessions (e.g. live supervision or review of taped sessions). Limitations in play therapists' training were also reported by Ryan, Gomory and Lacasse (2002) who found that 40% of play therapists had play therapy content in their graduate training and that only one-third had play therapy components to their practicum experience. They believed this finding suggested that some play therapists had received a basic play therapy course as part of their graduate training; however, they had not received experiential play therapy components incorporated into a practicum course. Ryan, Gomory, and Lacasse also thought that beginning play therapists' experience was limited due to the lack of supervision from a supervisor credentialed as a registered play therapists-supervisor through the Association for Play Therapy. Fall, Drew, Chute, and More (2007) believed that that new play therapists needed support and nurturance for professional growth and therefore recommended supervision with a registered play therapist supervisor.

## **Multiculturalism Training**

The Play Therapy Association (2009) recommends the awareness of personal cultural identity, obtaining continuous cultural knowledge, and displaying culturally appropriate practices in section G.2 of the Play Therapy Association *Best Practices*. However, it does not provide directives on how to become culturally competent. Ritter and Chang (2002), using the *Multicultural Counseling Competence and Training Survey*, found that play therapists felt that they had poor training but did feel competent in the area of multicultural issues. Ritter and Chang pondered how one becomes culturally competent if one perceived having received poor multicultural training. However, Ritter and Chang found that play therapists perceived an increase in cultural competence with increased multicultural coursework. Although the association does not offer such courses directly, the Play Therapy Association website (<http://www.a4pt.org/ps.training.cfm>, 2010) does offer information on continued education through the annual conference, approved centers of play therapy, and the e-learning center.

Another avenue through which the Play Therapy Association could increase cultural competence is through its publications: Ryan, Gomory, and Lacasse (2002) found that 67.1% of respondents read play therapy materials monthly. They believed that the number of play therapists, responding to the survey (n=144) who read the literature on a monthly basis was promising; they also reported that the association could better use the literature to inform and guide play therapists.

Play therapists surveyed by Ritter and Chang (2002) felt competent in areas relating to awareness and terminology, but not in areas of racial identity. They also found that approximately one quarter (24%) of surveyed play therapists had received no formal multicultural coursework and only 33% of surveyed play therapists had received two or more

graduate level multicultural courses. The more multicultural coursework play therapists received, the more capable they felt, and perceived their training more sufficient.

### **Multicultural Practices in Play Therapy**

Play therapy literature has begun to advocate the need for play therapists to expand their knowledge, skills and attitudes regarding culturally sensitive play therapy (e.g., Berting, 2009; Gil & Drewes, 2005; Rasmussen & Cunningham, 1995). Ritter and Chang (2002) stated that it is vital that play therapists gain multicultural competency by demonstrating awareness, knowledge, and skills in working with clients of diverse backgrounds. Cross-culturally and multiculturally, play therapists have noted the benefits of play therapy for clients who belong to the following cultural groups: Asian families (Chau & Landreth, 1997; Lee & Landreth, 2003; Yuen, Landreth, & Baggerly, 2002); Native American families (Glover & Landreth, 2000), German mothers (Grskovic & Goetze, 2008); Israeli parents (Kidron & Landreth, 2010); Hispanic populations (Constantino, Malgady, & Rogler, 1986; Garza, Kinsworthy, & Watts, 2009; Perez, Ramirez, & Kranz 2007; and African Americans (Solis, Meyers, & Varjas, 2004). More broadly defining culture, O'Connor (2005) has stated that cultures "include, but are not limited to, gender, gender role, sexual orientation, race, ethnicity, age, physical ability/disability, religion, and social class" (p. 566). Additionally, O'Connor reminded readers of the differences in perceived culture, (i.e., the culture others believe an individual is associated with) and internalized culture (i.e., the culture one believes they are associated with). O'Connor's expansive view of culture aligns with Sue's (1991) belief that one's collective experiences influence one's worldview. The Association for Play Therapy (2009) also encourages play therapists to be mindful of interventions prescribed in play therapy that are influenced by one's own cultural identity.

Play therapists need to be aware of the child's cultural identity, but O'Connor (2005) also discussed the need for attention to the child's experiences within his or her family of origin's cultural practices. Children of first generation immigrants may experience two cultures: a social culture and a home culture, thereby experiencing acculturation dilemmas. Hinman (2003) acknowledged those acculturation difficulties, stating that ethnic identity and acculturation may be multifaceted issues for a child and the child may require assistance navigating the path to cultural identity.

Acculturation may prove especially problematic for a child whose parents are not experiencing acculturation at the same rate, according to Hinman (2003). Similarly, O'Connor (2005) pointed out that there is a difference between perceived culture—the culture to which others perceive the child to belong—and internalized culture—the culture to which the child perceives to be his or her membership. Hinman further stated that the child's experiences must be taken into account; otherwise, the play therapist may simply apply stereotypes to the child. Hinman recommended gathering information from the family, but also seeking out additional resources regarding the possible cultural influences.

### **Universal Language**

Axline (1947) argued that play was the universal language of young children and play was their most natural form of communication. The argument of universality is defined currently by Axline, who stated that basic tenet of play therapy is rooted in the belief that play is the natural form of communication for children; and (2) children are able to express through play what they are unable to express verbally. Further discussing this notion, O'Connor (2005) has pointed out that one of the five existing problems in providing culturally sensitive play therapy was the notion of universality of play. He maintained that not all populations play in the same

manner. Furthermore, Sue (2003) cautioned against the utilization of “color blindness,” the belief that all citizens are equal and that color does not matter, stating that color blindness does not take into account minority experiences and racial variances. Sue explained that “color blindness uses “whiteness” as the default key to mimic the norms of fairness, justice and equity by “whiting” out differences and perpetuating the belief in sameness (p. 106).” He further explained that the idea of color blindness denies the experiences of individuals, whether privilege or racism and discrimination.

### **Guiding the Change**

Numerous recommendations to improve working with diverse populations in play therapy have been made, including increased awareness, personalization, and modifications. Coleman, Parmer, and Barker (1993) have stressed the importance of play therapists meeting the changing needs of the populations presenting for services, stating that the methods and techniques used when working with diverse populations still center around the mainstream Eurocentric idea of play therapy. They additionally recommended the following guidelines when working with multicultural populations: (1) respect the client’s cultural group, (2) examine how play is viewed in cultural groups, (3) work to gain greater knowledge about cultural distinctions of the populations served, (4) consistently seek out cultural learning opportunities, not just minimum standards set by a board, (5) adjust the techniques and methods to meet the population served, (6) consult professionals and the child’s support system to determine a best-fit approach, (7) gain awareness of personal biases, and (8) seek cultural experiences outside of the therapy session.

O’Connor further cautioned play therapists not to over-generalize when working with specific populations and stated that just because a client is from a specific area or is a certain



ethnicity does not mean that he or she encountered a specific experience. O'Connor explains that just because a child is African American does not necessary mean that the child has experienced discrimination in school and further encouraged play therapists to respect the child's experiences and identity. Chow (2010) also recommended that play therapists become aware of the facets of a client's perceived identity, ask questions, and modify existing practices to accommodate the client's cultural needs.

O'Connor's (2005) stated that there were existing problems in the delivery of cross-cultural play therapy, such as that some play therapists expect children to be able to express themselves verbally and non-verbally, which may not be comfortable for children of certain backgrounds. Continuing the call for increased awareness of the client's experiences, Hinman (2003) also cautioned play therapists to fully understand the cultural context of play and not make erroneous conclusions based on a preconceived idea of what play should look like. Echoing the call for greater understanding of the specific client belief system, O'Connor's report stated that play therapists depend on unstructured communication from the parents and the child, wherein may not occur with families who believe that problems are best addressed within the family. Additionally, O'Connor noted that play therapists in the United States aim to problem solve, whereas some cultures value a more holistic approach to wellbeing.

### **Cultural Perceptions, Expectations, and Considerations**

Hinman (2003) recommended that play therapists gain an 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, while refraining from overgeneralizing. Hinman also stated that the family could provide resources and relevant information regarding the child, but that ultimately

the caregiver decided if play therapy was an effective and worthwhile endeavor, or if premature withdrawal was necessary.

Kazdin, Holland, and Crowley (1997) found that prematurely ending play therapy services was significantly linked to several factors, including perceptions that the therapy was not important and a poor parent relationship with the therapist. Similarly, Garza, Kinsworthy, and Watts (2009) expanded upon the need for additional culturally sensitive research to better understand what cultural groups deem important, which could prevent prematurely ending play therapy services, which they described as “early withdrawal.” Also, Hinman advised play therapists to consider the individual client’s cultural history and experiences within the community, to lessen overgeneralization. Ultimately, Hinman thought that a child who is struggling to understand ethnic identity might benefit from a safe environment, such as the playroom, to explore ethnic status.

Perez, Ramirez, and Kranz (2007) emphasized the importance of utilizing therapeutic techniques and strategies based on the needs of the diverse client to ensure maximum therapeutic benefit. They also reminded therapists to be mindful of differences within a group, but prescribed changes to the limit-setting techniques utilized within most mainstream European-American children.

### **Trends, Change, and Culturally Sensitive Play Therapy**

The majority of play therapists registered with the Association of Play Therapy are White and female (Abrams et al., 2006; Fall, Drew, Chute, & More, 2007; Ryan, Gomory, & Lacasse, 2002). Kottman (2001) has stressed the importance that play therapists recognize the changing population and prepare to work with clients from a variety of backgrounds. However, O’Connor (2005) stated that the belief that play was the natural form of communication or that it was

universal across all cultures could trivialize cultural beliefs or ideas of a minority child. Sue (2004) further stated that limited worldviews hinder the clinician from appreciating alternative worldviews, such as those of the minority client. Sue (1991) believed that a person's worldview is greatly influenced by his or her experiences and background. More specifically, Sue (2004) went on to state that some White Americans believe that their experiences are normal and are unable to accept that others do not share that worldview or experience; this can be especially problematic in the playroom, if a child is surrounded by materials that do not fully represent his or her daily experiences.

When surveyed regarding the trends of multicultural toys used in the playroom, one of the main themes play therapists reported was that there were generally no differences in play therapy among diverse clients, citing that play is the worldwide language (Chang, Ritter, & Hays, 2005). Additionally, O'Connor (2005) stated that the notion of universality is an existing problem within play therapy arenas, citing that perceived beliefs are that play is universal or similar across all cultures, which can trivialize the cultural identification of the child. Hinman (2003) emphasized that Western views of play may not be appropriate for working with a child from a Far Eastern culture where play is seen as inconsequential, thus making non-directive play therapy a challenge.

Chang, Ritter, and Hays (2005) found that play therapists perceived more diversity in populations served, whereas historically more Caucasian families than multicultural families sought out play therapy services. With the perception that play therapists recently served a more diverse population, they also found that play therapists perceived ethnic minorities to have limited involvement, find decreased value in therapeutic services, and to prematurely terminate.

Chang, Ritter and Hays (2005) found responding play therapists registered with the Association for Play Therapy reported an increase in the selection of culturally based play materials. The respondents were asked, as part of a larger study, to complete two open-ended questions: “What trends, if any, do you see in play therapy with your culturally diverse clients?” and “What items do you include in your playroom to specifically represent culturally diverse populations?” Purposive sampling was utilized by Chang, Ritter and Hays; the sample consisted of 134 play therapists who represented major regions in the United States. Major themes identified in response to, “What items do you include in your playroom to specifically represent culturally diverse populations?” included ethnic dolls, sand tray items and puppets. Some participants also commented on the use of ethnic play food, dress-up clothing, miniatures, homes, and religious objects. Chang, Ritter, and Hays also noted play therapists’ comments on the variety of shades of crayons and play-dough available from vendors. From the date of Chang, Ritter, and Hays’ study, numerous materials have since been recommended by Gil and Drewes (2005), who cited a variety of culturally sensitive items, available for use with cultural subpopulations, including arts and crafts, board games, books, a dramatic play area, dolls, puppets, and sand tray miniatures.

### **Conclusion**

A review of the play therapy literature showed that there have been many advances in the field, from the time of Sigmund Freud’s work to that of universities offering degrees in play therapy. The Association for Play Therapy has recommended that play therapists become more culturally aware. Experts in the field published recommendations on how one should or could work with a child from a specific type of family, whether divorced, ethnically diverse, or otherwise dissimilar from mainstream America.

Historical experts in the field published recommendations for how a therapist should stock a playroom. However, few studies have examined how therapists define culturally sensitive play therapy or support those play therapists in meeting the needs of diverse clients, but instead give general recommendations for working with specific populations. Garza and Bratton (2005) suggested additional research was needed in the area of culturally specific toys used by children in the playroom versus traditional toys. As the field of play therapy grows, there has been steady progress in the area of research (Baggerly & Bratton, 2010). However, the call for continued growth in the play therapy research arena is also heard (Baggerly & Bratton).

## **CHAPTER THREE**

### **Method**

This methodology used in this study is described in chapter three. It includes the following sections: purpose of the study, research questions, participant selection criteria, instrument and instrument development, data collection plan, characteristics of the sample, and methods of data analysis.

### **Purpose of the Study**

The purpose of this study was to understand play therapists' definitions of culturally sensitive play therapy, beliefs about culturally sensitive play therapy, materials used to deliver culturally sensitive play therapy, and perceived barriers to implementing culturally sensitive play therapy. Additional purposes of this study were to examine the relationship between populations served and materials available in the playroom and to determine within group differences among play therapists based on sex, age, type of licensure, formal multicultural, and play therapy training.

### **General Research Question**

The general research questions guiding this study were, "How do play therapists define culturally sensitive play therapy and what culturally sensitive materials are used by play therapists?" Other research questions used to answer each question were as follows:

1. What is the relationship between the perceived barriers and the use of culturally sensitive play therapy materials available in the playroom?
2. What is the relationship between beliefs about culturally sensitive play therapy and the use of culturally sensitive play therapy materials?

3. Is there a relationship between the type of ethnic populations served and the use of culturally sensitive play therapy materials?
4. What types of culturally sensitive materials are available in play therapists' playrooms?

The following subquestions were addressed:

5. What level of formal play therapy training do play therapists receive?
6. What level of formal multicultural training do play therapists receive?
7. Are there differences in licensure obtained and use of culturally sensitive play therapy materials by play therapists?
8. Are there sex differences in play therapist use of culturally sensitive play therapy materials?
9. Is there a relationship between play therapists' level of education and their use of culturally sensitive play therapy materials?
10. Is there a relationship between play therapists' status (registered play therapist or registered play therapist supervisor) and their use of culturally sensitive play therapy materials?
11. Is there a relationship between play therapists' formal training and their use of culturally sensitive play therapy materials?
12. Is there a relationship between play therapists having a dedicated playroom and their use of culturally sensitive play therapy materials?

## Participants

Participants in this study consisted of play therapists who were members of the Association of Play Therapy. The Association of Play Therapy is an interdisciplinary association that promotes the value of play, play therapy, and credentialed play therapists (Association of Play Therapy *Bylaws*, 2006). The play therapist participants met the criteria of: (a) utilized play therapy within the past year; and (b) held, at minimum, a master's degree.

A list of potential participants was requested from the Association of Play Therapy by completing the "Mailing List Rental Agreement" (see Appendix A). The mailing list rented from the association listed play therapists' email addresses. The list was provided by the APT product services coordinator. The Association of Play Therapy has a total 5,955 members. The members identified as play therapists were entered into a generic electronic mailing list. Once the list was generated with the email addresses, no other identifying information was used. A mass email was sent asking for voluntary participation in the study. A reminder email followed approximately two weeks after the original mass email.

The sample for this study included members of the Association for Play Therapy (APT) who held at least a master's degree. The mailing list was developed by APT with the undeliverable email addresses removed by APT. This mailing list provided a possible 4,607 participants' email addresses. The online survey was initiated by 385 and completed by 348 play therapists.

The vast majority of participants were female (93%). This sample is similar to the makeup of play therapists reported by Lambert et al. (2005), who reported 92% of play therapists as female. Descriptive statistics appear in Table 1. The age of the respondents ranged from 24 to 82 years, with a mean of 47 years ( $SD = 12.76$ ).



Table 1

*Frequency Distributions of Participants by Gender*

Gender	n	%
Female	358	93
Male	27	7
Total	385	100

Table 2 includes the ethnicity of respondents. The majority of participants identified themselves as “Caucasian” (83%). “Hispanic” responses made up 5%, while 4% indicated “African American.” “Middle Eastern descent” was marked by 2% of the participants. Then, “Asian American,” “Native American,” and “Pacific Islander” each made up 1% of the responses. Last, “other” represented 4% of the participants.

Table 2

*Frequency Distributions of Participants by Ethnicity*

Ethnicity	n	%
African American	14	4
Asian American	5	1
Caucasian	318	83
Hispanic	21	5
Native American	5	1
Pacific Islander	2	1

Table 2 Continued

Middle Eastern descent	6	2
Other	14	4
Total	385	100

The ethnic diversity of clients presenting for play therapy was also collected. Participants were asked to indicate the percentage totaling 100%. “Caucasian” clients made-up (54.87%) of play therapists caseload, while “African American” clients comprised (17.76%). “Hispanic” clients represented 16.20% and “Asian American” clients encompassed 5.07%. “Native American” contain 2.02% of participants caseload, while “other” consisted 2.28%. “Middle Eastern descent” and “Pacific Islander” each included less than 1% of the clients. The range for each client ethnicity ranged from 0% to 100%, except for “Pacific Islander” and “Middle Eastern. “Pacific Islander” ranged from 0 to 85% of participants’ case load and “Middle Eastern” ranged from 0 to 50% of participants’ perceived total ethnic diversity of clientele.

Table 3

*Mean Percentage of Estimated Client Ethnicity*

Client Ethnicity	<i>M</i>	<i>SD</i>
African American	17.76	21.57
Asian American	5.07	13.93
Caucasian	54.87	31.77
Hispanic	16.20	23.57
Native American	2.02	9.31

Table 3 Continued

Pacific Islander	0.97	6.38
Middle Eastern descent	0.83	3.46
Other	2.28	8.94

Participants were asked to indicate their status as a play therapist. Options included “under supervision for registered play therapists (RPT) credentials,” “registered play therapist (RPT),” “registered play therapist supervisor (RPT-S)” and “other.” Almost one-fourth of respondents (23%) marked “under supervision for registered play therapists (RPT) credentials,” while 18% marked “registered play therapist (RPT)”. Twenty four percent of play therapists responded that they were “registered play therapist supervisor (RPT-S).” The remaining 36% of participants indicate their status as “other.” Results are shown in Table 4.

Table 4

*Frequency Distributions for Participants' Status as a Play Therapist*

Status	n	%
Under supervision for registered play therapist (RPT) credentials	87	23
Registered play therapists (RPT)	70	18
Registered play therapists supervisor (RPT-S)	91	24
Other	137	36
Total	385	100

Participants were asked to select their theoretical orientation. “Child-centered” had the highest representation with 214 play therapists. Following were the 49 play therapists who reported

their theoretical orientation as “cognitive behavioral.” “Adlerian” play therapists were represented by 36 respondents, while there were only 6 “gestalt” play therapists responding. Sixteen play therapists stated they were “psychoanalytic” and 17 stated they were “Jungian” play therapists. Finally, 42 play therapists choose “other” as their theoretical orientation. Frequency distributions are shown in Table 5.

Table 5

*Frequency Distributions for Participants' Theoretical Orientation*

Theoretical Orientation	n	%
Child-Centered	214	56
Cognitive Behavioral	49	13
Adlerian	36	9
Gestalt	6	2
Psychoanalytic	16	4
Jungian	17	4
Other	42	11
Total	380	100

Next, play therapists were asked to indicate their highest mental health degree earned; the results are shown in Table 6. Fifty-nine percent of play therapists stated they had earned a “master’s degree,” while 23% earned a “master’s +30.” Finally, 18% stated they earned a “doctorate.”

Participating play therapists were also asked to state their total years practicing as a mental health professional. The responses ranged from 1 to 42 years. The standard deviation was 9.70. The mean total years practicing as a mental health professional was 13.73.

Table 6

*Frequency Distributions for Participants' Level of Education*

Level of Education	n	%
Master's	225	59
Master's + 30	87	23
Doctorate	68	18
Total	380	100

Overall, play therapists in this sample were female (93%) and Caucasian (83%). While play therapists of most theoretical orientations were represented, child centered was the most common (56%). The participants also indicated that most held a master's degree (59%). They had a mean age of 47 and had worked an average of 13.73 years as a mental health professional.

### **Instrument Development**

No previous studies had quantitatively examined what culturally sensitive materials members of the Association of Play Therapy use; therefore, no instrument was available for use. My study was based on the work of Ritter and Chang (2002) and Chang, Ritter, and Hays (2005), who surveyed registered play therapy members of the Association for Play Therapy.

I developed the *Culturally Sensitivity Play Therapy Survey* for my study. It is a 40-question survey containing the following sections: personal information, training and preparedness, beliefs about culturally sensitive play therapy, perceived barriers, materials used in delivering culturally sensitive play therapy, and the definition of culturally sensitive play therapy. It was developed to determine the following: (a) the frequency of the use of culturally

sensitive play therapy materials by counselors who feel culturally sensitive play therapy is useful for clients; (b) play therapists' formal training in play therapy; (c) play therapists' formal training in multicultural counseling; (d) play therapists' beliefs regarding culturally sensitive play therapy; (e) play therapists' perceptions of the barriers to implementing culturally sensitive play therapy; (f) play therapists' top three identified barriers to implementing culturally sensitive play therapy; (g) methods play therapists used to overcome their top three barriers to implementing culturally sensitive play therapy; (h) materials used by play therapists who utilize culturally sensitive play therapy at their worksite; (i) sex differences in play therapists' use of culturally sensitive play therapy; (j) the relationship between play therapists' level of education and their use of culturally sensitive play therapy; (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 use of culturally sensitive play therapy; (m) the differences in play therapists' ethnicity and use of culturally sensitive play therapy; (n) the relationship between clients' ethnicity and use of culturally sensitive play therapy; (o) the relationship between play therapists' licensure type and use of culturally sensitive play therapy; (p) the relationship between having a designated playroom and use of culturally sensitive play therapy; (q) the relationship between years as a mental health professional and the use of culturally sensitive play therapy; (r) the relationship between years practicing as a Registered Play Therapist and the use of culturally sensitive play therapy; and (s) how play therapists define culturally sensitive play therapy.

The *Culturally Sensitive Play Therapy Survey* (see Appendix D) was based on a review of the literature on play therapy, the association of play therapy, recommended practices, and culturally specific play therapy. The items were based on literature that indicated play therapists'

training, their perceptions of their training, cultural awareness and general recommendations for culturally appropriate practices with regards to specific populations (see Table 7). Its aim was to gain a greater understanding of play therapists' use of culturally sensitive play therapy, training in culturally sensitive play therapy, beliefs about culturally sensitive play therapy, and perceived barriers to providing culturally sensitive play therapy.

Table 7

Literature Review

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Items:	<i>Literature</i>
Items:	
1 to 10	Demographics
12	Chang, Ritter, & Hays (2005);
13	Abrams, Post, Algozzine, Miller, Ryan, Gomory, et al.; Lambert, LeBlanc, Mullen, Ray, Baggerly, White, et al.; Kao & Landreth, (1997); Phillips & Landreth (1995); Ryan, Gomory, & Lacasse, (2002);
14	Coleman, Parmer, & Barker (1993);
15	Coleman, Parmer, & Barker (1993); Lambert, LeBlanc, Mullen, Ray, Baggerly, White, et al.; Phillips & Landreth (1995); Ryan, Gomory, & Lacasse, (2002);
30	Axline (1947); Gil & Drewes (2005);
31	Gil & Drewes (2005)
32	Axline (1947); Gil & Drewes (2005); Landreth (2002); Swank (2008);
33	Axline (1947); Garza & Bratton (2005) Gil & Drewes (2005); Landreth (2002); O'Connor (2005);
34	Chang, Ritter, and Hays (2005); Gil & Drewes (2005); O'Connor (2005)
35	Axline (1947); Cassel (1972); Gil & Drewes (2005); Landreth (2002);
36	Axline (1947); Gil & Drewes (2005); Landreth, Ray, & Bratton (2009)

Table 7

*Continued*

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37	Chang, Ritter, & Hays (2005); Nims (2007)
38	Axline (1947); Chang, Ritter, & Hays (2005); Gil & Drewes (2005); Rousseau, Benoit, Lacroix and Gauthier (2009)
39	Axline (1947); Graza & Bratton (2005); Gil & Drewes (2005); Kranz, Ramirez, Flores-Torres, Steele, & Lund (2005);

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Data gathered from the following sections were used to determine if there was a relationship between items. In Section I focused on personal information, participants were asked to respond to: sex, age, ethnicity, ethnic diversity of the population served (Abrams, Post, Algozzine, Miller, Ryan, Gomory, et al., 2006; Chang, Ritter, & Hays, 2005). For Section II, licensure, training and preparedness, participants were asked to respond to: (a) licensure; (b) status as a play therapist; (c) theoretical orientation; (d) highest mental health degree earned; (e) total number of years practicing as a mental health professional; (f) number of graduate level play therapy courses (Abrams et al., (2006); Lambert, LeBlanc, Mullen, Ray, Baggerly, White et al., (2005); Kao & Landreth, 1997; Phillips & Landreth 1995; Ryan, Gomory, & Lacasse, 2002); (g) number of graduate level multicultural counseling courses (Coleman, Parmer, & Barker, 1993), (h) amount of play therapy continuing education received (Coleman, Parmer, & Barker 1993; Lambert et al.; Phillips & Landreth 1995; Ryan, Gomory, & Lacasse, 2002), and (i) willingness to read latest play therapy literature (Ritter & Chang 2002; Ryan, Gomory, & Lacasse, 2002). In Section III, I focused on beliefs about culturally sensitive play therapy (Chang, Ritter, & Hays, 2005; Coleman, Parmer, & Barker, 1993). Participants were asked to



respond to: (a) belief that culturally sensitive play therapy is useful (Coleman, Parmer, & Barker, 1993), (b) belief that culturally sensitive play therapy is not necessary for a positive therapeutic outcome for clients, (c) belief regarding the necessity to have culturally sensitive materials in the playroom in order to engage children from diverse backgrounds in play therapy, (d) desire to have more culturally sensitive play materials, (e) the belief that culturally sensitive play therapy materials are not necessary based on practitioner's theoretical orientation, and (f) additional materials believed to make playroom more culturally sensitive. Section IV focused on perceived barriers to providing culturally sensitive play therapy; participants were asked to respond to: (a) perceived limitation of culturally sensitive play materials in current play therapy room, (b) perceived inability to conduct culturally sensitive play therapy due to inadequate training (Ritter & Chang 2002), (c) perceived difficulty finding culturally sensitive play materials, (d) perceived expense of purchasing culturally sensitive play materials, (e) perceived lack of control over culturally sensitive materials in playroom, (f) top three perceived barriers to implementing culturally sensitive play therapy, and (g) ability to overcome these barriers. In Section V, focused on the materials that are used for delivering culturally sensitive play therapy, participants were asked to respond to: materials used most often in delivery of culturally sensitive play therapy (Gil & Drewes, 2005). In Section VI, participants were asked to define culturally sensitive play therapy. In Section VII, participants were asked if there is additional information they would like to provide regarding culturally sensitive play therapy.

### **Expert Panel**

An expert panel was used to review the survey and provide feedback. The expert panel consisted of three registered play therapists, all female, all working in university settings. Two of the registered play therapists were also registered play therapy supervisors. Two of the panel

members have served on the board of the Louisiana chapter of the Association for Play Therapy, and the third member served on a committee for the Louisiana chapter of the Association for Play Therapy. Two of the expert panel members hold the PhD degree and the third member is a doctoral candidate with a master's degree. All three expert panel members hold licensure as Licensed Professional Counselors in the state of Louisiana. All three panel members have presented at state play therapy conferences.

The expert panel members were contacted via email asking for voluntary participation as expert panel members. Once an email was received confirming their participation, the researcher explained that the survey would be emailed as an attachment for review. The researcher stated that she was interested in finding out if any of the questions were unclear, needed additional instruction, or were poorly worded. Each member was told that the researcher was not looking for responses to individual items, but instead wanted to assure that the item was properly placed, and free of bias or errors.

Two of the panel members were able to meet with the researcher in person at their respective offices to further discuss the survey. One panel member requested that she forward all comments via email and would make herself available via telephone, if necessary. Two in-person discussions occurred, and numerous follow up emails.

The expert panel suggested that items previously numbered 14 and 15 be altered to ask for the approximate number of conferences/workshops attended on local, state, and national levels and then, in a separate question, to ask for information regarding the approximate number of books, newsletters, and journals read. The expert panel said that play therapists who sought out national workshops were perhaps exposed to a more culturally diverse experience than those

who just read journals. This change was discussed with the chair of the dissertation committee and the change was made.

The expert panel suggested certain grammatical changes, which were also addressed with the chair and the changes were made. Additionally, the expert panel concluded that item previously numbered 22 needed to be changed to state, “I do not use culturally sensitive play therapy materials because they are unrelated to the manner in which I conduct play therapy.” The panel discussed the previous use of the word “unnecessary” would result in socially desirable responses. This change was also addressed with the chair and the change was made.

One panel member suggested that the researcher define “culturally sensitive” in order to provide a framework for the participant, or that the researcher should add the qualitative element of having the participant define culturally sensitive play therapy. This change was also addressed with the chair, and the additional qualitative question was added to the survey as an open-ended question.

Last, there were additional qualitative questions that the panel said would add value to the quantitative nature of the survey. These open-ended questions are: (1) “How do you address culturally sensitive play therapy in your practice?” (2) “Do you still believe that you are culturally sensitive in your play therapy practice?” (3) “How do you define culturally sensitive play therapy with the clients that you work with?” (4) “What items would you consider adding to your playroom?” After a discussion with the chair of the dissertation committee, it was agreed that, while there was value in the suggested questions, the questions could lengthen the survey in a manner that could significantly decrease the return rate. Wilson, Petticrew, Calnan, and Nazareth (2010) advocated shorter surveys, which are believed to increase response rates.

After the above changes were made, the survey was loaded into Qualtrics™. After reviewing the survey in the online format, a panel member suggested that a question regarding theoretical orientation be added. After a discussion with the dissertation chair the item was added. An expert panel member once again suggested that an item be added to ask what culturally sensitive items play therapists believe would be beneficial in their respective playrooms. This was also discussed with the dissertation chair and the item was added. A panel member also suggested wording questions previously number 17 and 18 differently for clarification, these changes were made as well. Lastly, the expert panel member questioned if respondents would rate themselves as unprepared to conduct culturally sensitive play therapy and suggested that item previously number 16 be removed; this was discussed with the chair and removed.

### **Data Analysis**

Data analysis for this study used descriptive statistics, chi square tests, and analyses of variance. Statistical significance was set at  $p < .01$  because of the numerous statistical tests.

The following were research questions answered by the survey and the specific data analysis that was used to answer each question, including descriptive statistics, chi square tests, and analysis of variance.

#### **Research Question 1**

What formal training have play therapists had in play therapy?

##### *Data Analysis*

Descriptive survey statistics were calculated on survey responses to items 11, 13, and 14. Results are shown in frequency distributions.

#### **Research Question 2**

What formal training have play therapists had in multicultural counseling?

### *Data Analysis*

Descriptive survey statistics were calculated on survey responses to item 12. Results are shown in frequency distributions.

### **Research Question 3**

What are play therapists' beliefs regarding culturally sensitive play therapy?

### *Data Analysis*

Descriptive survey statistics were calculated on survey responses to items 16-19. Results of the data are shown in frequency distributions, means, and standard deviations.

### **Research Question 4**

What have play therapists identified as the top three barriers to implementing culturally sensitive play therapy?

### *Data Analysis*

Constant comparative analysis was used to identify major themes.

### **Research Question 5**

What methods have play therapists used to overcome their top three barriers to implementing culturally sensitive play therapy?

### *Data Analysis*

Constant comparative analysis was used to identify major themes.

### **Research Question 6**

How do play therapists who utilize culturally sensitive play therapy deliver it at their worksites?

### *Data Analysis*

Descriptive comparisons were used on items 30-39. Results of the data are shown in frequency distributions.

### **Research Question 7**

Is there a relationship between play therapists' level of education and their use of culturally sensitive play therapy?

#### *Data Analysis*

Chi square tests were used to determine the relationship between the level of education and use or availability of culturally sensitive materials listed in items 30-39.

### **Research Question 8**

Is there a relationship between play therapists' training in play therapy and use of culturally sensitive play therapy materials?

#### *Data Analysis*

Individual chi square tests were used to determine the relationship between the level of education (items 11, 12, and 13) and use and availability of culturally sensitive materials (items 30-39).

### **Research Question 9**

What is the relationship between play therapists' status as a play therapist and use of culturally sensitive play therapy?

#### *Data Analysis*

Individual chi square tests were used to determine the relationship between the status as a play therapist (item 7) and use or availability of culturally sensitive materials (items 30-39).

### **Research Question 10**

Are there differences in play therapists' ethnicity and use of culturally sensitive play therapy materials?

*Data Analysis*

Individual chi square tests were used to determine the relationship between the play therapists' ethnicity (item 4) and use or availability of culturally sensitive materials (items 30-39).

**Research Question 11**

Are there differences in clients' ethnicity and use of culturally sensitive play therapy materials?

*Data Analysis*

Individual analysis of variance tests were used to determine within and between group differences between the clients' ethnicity (item 5) and use or availability of culturally sensitive materials (items 30-39).

**Research Question 12**

Are there differences in play therapists' licensure type and use of culturally sensitive play therapy materials?

*Data Analysis*

Individual chi square tests were used to determine the relationship between the licensure types (item 4) and use or availability of culturally sensitive materials (items 30-39).

**Research Question 13**

Are there differences in having a designated playroom and use of culturally sensitive play therapy materials?

*Data Analysis*

Individual chi square tests were used to determine the relationship between having a designated playroom (item 6) and use or availability of culturally sensitive materials (items 30-39).

#### **Research Question 14**

What is the relationship between years as a mental health professional and the use of culturally sensitive play therapy?

##### *Data Analysis*

Individual analysis of variance tests were used to determine within and between group differences between the years as a mental health professional (item 10) and use or availability of culturally sensitive materials (items 30-39).

#### **Research Question 15**

How do you define culturally sensitive play therapy?

##### *Data Analysis*

Themes were identified using the qualitative method of constant comparative analysis.

### **Procedures**

An application for review and approval was sent to the University of New Orleans Committee for the Protection of Human Subjects in Research (IRB) (see Appendix B). After approval, the email addresses needed to contact the play therapists were obtained from the Association for Play Therapy. Once the email list was populated, all identifiable information was removed. Participants were contacted by mass email requesting voluntary participation (see Appendix C). The email described the purpose of the study, explained the IRB process, and provided a link to the survey on Qualtrics™. Qualtrics™ allowed for anonymous data collection by providing a link in a mass email sent to potential participants. Once the Qualtrics™ link was



accessed, the participants were not asked for identifying information. Demographic information such as sex, age, ethnicity, licensure and years practicing was used as independent variables for comparisons between groups.

The participants who were originally included in the mass email were sent a “reminder” email after three weeks, which also thanked participants who completed the survey. The end of the survey notification was sent to the original list of potential participants.

## CHAPTER FOUR

### RESULTS

The purpose of this study was to better understand how play therapists, who are members of the Association of Play Therapy, perceived multicultural play therapy: their perceived barriers to implementing culturally sensitive play therapy, their use of materials, and how they defined multicultural play therapy. Play therapists were also asked about their level of formal play therapy training, their level of formal multicultural training, if there were differences in licensure obtained and use of culturally sensitive play therapy materials, and last, if there were sex differences in play therapists' use of culturally sensitive play therapy materials. This study also sought to determine if there was a relationship between play therapists' level of education and their use of culturally sensitive play therapy materials and if there was a relationship between play therapists' status (registered play therapist or registered play therapist supervisor) and their use of culturally sensitive play therapy materials.

Additionally, the study examined the relationship between play therapists' formal training and their use of culturally sensitive play therapy materials. Further, the relationship between play therapists having a dedicated playroom and their use of culturally sensitive play therapy materials was investigated.

#### **Analysis of Research Questions**

##### *Research Question*

The general research question guiding this study was, "How do play therapists define culturally sensitive play therapy and what culturally sensitive materials are used by play therapists?"

## **Instrumentation**

The *Culturally Sensitive Play Therapy Survey* (CSPTS) is a 41-item survey created by me for this study to determine members of the Association for Play Therapy's definition of culturally sensitive play therapy and what culturally sensitive materials are used by play therapists. The CSPTS was also created to determine what barriers play therapists encounter when using multicultural play therapy materials and how they overcame those identified barriers. The CSPTS is divided into sections: personal information, training and preparedness, beliefs about culturally sensitive play therapy, perceived barriers, materials used in delivering culturally sensitive play therapy, and the definition of culturally sensitive play therapy.

### *Research Question 1*

Research Question 1 asked "What formal training have play therapists had in play therapy?" Descriptive survey statistics were calculated on survey responses to items 11, 13, and 14. Results for items 11, 13, and 14 were calculated and are shown in frequency distributions in Table 8.

Descriptive statistics were calculated for responses to item 11, which asked participants the approximate number of graduate level courses that they have taken in play therapy from an accredited university or college. The results indicated that, of the 380 responses, 135 (36%) did not take a play therapy course from an accredited university or college. Responses indicated that 70 play therapists (18%) took only one play therapy course, while 86 respondents represented (23%) play therapists who had four or more courses in play therapy from an accredited university.

Descriptive survey statistics were calculated on item 13, which asked for the approximate number of play therapy workshops or special institutes participants have attended in the past two

years from all sources. The minority of responses, 8 of 380 (2%), indicated they had not attended any play therapy workshop or special institute. Another 18 respondents (5%) indicated that they had attended one play therapy workshop or special institute. About 12%, or 47 respondents, stated that they attended two play therapy workshops or special institutes. Well over half of the respondents, 264 (69%), attended four or more play therapy workshops or special institutes.

Additionally, item 14 asked play therapists to respond to, “I keep current on the latest play therapy techniques by attending conferences, conventions, and presentations.” Over 40% of the play therapists responded that they strongly agreed—157 of the 380 responding (41%). The results also showed that 11 (3%) stated that they neither agreed nor disagreed. Lastly, 9 (2%) of play therapists responding signified they strongly disagreed with the statement.

Table 8

*Frequency Distributions for Items 11, 13, and 14 for Research Question 1*

Item	<i>n</i>	<i>%</i>
Education and Training		
11. Approximate number of graduate level courses that you have taken in play therapy from an accredited university or college.		
0 courses	135	36
1 course	70	18
2 courses	55	14
3 courses	34	9
4 + courses	86	23
	380	100

Table 8 Continued

Frequency Distributions for Items 11, 13, and 14 for Research Question 1

13. Approximate number of play therapy workshops or special institutes you have attended in the past two years from all sources

0 play therapy workshops or special institutes	8	2
1 play therapy workshop or special institute	18	47
2 play therapy workshops or special institutes	47	12
3 play therapy workshops or special institutes	43	11
4+ play therapy workshops or special institutes	<u>264</u>	<u>69</u>
	380	100

14. I keep current on the latest play therapy techniques by attending conferences, conventions, and presentations.

Strongly Disagree	9	2
Disagree	3	1
Somewhat Disagree	8	2
Neither Agree nor Disagree	11	3
Somewhat Agree	73	19
Agree	119	31
Strongly Agree	<u>157</u>	<u>41</u>
	380	100

*Note.* Strongly Disagree=1, Disagree=2, Somewhat Disagree=3, Neither Agree nor Disagree=4, Somewhat Agree=5, Agree=6, Strongly Agree=7

Thus, it appears that play therapists are receiving education and training through workshops, special institutes, and conferences. However, fewer play therapists received formal play therapy courses through an accredited university or college. So, it appeared that more play therapists in this study received play therapy education through workshops or continuing education workshops than in university or college graduate programs. It appears that one of the best ways to train practicing play therapists would be through continuing education at workshops, conferences or special institutes.

*Research Question 2*

Research Question 2 asked what formal training have play therapists had in multicultural counseling. Descriptive survey statistics were calculated on survey responses to item 12. Results are shown in frequency distributions in Table 9. The results showed that 47 (12%) play therapists responded that they had 0 courses in multicultural counseling from an accredited university or college. Most respondents, 125 (33%), reported that they had taken one course in multicultural counseling from an accredited university or college. Following closely were respondents who reported taking 2 courses—123 (32%).

Table 9

*Frequency Distributions for Item 12 for Research Question 2*

Item	<i>n</i>	<i>%</i>
Multicultural Education		
12. Approximate number of graduate level courses that you have taken in multicultural counseling from an accredited university or college.		
0 courses	47	12
1 course	125	33

Table 9 Continued

*Frequency Distributions for Item 12 for Research Question 2*

2 courses	123	32
3 courses	43	11
4 + courses	42	11
	380	100

It appears that play therapists received courses in multicultural counseling from an accredited university. Play therapists are following the recommendations of the Association of Play Therapy (2009), which encouraged cultural knowledge.

*Research Question 3*

Research Question 3 asked play therapists their beliefs regarding culturally sensitive play therapy. This research question was answered by calculating descriptive survey statistics on survey responses to items 16-19. Results of the data are shown in frequency distributions (see Table 10), and in means and standard deviations.

Item 16 asked play therapists to indicate their agreement with the statement, “I believe there is a relationship between culturally sensitive play therapy and a positive outcome for my clients.” The play therapists were asked to answer on a 7-point scale ranging from strongly disagree to strongly agree. Play therapists stated that they strongly disagreed, disagreed, and somewhat agreed, with 1 respondent answering in each category respectively. Far more play therapists signified that they somewhat agreed: 46 play therapists (12%) chose this statement. The largest number of respondents, 160 (43%), indicated that they agreed with the statement, “I believe there is a relationship between culturally sensitive play therapy and a positive outcome for my clients.”

Play therapists rated their extent of agreement with the statement, “Culturally sensitive play therapy is useful for my clients” on item 17. A 7-point scale ranging from strongly disagree to strongly agree allowed play therapists to indicate their level of agreement with the statement. Only one person stated that he or she strongly disagreed with the statement, while no one reported that they disagreed. However, one person acknowledged that he or she somewhat disagreed that “Culturally sensitive play therapy is useful for my clients.” A large portion, 169 (46%), stated that they agreed with the statement, “Culturally sensitive play therapy is useful for my clients.” A similar number of play therapists strongly agreed, 140 (38%), that “Culturally sensitive play therapy is useful for my clients.”

Item 18 asked play therapists to note their level of agreement with the statement, “Culturally sensitive play therapy is not necessary for a positive outcome for my clients,” again allowing responses on a 7-point scale ranging from strongly disagree to strongly agree. Approximately one-quarter of respondents, 90 (24%), strongly disagreed with the statement, while 132 (36%) disagreed with the statement. Twenty percent (73) play therapists expressed “Culturally sensitive play therapy is not necessary for a positive outcome for my clients.” However, 27 (7%) neither agreed nor disagreed with the statement. Fewer respondents 18 (5%), stated that they agreed with the statement. The variance in the responses on item 18 could be due to the negatively phrased question.

Frequencies were calculated for responses to item 19, which asked play therapists to rate the extent of their agreement with the statement, “It is necessary to have culturally sensitive materials in the play therapy room in order to engage children from diverse backgrounds in play therapy.” The responses consisted of a 7-point scale ranging from strongly disagree to strongly agree. The results indicated that of the 371 responses, two (1%) strongly disagreed. Only one



respondent stated that they disagreed, while 12 (3%) expressed that they somewhat disagreed. More respondents 46 (12%) stated they somewhat agreeing with the statement, while 132 (36%) stated that they agreed. Also, 166 play therapists (45%) stated that they strongly agreed with the statement, “It is necessary to have culturally sensitive materials in the play therapy room in order to engage children from diverse backgrounds in play therapy.”

Table 10  
*Frequency Distributions for Items 16-19 for Research Question 3*

Item	<i>n</i>	<i>%</i>
<b>Beliefs about Culturally Sensitive Play Therapy</b>		
16. I believe there is a relationship between culturally sensitive play therapy and a positive outcome for my clients.		
Strongly Disagree	1	0
Disagree	1	0
Somewhat Disagree	1	0
Neither Agree nor Disagree	12	3
Somewhat Agree	46	12
Agree	160	43
Strongly Agree	150	40
	371	100
17. Culturally sensitive play therapy is useful for my clients.		
Strongly Disagree	1	0
Disagree	0	0
Somewhat Disagree	1	0
Neither Agree nor Disagree	12	3
Somewhat Agree	48	13
Agree	169	46
Strongly Agree	140	38
	371	100

Table 10 Continued

*Frequency Distributions for Items 16-19 for Research Question 3*

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18. Culturally sensitive play therapy is not necessary for a positive therapeutic outcome for my clients.

Strongly Disagree	90	24
Disagree	132	36
Somewhat Disagree	73	20
Neither Agree nor Disagree	27	7
Somewhat Agree	25	7
Agree	18	5
Strongly Agree	6	2
	<hr/>	
	371	100

19. It is necessary to have culturally sensitive materials in the play therapy room in order to engage children from diverse backgrounds in play therapy.

Strongly Disagree	2	1
Disagree	1	0
Somewhat Disagree	12	3
Neither Agree nor Disagree	12	3
Somewhat Agree	46	12
Agree	132	36
Strongly Agree	166	45
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	371	100

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*Note.* Strongly Disagree=1, Disagree=2, Somewhat Disagree=3, Neither Agree nor Disagree=4, Somewhat Agree=5, Agree=6, Strongly Agree=7. 0= less than 1 percent

Play therapists indicated that they agreement with the statement “there is a relationship between culturally sensitive play therapy and a positive outcome for my clients.” Additionally, play therapists showed agreement with the statement, “Culturally sensitive play therapy is useful for my clients.” Finally, play therapists indicated strong agreement with the statement, “It is

necessary to have culturally sensitive materials in the play therapy room in order to engage children from diverse backgrounds in play therapy.”

Means and standard deviations were also calculated on items 16-19, which are presented in Table 11. An answer of strongly agree represented a higher mean, while an answer of strongly disagree represented a lower mean score. Higher mean scores on item 16 ( $M= 6.18$ ,  $SD=.87$ ) indicated that play therapists agreed with the statement, “I believe there is a relationship between culturally sensitive play therapy and a positive outcome for my clients.” On item 17, higher mean scores ( $M= 6.16$ ,  $SD=.84$ ) showed that play therapists responded in agreement that “Culturally sensitive play therapy is useful for my clients.” Lower mean scores ( $M= 2.58$ ,  $SD=1.48$ ) on item 18 indicated individuals disagreed with the statement, “Culturally sensitive play therapy is not necessary for a positive therapeutic outcome for my clients.” Lastly, responses to item 19 revealed a mean ( $M= 6.18$ ,  $SD=.87$ ) which showed strong agreement with the statement that “It is necessary to have culturally sensitive materials in the play therapy room in order to engage children from diverse backgrounds in play therapy.”

Table 11

*Means and Standard Deviations for Items 16-19 for Research Question 3 (n= 371)*

Item	<i>M</i>	<i>SD</i>
Beliefs about culturally sensitive play therapy		
16. I believe there is a relationship between culturally sensitive play therapy and a positive outcome for my clients.	6.18	0.87
17. Culturally sensitive play therapy is useful for my clients.	6.16	0.84
18. Culturally sensitive play therapy is not necessary for a positive therapeutic outcome for my clients.	2.58	1.48

Table 11 Continued

*Means and Standard Deviations for Items 16-19*

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19. It is necessary to have culturally sensitive materials in the play therapy room in order to engage children from diverse backgrounds in play therapy.

6.12 1.16

*Note.* Strongly Disagree=1, Disagree=2, Somewhat Disagree=3, Neither Agree nor Disagree=4, Somewhat Agree=5, Agree=6, Strongly Agree=7

Thus, it appears that play therapists believed that culturally sensitive play therapy is not only useful, but beneficial for their clients. Additionally, play therapists reported that it was necessary to have culturally sensitive materials to engage children from diverse backgrounds in play therapy. Therefore, play therapists reported culturally sensitive play therapy was advantageous and believed in the positive attributes of providing culturally sensitive play therapy.

*Research Question 4*

Play therapists were asked in Research Question 4 to identify the top three barriers to implementing culturally sensitive play therapy. Participants listed their top three perceived barriers to implementing culturally sensitive play therapy in a free form field. They were required to rank order their responses. This item was not a forced response; therefore, only 285 responses were received. Because participants were not asked to rank order their perceived barrier, the items were collapsed and then examined. Play therapists reported largely that lack of resources, availability, space, and client diversity were the perceived barriers to implementing culturally sensitive play. For example, participants indicated,

*Acquiring materials*

*Affording multiple sets of the same toys*

*Costs*

Play therapists additionally commented on the lack of availability as a perceived barrier to implementing culturally sensitive play therapy. The following are samples of their statements.

*Limited number of items available*

*Culturally sensitive materials are not available*

*Lack of appropriate toys available*

Participants commented that space often prohibited the use of culturally sensitive play therapy. Below are examples of some of those comments.

*Being able to get all types of ethnicities presented in the playroom*

*Shared playroom materials*

*Outreach therapy-out of my car trunk*

Play therapists also perceived the barrier of a lack of diversity among clients served. The following remarks are examples.

*Clients are not as diverse given the physical location*

*Changing clientele*

*Majority of client base is Caucasian*

Overall, play therapists reported that they perceived barriers to implementing culturally sensitive play therapy. Specifically, many play therapists described barriers such as costs, availability, lack of clientele diversity, and limited space. Respondents openly discussed obstacles they encounter when implementing culturally sensitive play therapy, which may limit the materials offered or made available to clients.

#### *Research Question 5*

Research Question 5 asked play therapists what methods they used to overcome their barriers to implementing culturally sensitive play therapy. Play therapists were allowed to type

responses into three free-form fields. Again, this question did not require an answer; responses were provided by only 250 of the responding play therapists. Following Creswell's (2007) recommendations for constant comparative analysis, themes were identified, and codes assigned, and then grouped into axial codes. The more common themes identified were education, purchasing materials personally, and networking for ideas on uses, availability, and additional resources. For example,

*Trainings have been provided at the office to train staff in becoming culturally sensitive*

*Attempt to maintain cultural education/research*

*Education, had therapists "assume a persona of a child and have them tour a space and notice the materials through the eyes of this child, did they see things that were similar to them, could they tell their story with the toys there. what would be missing (sic.)*

Play therapists also commented on the fact that they often purchased materials personally. The following are samples of those types of comments.

*Use own money for buying materials*

*Contribute to a fund to buy materials for my site in my system*

*When traveling to trainings buy stuff @ workshops.(sic.)*

Additionally, play therapists commented on their need to network to overcome the perceived barriers to implementing culturally sensitive materials. The networking was reportedly used to acquire ideas, locate materials, and for additional resources. The following are examples of those contributions.

*Asking others about where to purchase materials*

*Ask friends for help to find stuff*

*Research and ask people to buy things in different countries*

*Ask community members, family, peers to help locate*

*Share expenses with others in Private Practice*

Play therapists listed many ways they overcame perceived barriers to implementing culturally sensitive play therapy. The more commonly stated methods for overcoming perceived barriers were education, purchasing materials personally, and networking for ideas on uses, availability, and additional resources. It seems that many play therapists have encountered obstacles to implementing culturally sensitive play therapy, however, some report using a variety of methods to overcome barriers.

*Research Question 6*

Research Question 6 asked how play therapists who utilize culturally sensitive play therapy deliver it at their worksites. Items 30-39 inquired about the use of culturally sensitive materials available to clients and more specifically about the following categories of culturally sensitive materials: art and craft, books, board games, dramatic play, dress up clothes, dolls, dollhouse and/or materials, puppets, sand tray materials, and musical instruments. Play therapists were asked to check all that applied. Each category included examples of materials, other, and none. Play therapists could check all that applied, if they had multiple types of toys in that category, or other if they had an item not included in the examples. Each category included the option, none, if the play therapist believed they had no such items in that category available for use in their playroom. The available responses included examples of materials, other, and none. Responses and frequency distributions are presented in Table 12.

Table 12

*Frequency Distributions for Items 30-39*

Item	<i>n</i>	<i>%</i>
Materials Used or Available		
30. Which culturally sensitive art and craft materials do you use or have available to your clients? (Please check all that apply).		
Clay (1)	257	72
Multicultural crayons (representing various skin tones) (2)	265	74
Multicultural pencils (representing various skin tones) (3)	198	56
Multicultural markers (representing various skin tones) (4)	187	53
Multicultural fabrics (i.e., kente cloth, batik cloth, or leather) (5)	83	23
Origami paper (for artwork or folding) (6)	138	39
Native American impression for clay (7)	41	12
Other (8)	168	47
None (9)	16	4
31. Which culturally sensitive books do you use or have available to your clients? (Please check all that apply)		
African American themed (e.g., <i>Amazing Grace</i> ) (1)	171	48
Asian American themed (e.g., <i>Dumpling Soup</i> ) (2)	91	26
Hispanic themed (e.g., <i>Too Many Tamales</i> ) (3)	131	37
Native American themed (e.g., <i>Mama, Do You Love Me?</i> ) (4)	109	31
Multicultural (e.g., <i>Different Just Like Me</i> ) (5)	199	56
Disabilities (e.g., <i>Someone Special Just Like You</i> ) (6)	191	54
Diverse family makeup (e.g., <i>Heather Has Two Mommies</i> ) (7)	176	49
Other (8)	105	29
None (9)	77	22
32. Which culturally sensitive board games do you use or have available to your clients? (Please check all that apply)		



Table 12 Continued

*Frequency Distributions for Items 30-39*


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African American themed (1)	24	7
Asian American themed (2)	4	1
Hispanic themed (3)	20	6
Native American themed (4)	7	2
Multicultural themed (5)	75	21
Disability themed (6)	44	12
Diverse family makeup (7)	83	23
Other (8)	44	12
None (9)	206	58

33. Which culturally sensitive dramatic play materials do you use or have available to your clients? (Please check all that apply)

Dishes (e.g., gender neutral) (1)	265	74
Eating/cooking utensils (e.g., chopsticks) (2)	118	33
Pots and pans (e.g., wok or tortilla press) (3)	84	24
Food items (e.g., sushi or taco) (4)	148	42
Ethnic rugs (5)	39	11
Other (6)	107	30
None (7)	55	15

34 Which culturally sensitive dress up clothes do you use or have available to your clients? (Please check all that apply).

African American clothing (e.g., Kaftan) (1)	18	5
Asian American clothing (e.g., Kimono) (2)	32	9
Hispanic clothing (e.g., sombrero) (3)	64	18
Native American clothing (e.g., buckskin) (4)	37	10
Multicultural clothing (5)	53	15
Special needs (e.g., sling, crutch, etc.) (6)	61	17

Table 12 Continued

*Frequency Distributions for Items 30-39*

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Other (7)	55	15
None (8)	212	60

35. Which culturally sensitive dolls do you use or have available to your clients? (Please check all that apply).

African American dolls (1)	296	83
Asian American dolls (2)	161	45
Hispanic dolls (3)	216	61
Native American dolls (4)	99	28
Multicultural dolls (5)	135	38
Special needs dolls (6)	108	30
Fabrics for dressing (7)	59	17
Other (8)	48	13
None (9)	23	6

36. Which culturally sensitive dollhouse and/or materials do you use or have available to your clients? (Please check all that apply)

African American dolls (1)	264	76
Asian American dolls (2)	142	41
Hispanic dolls (3)	199	57
Native American dolls (4)	84	24
Multicultural dolls (5)	120	34
Special needs dolls (6)	116	33
Multiple houses (7)	152	44
Multiple sexes (representing grandparents, extended family members, or blended families) (8)	289	83
Multiple dolls (representing same-sex parents) (9)	221	64
Special Needs Equipment (e.g., wheelchair) (10)	117	34
Other (11)	40	11

Table 12 Continued

*Frequency Distributions for Items 30-39*

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None (12)	20	6
37. Which culturally sensitive puppets do you use or have available to your clients? (Please check all that apply)		
African American puppets (1)	139	40
Asian American puppets (2)	68	20
Hispanic puppets (3)	103	30
Native American puppets (4)	40	11
Multicultural puppets (5)	74	21
Special needs puppets (6)	31	9
Occupational puppets (e.g., clergy, postal worker, doctor, firefighter, construction worker, etc.) (7)	155	45
Other (8)	67	19
None (9)	100	29
38. Which culturally sensitive sand tray materials do you use or have available to your clients? (Please check all that apply)		
Religious figures and symbols (1)	249	72
Landscape figures (2)	262	75
African American figures (3)	230	66
Asian American figures (4)	147	42
Hispanic American figures (5)	189	54
Native American figures (6)	170	49
Multicultural figures (7)	184	53
Special needs figures (8)	152	44
Other (9)	82	24
None (10)	48	14
39. Which culturally sensitive musical instruments do you use or have available to your clients? (e.g., Chilean rain stick, den den drum, maracas, or rice shaker) (Please check all that apply)		

Table 12 Continued

*Frequency Distributions for Items 30-39*

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African musical instrument/s (1)	96	28
Asian music instrument/s (2)	27	8
Hispanic music instrument/s (3)	92	26
Native American music instrument/s (4)	89	26
Multicultural music instrument/s (5)	78	22
Other (6)	38	11
None (7)	162	44

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Item 30 asked “Which culturally sensitive art and craft materials do you use or have available to your clients.” The list included clay, multicultural crayons (representing various skin tones), multicultural pencils (representing various skin tones), multicultural markers (representing various skin tones), multicultural fabrics (e.g., kente cloth, batik cloth, or leather), Origami paper (for artwork or folding), Native American impression for clay, other, and none. There were 356 play therapists who responded to this item. Most commonly, play therapists stated they had clay available 257 (72%), multicultural crayons 265 (74%), multicultural pencils 198 (56%), and multicultural markers 187 (53%). Reported less frequently were multicultural fabrics 83 (23%), Origami paper 138 (39%), and Native American impression for clay 41 (12%).

Item 31 asked the 356 respondents, “Which culturally sensitive books do you use or have available to your clients?” They were requested to please check all that apply. Again, other and none were options. Play therapists were given the following items and examples to choose from in the books section African American themed (e.g., *Amazing Grace*), Asian American themed (e.g., *Dumpling Soup*), Hispanic themed (e.g., *Too Many Tamales*), Native American themed (e.g., *Mama, Do You Love Me?*), Multicultural (e.g., *Different Just Like Me*), Disabilities (e.g.,

Someone Special Just Like You), Diverse family makeup (e.g., Heather Has Two Mommies), Other, and None. Play therapists 171 (48%) stated that they had African American themed books such as *Amazing Grace* available, while 91 (26%) reported having Asian American themed books such as *Dumpling Soup*. However, 131 (37%) reported Hispanic themed books available. Diverse family makeup books were available in 176 (49%) of play therapists' workplaces. Additionally, 105 (29%) reported having other culturally sensitive books. Surprisingly, 77 (22%) respondents reported no culturally sensitive books.

Next, play therapists were asked which culturally sensitive board games they used or had available to clients, once again asking that they please check all that apply. The participants chose from the following: African American themed, Asian American themed, Hispanic themed, Native American themed, multicultural themed, disability themed, diverse family makeup, other, or none. Of the 356 respondents, few, 24 (7%) reported using or having available African American themed games and fewer still, 4 (1%) reported Asian American themed board games. More often play therapists chose multicultural themed 75 (21%), disability themed 44 (12%), and diverse family makeup 83 (23%). However, the majority, 206 (58%) indicated that they had no culturally sensitive board games available to their clients.

The CSPTS asked participants to respond to, "Which culturally sensitive dramatic play materials do you use or have available to your clients" and asked that they please check all that applied. The choices included: dishes (e.g., gender neutral), eating/cooking utensils (e.g., chopsticks), pots and pans (e.g., wok or tortilla press), food items (e.g., sushi or taco), ethnic rugs, other, and none. An overwhelming majority, 265 (74%), reported having dishes, while 118 (33%) reported eating/cooking utensils, such as chopsticks. Eighty-four (24%) reported having pots and pans that were culturally specific such as a wok or tortilla press. More often,

respondents, 148 (42%), chose food items to have available for their clients. Only 55 (15%) individuals responded that they had no culturally sensitive dramatic play materials. Item 34 asked the 356 participants to reveal, “Which culturally sensitive dress up clothes do you use or have available to your clients?” The play therapists were asked to please check all that apply, given the following items: African American clothing (e.g., kaftan), Asian American clothing (e.g., kimono), Hispanic clothing (e.g., sombrero), Native American clothing (e.g., buckskin), Multicultural clothing, Special needs (e.g., sling, crutch, etc.), other, or none. The fewest number of respondents, 18 (5%), indicated that African American clothing was available in their playrooms. Slightly more, 32 (9%), reported Asian American clothing, such as the kimono. Sixty-four participants (18%) revealed the availability of Hispanic clothing in their playrooms. Higher numbers of respondents, 53 (15%), indicated the availability of multicultural clothing, while 61 (17%) reported availability of special needs items such as a sling or crutch. Dress up clothing is available online and through local vendors, but surprisingly, “none” was chosen by 60% (n=212) of contributing play therapists.

Item 35 inquired about culturally sensitive dolls asking, “Which do you use or have available to your clients?” The following entries were listed as possible selections: African American dolls, Asian American dolls, Hispanic dolls, Native American dolls, multicultural dolls, special needs dolls, fabrics for dressing, other, or none. An astonishing number, 83% (n=296), reported African American dolls, 45% (n=161) elected Asian American dolls, and 61% (n=216) picked Hispanic dolls. Twenty-eight percent (n=99), opted for Native American dolls. Much reduced were the number of contributors 17% (n=59) who reported fabrics for dressing and only (n=48) articulated other culturally sensitive dolls.

Information about respondent's use or availability of culturally sensitive dollhouse and/or materials was asked in item 36. Participants chose from the following and were instructed to check all that applied: (a) African American dolls, (b) Asian American dolls, (c) Hispanic dolls, (d) Native American dolls, (e) multicultural dolls, (f) special needs dolls, (g) multiple houses, (h) multiple sexes (representing grandparents, extended family members, or blended families), (i) multiple dolls (representing same-sex parents), (j) special needs equipment (e.g., wheelchair), (k) other, or (l) none. Most commonly chosen were multiple sexes (representing grandparents, extended family members, or blended families) (83%) and African American dolls (76%). Only 6% of play therapists responded that they had no culturally sensitive dollhouse and/or materials available to clients.

Play therapists reported their use or availability of culturally sensitive puppets in item 37. Choices included African American puppets, Asian American puppets, Hispanic puppets, Native American puppets, multicultural puppets, special needs puppets, occupational puppets (e.g., clergy, postal worker, doctor, firefighter, construction worker, etc.), other, or none. Play therapists responding to item 37 were once again asked to please check all that apply. Most frequently checked were occupational puppets (e.g., clergy, postal worker, doctor, firefighter, construction worker, etc.) 45% (n=155), African American puppets 40% (n=139), and Hispanic puppets 30% (n=103). Only 7% of play therapists reported having special needs puppets. A surprisingly large number of play therapists (29%) conveyed they had no culturally sensitive puppets.

Item 38 asked which culturally sensitive sand tray materials they used or have available to their clients, please check all that apply. Options included religious figures and symbols, landscape figures, African American figures, Asian American figures, Hispanic American

figures, Native American figures, multicultural figures, special needs figures, other, and none. Few (14%) play therapists reported not having sand tray and tray materials. A large amount of participating play therapists had the following available for use: religious figures and symbols (72%, n=249), landscape figures (75%, n=262), African American figures (66%, n=230), Asian American figures (42%, n=147), Hispanic American figures (54%, n=189), Native American figures (49%, n=170), multicultural figures (53%, n=184), special needs figures (44%, n=152), and other materials reported by (24%, n=82).

Finally, play therapists were asked about their availability or use of culturally sensitive musical instruments (e.g., Chilean rain stick, den den drum, maracas, or rice shaker). African musical instrument(s), Asian music instrument(s), Hispanic music instrument(s), Native American music instrument(s), multicultural music instrument(s), other, and none were given as available options in the survey. Almost half of responding play therapists reported having no culturally sensitive musical instruments: 162, (47%). Less frequently chosen were Asian music instrument/s 27 (8%) and other 38 (11%). The remaining options for musical instruments were closely distributed: African musical instrument/s 96 (28%), Hispanic music instrument/s, 27 (8%), Native American music instrument/s 89 (26%), and multicultural music instrument/s 78 (22%). Play therapists indicated a variety of materials were used or made available when providing culturally sensitive play therapy. The most commonly used category of culturally sensitive play therapy material was arts and crafts, while the least commonly used was dress up clothing. Thus, it appears that many participating play therapists used materials available for culturally sensitive play therapy.

#### *Research Question 7*



Research Question 7 asked “Is a relationship between play therapists’ level of education and their use of culturally sensitive play therapy?” Responding play therapists reported their level of education as follows: master’s degree—225 (59%), master’s plus 30—87 (23%), and doctorate—68 (18%). Chi square tests were used to determine the relationship between the level of education and the use or availability of culturally sensitive materials listed in items 30-39. To reduce the chance of a Type I error, a conservative  $p$  level of .01 was used. Results are presented in Table 13. Of the ten categories of culturally sensitive play therapy materials listed in the CSPTS, statistical significance was found only between play therapists’ level of education and use and/or availability of culturally sensitive books ( $\chi^2=10.44, n=380, p=0.005$ ).

Table 13

*Chi square Analyses of Materials Used or Available Between Levels of Education*

Variables	Master's	Master's + 30	Doctorate	$\chi^2$	$p$
Arts and Crafts Materials				5.54	0.06
Any	211	86	67		
None	24	1	1		
Books				10.44	0.01
Any	176	79	48		
None	49	8	20		
Board Games				6.21	0.05
Any	95	50	29		
None	130	37	39		
Dramatic play materials					
Any					
None					

Table 13 Continued

Dress up clothes				4.27	0.12
Any	91	40	37		
None	134	47	31		
Dolls				0.52	0.77
Any	213	81	63		
None	12	6	5		
Dollhouse and/or materials				1.17	0.56
Any	213	84	64		
None	12	3	5		
Puppets				3.45	0.18
Any	158	69	53		
None	67	18	15		
Sand tray materials				5.01	0.08
Any	191	82	59		
None	34	5	9		
Musical				1.09	0.58
Any	125	54	39		
None	100	33	29		

Therefore, it appears there is little relationship between level of education and the use or availability of culturally sensitive play therapy materials. Of the ten categories listed in the CSPTS, the only statistical significance was found between play therapists' level of education and use and/or availability of culturally sensitive books ( $\chi^2=10.44, n=380, p=0.005$ ). Hence,

there is a very limited relationship between the level of education obtained and the use or availability of culturally sensitive play therapy materials.

#### *Research Question 8*

Research question 8 examined if there was a relationship between play therapists' training in play therapy and use of culturally sensitive play therapy materials. To answer this research question, items 11, 12 and 13 (training) were compared on items 30-39 (culturally sensitive play therapy materials). Individual chi square tests were completed with a conservative  $p$  level of .01 to reduce the risk of a Type I error.

Play therapists reported that they had the following levels of formal play therapy education: 0 courses, 135 (36%); 1 course 70 (18%); 2 courses 55 (14%); 3 courses 34 (9%); and 4 plus courses, 86 (23%). The mean was 2.65 play therapy courses from an accredited university or college and the standard deviation was 1.58. Item 11 (number of graduate level play therapy courses) was compared on items 30-39 (culturally sensitive play therapy materials) to determine if there was a difference between education and use or availability of materials listed. For these chi square tests, play therapy courses were collapsed into two groups due to the lack of variability in some categories. The two collapsed categories were 0 play therapy courses or 1 or more play therapy courses. The standard deviation was 1.58. Results are shown in Table 14. No statistical significance was found between graduate courses in play therapy and use or availability of culturally sensitive play therapy materials. Thus, there is no relationship between graduate play therapy courses and the use or availability of culturally sensitive play therapy materials.

Table 14

*Chi square Analyses of Materials Used or Available Between Levels of Play Therapy Graduate Courses*

Variables	No Courses In Play Therapy	1 or More Courses in Play Therapy	$\chi^2$	<i>p</i>
Arts and Crafts Materials			0.03	0.87
Any	129	235		
None	6	10		
Books			0.94	0.33
Any	104	199		
None	31	46		
Board Games			0.67	0.41
Any	58	116		
None	77	129		
Dramatic play materials			0.56	0.45
Any	113	212		
None	22	33		
Dress up clothes			0.25	0.62
Any	62	106		
None	73	139		
Dolls			2.03	0.15

Table 14 Continued

Any	130	227		
None	5	18		
Dollhouse and/or materials			0.00	0.96
Any	128	232		
None	7	13		
Puppets			0.01	0.91
Any	99	181		
None	36	64		
Sand tray materials			0.09	0.76
Any	117	215		
None	18	30		
Musical			0.98	0.75
Any	76	142		
None	59	103		

Next, to examine Research Question 8, responses to item 12 (approximate number of graduate level multicultural courses) was compared on items 30-39 (culturally sensitive materials). In examining this question, multicultural courses were collapsed into two groups, 0 courses or 1 or more courses. Again, individual chi square tests were completed with a *p* level of .01. Most play therapists reported taking one (n=125-33%) or two (n=123-32%) courses in multicultural counseling. Results are shown in Table 15. No statistical significance was found

when comparing culturally sensitive materials and multicultural courses taken. Thus, there is no relationship between completion of multicultural courses and the use or availability of culturally sensitive play therapy materials.

Table 15

*Chi square Analyses of Materials Used or Available Between Levels of Multicultural Counseling Graduate Courses*

Variables	No Courses In Multicultural Counseling	1 or More Courses in Multicultural Counseling	$\chi^2$	<i>p</i>
Arts and Crafts Materials			0.58	0.45
Any	46	318		
None	1	15		
Books			0.03	0.85
Any	37	266		
None	10	67		
Board Games			0.62	0.43
Any	19	155		
None	28	178		
Dramatic play materials			0.00	0.93
Any	40	285		
None	7	48		
Dress up clothes			0.15	0.70
Any	22	146		

Table 15 Continued

None	25	187		
Dolls			0.57	0.45
Any	43	314		
None	4	19		
Dollhouse and/or materials			0.13	0.71
Any	44	316		
None	3	17		
Puppets			0.02	0.90
Any	35	245		
None	12	88		
Sand tray materials			2.06	0.15
Any	38	294		
None	9	39		
Musical			0.38	0.53
Any	25	193		
None	22	140		

Finally, Research Question 8 was analyzed by completing individual chi square analysis of item 13 (approximate number of play therapy workshops or special institutions attended) and items 30-39 (culturally sensitive play therapy materials). These chi square tests were completed

with responses to workshops or special institutes being collapsed into two groups due to lack of variability in certain categories. Collapsing the data into two groups also allowed for the examination of the relationship between having attended some or no workshops or special institutes and the use or availability of culturally sensitive materials. The two groups examined were 0 play therapy workshops or special institutes or 1 or more play therapy workshops or special institutes. The majority, 264 (69%), of play therapists reported 4 plus play therapy workshops or special institutes. The results are presented in Table 16. Once more, a conservative  $p$  level of .01 was used to reduce the risk of a Type I error. There was no statistical significance found when comparing categories of culturally sensitive materials and attendance at play therapy workshops or special institutions. Thus, there is no relationship between the use or availability of culturally sensitive materials and attendance at play therapy workshops or special institutions.

Table 16

*Chi square Analyses of Materials Used or Available Between Levels of Attendance at Play Therapy Workshops and Special Institutes*

Variables	No Play Therapy Workshops or Special Institutes	1 or More Play Therapy Workshops or Special Institutes	$\chi^2$	$p$
Arts and Crafts Materials			0.36	0.55
Any	8	318		
None	0	16		
Books			0.11	0.74
Any	6	297		
None	2	75		



Table 16 Continued

Board Games				0.06	0.80
Any	4	170			
None	4	202			
Dramatic play materials				1.38	0.24
Any	8	317			
None	0	55			
Dress up clothes				0.11	0.74
Any	4	164			
None	4	208			
Dolls				5.16	0.02
Any	6	351			
None	2	21			
Dollhouse and/or materials				6.38	0.01
Any	6	354			
None	2	18			
Puppets				5.52	0.01
Any	3	277			
None	5	95			
Sand tray materials				1.18	0.28
Any	8	324			

Table 16 Continued

None	0	48		
Musical			1.03	0.30
Any	6	212		
None	2	160		

Thus, there is no relationship between graduate play therapy courses and the use or availability of culturally sensitive play therapy materials. Additionally, there is no relationship between the use or availability of culturally sensitive materials and attendance at play therapy workshops or special institutions. Finally, there is no relationship between completion of multicultural courses and the use or availability of culturally sensitive play therapy materials. Hence, the education or training play therapists receive appears to have little relationship to the use or availability of culturally sensitive play therapy.

*Research Question 9*

Research Question 9 asked, “What is the relationship between play therapists’ status as a play therapist and use of culturally sensitive play therapy?” Data analysis included several chi square analyses on item 7 (status as play therapist) and items 30-39 (use and/or availability of culturally sensitive play therapy materials). To reduce the possibility of a Type I error, a conservative *p* level of .01 was used. Table 17 presents the results. Of the ten categories of culturally sensitive materials included in the CSPTS, statistical significance was found only in the use of a dollhouse and/or materials ( $\chi^2=15.57$   $n=385$ ,  $p=0.001$ ).

Table 17

*Chi square Analyses of Materials Used or Available Between Levels of Play Therapy Status*

Variables	Under Supervision	Registered Play Therapist	Registered Play Therapist Supervisor	Other	$\chi^2$	<i>p</i>
Arts and Crafts Materials					3.52	0.32
Any	82	65	89	133		
None	5	5	2	4		
Books					3.21	0.36
Any	65	58	77	108		
None	22	12	14	29		
Board Games					8.89	0.03
Any	46	24	37	72		
None	41	46	54	65		
Dramatic play materials					1.32	0.73
Any	74	58	81	117		
None	13	12	10	20		
Dress up clothes					3.99	0.26
Any	36	31	49	57		
None	51	39	42	80		
Dolls					0.18	0.98
Any	81	66	86	129		

Table 17 Continued

None	6	4	5	8		
Dollhouse and/or materials					15.57	0.001
Any	84	60	90	131		
None	3	10	1	6		
Puppets					6.23	0.10
Any	56	53	73	103		
None	31	17	18	34		
Sand tray materials					8.53	0.04
Any	77	58	87	115		
None	10	12	4	22		
Musical					3.40	0.33
Any	50	39	60	74		
None	37	31	31	63		

Thus, there is a relationship between status as a play therapist and the use or availability of a dollhouse and/or materials. However, there was no relationship found when examining the remaining 9 categories of culturally sensitive play therapy materials. So, it appears there is a limited relationship between a play therapist's use or availability of culturally sensitive play therapy materials and status as a play therapist.

*Research Question 10*

Research question 10 asked, “Are there differences in play therapists’ ethnicity and use of culturally sensitive play therapy materials?” To analysis these data, individual chi square tests were computed to compare item 4 (ethnicity) and items 30-39 (use and/or availability of culturally sensitive play therapy materials). Using a conservative  $p$  level of .01, no statistical significance was found between play therapists’ ethnicity and use of culturally sensitive play therapy materials. Results are shown in Table 18, indicating that there is no relationship between play therapists’ ethnicity and use of culturally sensitive play therapy materials.

Table 18

*Chi square Analyses of Materials Used or Available Between Ethnicity*

Variables	African American	Asian American	Caucasian	Hispanic	Native American	Pacific Islander	Middle Eastern descent	Other	$\chi^2$	<i>p</i>
Arts and Crafts Materials									2.27	0.94
Any	14	5	303	20	5	2	6	14		
None	0	0	25	1	0	0	0	0		
Books									17.27	0.02
Any	13	5	257	13	4	0	6	10		
None	1	0	61	8	1	2	0	4		
Board Games									7.46	0.38
Any	8	3	142	8	3	1	5	9		
None	6	2	176	13	2	1	1	5		
Dramatic play materials									6.09	0.53

Table 18 Continued

Any	11	3	274	18	5	2	6	11		
None	3	2	44	3	0	0	0	3		
Dress up clothes									9.00	0.25
Any	7	3	134	11	4	1	5	8		
None	7	2	184	10	1	1	1	6		
Dolls									4.18	0.76
Any	13	4	301	19	5	2	5	13		
None	1	1	17	2	0	0	1	1		
Dollhouse and/or materials									14.88	0.04
Any	13	4	306	17	5	2	6	12		
None	1	1	12	4	0	0	0	2		
Puppets									9.89	0.20
Any	10	5	228	16	5	2	6	13		
None	4	0	90	5	0	0	0	1		

Table 18 Continued

Sand tray materials										15.1	0.04
Any	14	4	282	15	5	1	6	10			
None	0	1	36	6	0	1	0	4			
Musical										6.56	0.48
Any	7	2	181	14	2	1	5	11			
None	7	3	137	7	3	1	1	3			



There was no relationship found between play therapists' ethnicity and use of culturally sensitive play therapy materials. It appears that play therapists' ethnicity does not have an association with their use or availability of culturally sensitive play therapy materials.

*Research Question 11*

Research question 11 asked, “Are there differences in client’s ethnicity and use of culturally sensitive play therapy?” The responses to item 5 were compared using individual analysis of variance tests on items 30-39. Tables 19-27 reflect the results of the comparisons. Only one of the ten culturally sensitive play therapy categories indicated significance—puppets ( $F=8.77, p=0.003$ ).

Table 19

*Analysis of Variance for Art and Crafts Materials Available or Used and Client’s Ethnicity for Research Question 11*

Source	SS	df	MS	F	p
Between groups	108.57	1	108.57	0.11	0.74
Within Groups	38493.59	382	1006.27		
Total	384502.16	383	1003.92		

Table 20

*Analysis of Variance for Books Available or Used and Client’s Ethnicity for Research Question 11*

Source	SS	df	MS	F	p
Between groups	75.88	1	75.88	0.08	0.78
Within Groups	384426.28	382	1006.35		

Table 20 Continued

Total	384502.16	383	1003.92
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Table 21

*Analysis of Variance for Board Games Available or Used and Client's Ethnicity for Research Question 11*

Source	SS	df	MS	F	p
Between groups	1124.92	1	1124.92	1.12	0.29
Within Groups	383377.24	382	1003.60		
Total	384502.16	383	1003.92		

Table 22

*Analysis of Variance for Dramatic Play Materials Available or Used and Client's Ethnicity for Research Question 11*

Source	SS	df	MS	F	p
Between groups	318.99	1	318.99	0.32	0.57
Within Groups	384183.17	382	1005.72		
Total	384502.16	383	1003.92		

Table 23

*Analysis of Variance for Dress Up Materials Available or Used and Client's Ethnicity for Research Question 11*

Source	SS	df	MS	F	p
Between groups	41.28	1	41.28	0.04	0.84

Table 23 Continued

Within Groups	384460.88	382	1006.44
Total	384502.16	383	1003.92

Table 24

*Analysis of Variance for Dolls Available or Used and Client's Ethnicity for Research Question 11*

Source	SS	df	MS	F	p
Between groups	441.59	1	441.59	0.44	0.51
Within Groups	384060.57	382	1005.39		
Total	384502.16	383	1003.92		

Table 25

*Analysis of Variance for Dollhouse and/or Materials Available or Used and Client's Ethnicity for Research Question 11*

Source	SS	df	MS	F	p
Between groups	4629.25	1	4629.25	4.66	0.03
Within Groups	379872.92	382	994.43		
Total	384502.16	383	1003.92		

Table 26

*Analysis of Variance for Puppets Available or Used and Client's Ethnicity for Research Question 11*

Source	SS	df	MS	F	p
Between groups	8624.95	1	8624.95	8.77	<.00

Table 26 Continued

Within Groups	375877.21	382	983.97
Total	384502.16	383	1003.92

Table 27

*Analysis of Variance for Sand Tray Materials Available or Used and Client's Ethnicity for Research Question 11*

Source	SS	df	MS	F	p
Between groups	2.19	1	2.19	<0	0.96
Within Groups	384499.97	382	1006.54		
Total	384502.16	383	1003.92		

Thus, the only significant relationship was between the use of culturally sensitive puppets and client's ethnicity. This finding indicates that overall a play therapist is not likely to use culturally sensitive materials based on the client's ethnicity. Specifically the results showed, of the ten categories of culturally sensitive play therapy materials examined, only one of the culturally sensitive play therapy categories indicated significance—puppets ( $F=8.77, p=0.003$ ). Thus, there appears to be a relationship between the use of culturally sensitive puppets and the clients' ethnicity, meaning play therapists are more likely to use culturally sensitive puppets when working with specific ethnic populations.

*Research Question 12*

Research question 12 asked if there are differences in play therapists' licensure type and use of culturally sensitive play therapy. Item 4 (licensure type) and items 30-39 (use and/or availability of culturally sensitive play therapy materials) were compared using individual chi

square tests. No statistical significance was found using a conservative  $p$  level of .01, which was used to reduce the likelihood of a Type I error. The results are presented in Table 28.

Table 28

*Chi square Analyses of Materials Used or Available Between Levels of Education*

Variables	Licensed Marriage and Family Therapist (LMFT)	Licensed Professional Counselor (LPC)	Licensed Clinical Social Worker (LCSW)	Licensed School Psychologist	Licensed Psychologist	Other	$\chi^2$	$p$
<b>Arts and Crafts Materials</b>							2.79	0.73
Any	53	135	93	3	26	59		
None	1	8	4	0	0	3		
<b>Books</b>							3.5	0.62
Any	45	113	82	2	19	47		
None	9	30	15	1	7	15		
<b>Board Games</b>							2.21	0.82
Any	29	63	46	2	12	27		
None	25	80	51	1	14	35		
<b>Dramatic play materials</b>							3.09	0.69
Any	45	123	86	3	20	53		
None	9	20	11	0	6	9		
<b>Dress up clothes</b>							2.19	0.82
Any	24	69	40	2	10	28		
None	30	74	57	1	16	34		

Table 28  
Continued

Dolls								5.04	0.41
Any	50	136	92	3	22	59			
None	4	7	5	0	4	3			
Dollhouse and/or materials								5.25	0.39
Any	52	135	95	3	24	56			
None	2	8	2	0	2	6			
Puppets								5.84	0.32
Any	40	108	64	2	22	49			
None	14	35	33	1	4	13			
Sand tray materials								3.2	0.67
Any	49	125	87	3	21	52			
None	5	18	10	0	5	10			
Musical								6.66	0.25
Any	38	78	54	3	14	36			
None	16	65	43	0	12	26			

Thus, there were no significant relationships found between the use or availability of culturally sensitive materials and play therapist licensure type. This suggests that the use of culturally sensitive play therapy is similar across licensure types. Perhaps if one licensure type used culturally sensitive play therapy more than the others did, then it would be beneficial to train play therapists differently.

*Research Question 13*

Research Question 13 examined if there are differences in having a designated playroom and use of culturally sensitive play therapy. Individual chi square tests were used to compare item 6 (designated playroom) and items 30-39 (use and/or availability of culturally sensitive play therapy materials). To reduce the likelihood of a Type I error, a *p* level of .01 was utilized. Of the ten culturally sensitive play therapy material categories, seven did not show statistical significance (arts and crafts, books, dress up clothing, dolls, musical instruments, board games, and puppets). The results are shown in Table 29. The following categories showed significance: dramatic play materials ( $\chi^2=31.59$ ,  $n=385$ ,  $p=0.001$ ), dollhouse and/or materials ( $\chi^2=12.52$ ,  $n=385$ ,  $p<0.001$ ) and, sand tray materials ( $\chi^2=11.35$ ,  $n=385$ ,  $p=0.001$ ). Overall, it appears that having a designed play therapy room was related to the use or availability of dramatic play materials, dollhouse and/or materials, and sand tray materials. The remaining seven categories of culturally sensitive materials used or made available did not appear related to having a designed play therapy room.

Table 29

*Chi square Analyses of Materials Used or Available Between Availability of Playroom*

Variables	Yes	No	$\chi^2$	<i>p</i>
Arts and Crafts Materials			0.32	0.57
Any	298	71		
None	12	4		
Books			0.10	0.74
Any	249	59		
None	61	16		
Board Games			1.58	0.21
Any	149	30		
	107			

Table 29 Continued

None	161	45		
Dramatic play materials			31.59	<.00
Any	281	49		
None	29	26		
Dress up clothes			6.29	0.01
Any	149	24		
None	161	51		
Dolls			6.02	0.01
Any	296	66		
None	14	9		
Dollhouse and/or materials			12.53	<.00
Any	300	65		
None	10	10		
Puppets			0.52	0.46
Any	227	58		
None	83	17		
Sand tray materials			11.35	<.00
Any	280	57		
None	30	18		
Musical			6.06	0.01
Any	189	34		
None	121	41		

Thus, there is a significant relationship between having a designated playroom and the use or availability of dramatic play materials, dollhouse and/or materials and, sand tray materials. However, there were no relationships between having a designated playroom and the use or



availability of arts and crafts, books, dress up clothing, dolls, musical instruments, board games, and puppets. Hence, having a designated playroom may allow for the use of larger items such as dramatic play materials, dollhouse and/or materials and, sand tray materials, whereas not having a designated playroom may limit space and prohibit the use of materials that require larger amounts of storage space.

#### *Research Question 14*

Research question 14 asked, “What is the relationship between years as a mental health professional and the use of culturally sensitive play therapy?” Item 10 asked respondents to indicate the total number of years practicing mental health with choices given ranging from 1 to 50. Play therapists ( $n=380$ ) indicated years practicing mental health ranging from 1 to 42, with a mean of 13.73 years and standard deviation of 9.70. The research question was answered with individual analysis of variance procedures. No statistical significance was found.

Therefore, it appears that there is no association between years as a mental health professional and the use of culturally sensitive play therapy. Time spent as a mental health professional did not seem to impact play therapists’ use of culturally sensitive play therapy.

#### *Research Question 15*

Research Question 15 asked, “How do you define culturally sensitive play therapy?” The survey allowed respondents to type in a free-form field with a 150-character limit. Themes were identified using Creswell’s (2007) recommendations for constant comparative analysis. Codes were assigned after the initial reviewing of the text for themes, then the text was continually reviewed until similar codes were grouped into axial codes, which led to themes, such as: awareness, individuality, knowledge, and acceptance.

Play therapists described the need to be aware of the child, the culture of the child, and the awareness of differences. The following are examples of statements given:

*Being sensitive of clients' cultural background and using that awareness when implementing play therapy practices.*

*Being aware of your client's culture and customs and providing a safe and welcoming environment for them to explore their current struggles.*

*I don't define it. I choose to be aware of the dynamics in a family and in a culture. I ask parents how they see their lives as different.*

Additionally, play therapists discussed the need to respect the whole child and respecting individual differences. Statements below are samples of those items relating to this theme:

*Play therapy that is sensitive to and inclusive of each client's culture and their individual and collective perspective.*

*This is a big question-play therapy adapts itself to the diverse needs of the individual in front of you*

*Understanding the whole child and the impact of his culture within the neighborhood that he lives, including home life, customs, language, food, social (sic.)*

Participants also reported that it was important to have knowledge about the child's culture and offered the following as their working definition of culturally sensitive play therapy:

*Sensitivity to diversity issues, knowledge of the many groups who may seek our services, and personalized response to each person's specific history.*

*Having a working knowledge of the culture and incorporating it into the context /(sic.)*

*Having knowledge about the traditions and strategies of children, their families and / (sic.)*

*Includes understanding/knowledge re cultural differences and a therapist who makes that knowledge practical and relevant in session vs specific toys*

*Therapist who works with a client with a knowledge and awareness of their clients unique ethnic, cultural and environmental backgrounds.*

Finally, play therapists believe that acceptance was an important component to properly explaining culturally sensitive play therapy. Those individuals offered the following examples:

*Play therapy in which the child has the tools, materials & acceptance from therapist to express their own culture & other cultures that influence them*

*Allows all clients to express themselves, nonjudgemental, accepting. Sometimes using less specific objects that can be anything. (sic.)*

*To provide toys and objects that represent their culture so that they feel accepted for who they are in the playroom.*

*Providing an inviting space, materials and my awareness for all children in order to feel accepted and comfortable to do therapeutic work....*

Thus, it appears that responding play therapists defined culturally sensitive play therapy in a variety of manners; however, they commonly reported the need to be aware of the child, the culture of the child, and aware of differences. Many reported gaining more education about cultural issues as a means to overcome perceived barriers, which was supported by Ritter and Chang (2002) who reported play therapists felt more competent with increased multicultural courses. However, a traditional multicultural course focuses on awareness, knowledge, and skills, it does not necessarily focus on incorporating multiculturalism in play therapy. VanderGast, Post, and Kascsak-Miller (2010) studied and addressed that need by providing students the opportunity to experience an immersion program while offering child–parent relationship training (CPRT; Landreth & Bratton, 2006) to families in a southwestern town. VanderGast, Post, and Kascsak-Miller reported positive outcomes as detailed in students’ personal journals. They believed this type of immersed training provided a learning opportunity to students and provided social justice to underserved populations. This type of immersive training could provide an alternative teaching method for master’s and doctoral students when learning play therapy and multicultural skills.

## **Summary**

In this exploratory survey into play therapists' perceptions of culturally sensitive play therapy, a number of items when explored indicated a significant relationship to the use or availability of culturally sensitive play therapy materials. When exploring the ten categories of culturally sensitive play therapy materials listed in the *CSPTS*, play therapists' level of education and use and/or availability of culturally sensitive books showed a significant relationship ( $\chi^2=10.44$ ,  $n=380$ ,  $p=0.005$ ), meaning that there is a relationship between the level of education and the use or availability of culturally sensitive books. Also, status as a play therapist and the use of a dollhouse and/or materials ( $\chi^2=15.57$ ,  $n=385$ ,  $p=0.001$ ) showed significance, meaning that there is a relationship between a play therapist's status and the use of a dollhouse and/or materials. This could be related to the costs of the dollhouse and the play therapist's commitment to the field; for example, the person has to seek out additional and/or specific trainings to become a registered play therapist. Lambert, LeBlanc, Mullen, Ray, Baggerly, White and Kaplan (2005) found that therapists who were members of the Association for Play Therapy were more likely than members of the American Counseling Association to identify themselves as experts in play therapy and seek out such trainings. While this does not directly address the use of a dollhouse, it does speak to individuals' commitment to the field of play therapy, trainings, and professional identification.

When exploring clients' ethnicity and the use of culturally sensitive play therapy materials, only one category showed significance—the use or availability of culturally sensitive puppets ( $F=8.77$ ,  $p=0.003$ ). Again, costs could be a prohibitive factor in acquiring a diverse puppet population. The storage of puppets could also exclude certain play therapists from using and acquiring a multitude of culturally sensitive puppets. Storage restrictions could also exclude play therapists who travel from site to site from attaining multiple culturally sensitive puppets.

The differences in having a designated playroom and use of culturally sensitive play therapy materials were also examined. The following categories showed significance: dramatic play materials ( $\chi^2=31.59$ ,  $n=385$ ,  $p=0.001$ ), dollhouse and/or materials ( $\chi^2=12.53$ ,  $n=385$ ,  $p=<0.001$ ), and sand tray materials ( $\chi^2=11.35$ ,  $n=385$ ,  $p=0.001$ ). This could be attributed to the space required to house these types of items. This theory could be supported by an examination of the storage requirements for materials not found significant when exploring the relationship between having a designated playroom and use of culturally sensitive play therapy (arts and crafts, books, dress up clothing, dolls, musical instruments, board games, and puppets).

Additionally, play therapists were able to identify barriers that impacted their perceived ability to provide culturally sensitive play therapy. The barriers to implementing culturally sensitive play therapy most often commented on were cost, storage, limited client diversity and availability. For example, individuals shared the following perceived barriers: *“having money to buy the toys,” “lack of client diversity,” “storage space for enough diverse toys that represent current clients,”* and *“availability challenges.”* Thus, it appeared that play therapists perceived that they encountered barriers to implementing culturally sensitive play therapy.

However, a number of those play therapists had identified ways to overcome barriers to implementing culturally sensitive play therapy, such as networking for ideas, resource locations, and availability. Some participants shared ideas such as, *“always vigilant when shopping to find culturally sensitive materials,” “use conferences and interned to find ethnic and multiracial materials,”* and *“networking.”* It could be helpful for play therapists to educate, share, and exchange ideas on culturally sensitive play therapy. This network could allow for the facilitation of discussions on how one navigates the paths of change when faced with obstacles regarding the use or availability of culturally sensitive play therapy materials.

The *CSPTS* also revealed that certain variables had no relationship to the use or availability of culturally sensitive materials. Surprisingly, there was no relationship found between graduate coursework or training. In particular, there was no relationship between completing graduate level play therapy or multicultural courses and the use or availability of culturally sensitive materials. Additionally, the attendance at play therapy workshops and the use or availability of culturally sensitive materials showed no significant relationship. Other variables not related to the use or availability of culturally sensitive materials were play therapists' ethnicity, years of experience or licensure type. Overall, there were no relationships found between the use of culturally sensitive play therapy materials and the following: training, coursework, ethnicity, years of experience or licensure type.

By completing the *CSPTS*, play therapists shared their perspectives on culturally sensitive play therapy. Their answers indicated a wide variety of materials used in and out of playrooms. They also shared which materials were used less commonly, such as dress up clothing and board games. They noted perceived barriers and methods used to overcome those barriers. While play therapists acknowledged they sought out continued education and materials, others wished for more workshops to directly address selecting materials and culturally sensitive play therapy. As the field of play therapy continues to grow, so shall play therapists' desire for additional information and continued growth.

## **CHAPTER FIVE**

### **DISCUSSION**

Chapter Five includes a discussion of the results of this study as well as a summary of the findings and recommendations for future research. Implications as well as limitations are also discussed.

#### **Purpose of the Study**

The purpose of this study was to understand how play therapists define and provide culturally sensitive play therapy, the materials they use, and barriers that prohibit providing culturally sensitive play therapy. Additional purposes of this study were to examine the relationship between populations served and materials available in the playroom and to determine differences among play therapists based on sex, age, type of licensure, formal multicultural training, and play therapy training.

#### **Discussion of Findings**

This study was based on the work of Ritter and Chang (2002), who surveyed members of the Association for Play Therapy using the *Multicultural Counseling Competence and Training Survey*. To enhance their findings, they included two optional open-ended questions following the survey: “What trends, if any, do you see in the play therapy with your culturally diverse clients?” and “What items do you include in your playroom to specifically represent culturally diverse populations?” The responses to the open-ended questions were separately detailed in 2005 by Chang, Ritter, and Hays.

In 2002, Ritter and Chang published their findings that 24% of the members of the association felt competent about cultural awareness despite not having multicultural coursework.

The responding 134 members of the Association for Play Therapy, however, reported feeling poorly trained in the five subscales assessed (knowledge, awareness, terminology, racial identity development, and skills), rating racial identity as the lowest. Ritter and Chang (2002) discussed the need for more research to explore the rationale for play therapists feeling competent, but also reporting a perception of poor multicultural training.

Later, in 2005, Chang, Ritter, and Hays reported on participants' responses to the two qualitative questions originally asked in combination with their 2002 study on cultural competency. They found five themes in play therapists' responses to "*What trends, if any, do you see in play therapy?*" These themes included no differences, increase in minority client numbers, play differences, family differences, and general trends. They stated that surveyed play therapists reported that there were generally no differences in play among diverse clients, noting that play is the worldwide language of children. Additionally, play therapists in the Chang, Ritter, and Hays study reported qualitatively that they were serving a more diverse clientele, stating from their perspective historically more Caucasian families presented for services than multicultural families. In addition, they found that play therapists perceived ethnic minorities to have less involvement, value services less, and prematurely terminate those services.

Chang, Ritter, and Hays (2005) examined responses to, "*What items do you include in your play to specifically represent culturally diverse populations?*" Play therapists reported the use of ethnic dolls, sand tray items, and puppets. They found, however, a limited number of play therapists who described using specialized play food, dress-up clothing, and miniatures. Play therapists also reported having a variety of shades of crayons and play-dough available.

My study asked members of the Association for Play Therapy who held at least a Master's degree to provide a working definition of culturally sensitive play therapy as determined by their responses to an open-ended question. The survey also inquired about



culturally sensitive materials used or available to clients in their playrooms as determined by ten items that allowed respondents to check all materials used, but also included options for “other” and “none.” The information I gathered was different from the previous research because it asked about the perceived barriers to implementing culturally sensitive play therapy, and the methods used to overcome those barriers. Play therapists’ reported barriers included cost, availability of materials, space and their perception of a lack of diversity among clientele. To overcome their perceived barriers, play therapists reported personally buying materials, continued education, and networking for uses, resources, and availability.

Data were also gathered about the training and preparedness play therapists received, including formal play therapy, formal multicultural courses, workshops and special institutes, and whether play therapists were keeping current on research published in journals. Play therapists were also asked about their agreement with statements regarding beliefs about culturally sensitive play therapy, including “There is a relationship between culturally sensitive play therapy and a positive outcome for my clients;” “Culturally sensitive play therapy is useful for my clients;” “Culturally sensitive play therapy is not necessary for a positive outcome for my clients;” and “It is necessary to have culturally sensitive materials in the play therapy room in order to engage children from diverse backgrounds in play therapy.” This survey also asked how play therapists who utilize culturally sensitive play therapy deliver it at their worksites, allowing for indications in ten categories of play therapy materials. The responses provided information regarding play therapists’ training, status as a play therapist, ethnicity, clients’ ethnicity and the availability or use of culturally sensitive play therapy. Finally, my study explored whether there were perceived differences in licensure type, having a designated playroom, or years as a mental health professional and the use of culturally sensitive play therapy materials.

To that end, the *Culturally Sensitive Play Therapy Survey* (CSPTS) was created specifically for this study. The 41-item online survey was used to determine the following: demographics, beliefs regarding culturally sensitive play therapy, perceptions of the barriers to implementing culturally sensitive play therapy, perceived barriers to implementing culturally sensitive play therapy, culturally sensitive materials used by play therapists, and how play therapists define culturally sensitive play therapy.

#### *Overview of Culturally Sensitive Play Therapy*

Overall, culturally sensitive play therapy materials were used by most responding play therapists, who generally were female (93%), Caucasian (83%), and work from a child-centered perspective (56%). The demographic findings in this study are similar to those of Abrams et al. (2006), Fall, Drew, Chute, and More (2007); Ryan, Gomory, and Lacasse (2002) that reported commonly the play therapists registered with the Association of Play Therapy are White and female. These findings also support earlier work of Lambert et al. (2005) 66.6% of Lambert's responding practitioners identified their theoretical orientation as child-centered.

Most commonly used culturally sensitive materials were arts and crafts, with a small percentage ( $n=16$ , 4%) of participants who indicated no art or craft materials were available or used with their clients. The use of arts and crafts materials is supported by historical play therapists, such as Axline (1947), as well as the current body of literature (Gil & Drewes, 2005). Additionally, the findings suggested that the least commonly used culturally sensitive categories were dress-up clothing and board games. Whereas the participating play therapists used some culturally sensitive materials, they also reported encountering barriers to implementation of such materials. Barriers were mainly costs, space, availability, and lack of clientele diversity. Some play therapists were able to overcome those perceived barriers to implementation by purchasing materials personally and networking to find alternative uses, available resources, and continued

education. Similar findings were reported by Shen (2008), who found that school counselors who did not use play therapy reported barriers such as training, confidence, time and money.

### *Arts and Crafts Materials*

The findings of this study show that most play therapists reported the use or availability of culturally sensitive art and craft materials. Most play therapists stated they had clay available, multicultural crayons, multicultural pencils, and multicultural markers. This availability could be related to the costs of most art materials, which are relatively inexpensive. Participating play therapists commonly reported costs and availability as barriers to implementing culturally sensitive play therapy. Art and craft materials are both cost effective and readily available at most big box stores as well as specialty shops. Supporting this notion, Gil and Drewes (2005) recommended acquiring art and craft supplies from companies such as the Crayola Company and S & S Worldwide, making them more accessible to play therapists across the United States. This is similar to the findings of Chang, Ritter, and Hays (2005) who found general trends noted by play therapists, such as reports of using arts and crafts materials and an upsurge in the availability of multicultural items. Chang, Ritter, and Hays also inquired, “What items do you include in your play to specifically represent culturally diverse populations?” and found play therapists reported an increase in the availability of shades of crayons, markers, and Play-doh from vendors.

The results also showed that there was no statistical difference between a play therapist’s use of arts and craft materials and client’s ethnicity, educational level, having a designated playroom or status as a play therapist. Overall, these findings suggest that play therapists are using arts and craft materials across all dimensions; that is regardless of their ethnicity or educational level. The findings also suggest that play therapists understand the use and benefits of art and craft materials, and these types of materials do not require a designated playroom. The

findings that showed play therapists possessed the arts and crafts materials supported Landreth's (1993) recommendation; specifically, he prescribed a "tote bag" playroom should include crayons, newsprint, clay or Play-doh, popsicle sticks, and pip cleaners.

The large amount of arts and crafts materials reported by participants could be due to the amount of historical play therapy literature that supports such materials. The results support art materials discussed by Levy (1938) who recounted using clay with a small child during release therapy. The outcome of the CSPTS also supports Cassell (1972) recommendations that artistic supplies be included in a suitcase playroom, when a designated playroom is unavailable. Additionally, Axline (1947) supported the use of arts and crafts materials when working with children. For example, she suggested more than half a century ago that a playroom should have paints, clay, crayons, and drawing paper.

#### *Culturally Sensitive Games and Books*

Gil and Drewes (2005) acknowledged that cultural games may prove difficult to find and the majority, 206 (58%), of the respondents indicated that they had no culturally sensitive games available to their clients. This was supported by comments from play therapists who explained, "*It's hard to find some of the things you've listed above,*" while another stated "*Lack of access games and books.*"

Additionally, it was noted that a large majority of participants identified their theoretical orientation as child-centered (56%), and Landreth (2002) believes games do not fit within child-centered play therapy. Landreth proposed that games directly involve the therapist and may require that the therapist win by defeating the child or lose through deceit, either way possibly affecting the child's self-esteem or the relationship. Historically, Axline (1947) discussed the use of checkers explaining that mechanical toys inhibit creative play for children, which could also explain the reasons for the lack of games provided by participants.

The findings of the CSPTS could also support Swank's (2008) beliefs regarding the use of games with children and families. She argued that the use of games was not supported in child-centered play therapy as prescribed by Landreth (2002), but that games could be supported in the playroom by such theoretical frameworks as cognitive behavioral, psychoanalytic, and gestalt therapies (Swank, 2008). Again, it is noted that 214 (56%) of responding play therapists identified their theoretical orientation as child-centered and 58% stated they had no games available to clients, which aligns with Swank's belief that games are not supported by child-centered play therapy. While Swank did not specifically address the use of games with culturally diverse clientele, she indicated that the use of games assists in meeting the goals of specific theoretical orientations. These findings may suggest that play therapists need more education on how one may use board games to build rapport or open communication. Swank also believed that games support building a relationship, making a diagnosis, opening communication, deepening insights through decreased anxiety, and increasing socialization.

Ritter and Chang (2002) did not report on culturally sensitive materials in relation to level of education. They did find, however, that play therapists who had more multicultural courses perceived themselves to be more competent, and believed their training was adequate. The findings of this survey suggest that there is a relationship between a play therapist's level of education and use of culturally sensitive books, but not with the other nine categories of culturally sensitive materials. It was also shown that 33% of play therapists reported taking one course ( $n=125$ ) and 32% reported taking two courses ( $n=123$ ) in multicultural counseling. Thus, it could be that play therapists with more multicultural training feel better prepared to incorporate culturally sensitive books, into their playrooms.

Despite the recommendations for culturally sensitive books made by Gil and Drewes (2005), who offered many suggested books for use with specific populations such as African-

American, Asian-American, Hispanic, Native American, and multicultural, 22% of respondents reported that they did not use culturally sensitive books. This may suggest that more education is needed on the use of culturally sensitive materials, such as books; as one participant requested, “*education on what is most important regarding types of culturally sensitive toys/materials (sic.)*.”

Play therapists identified costs as a barrier. Individual books are inexpensive, but acquiring numerous books on a variety of topics and diversities could possibly be cost prohibitive to many agencies and even more so to individual play therapists in private practice. Alternatively, one play therapist noted a “*lack of access games and books*” as a perceived barrier to implementing culturally sensitive play therapy. Another individual believed that “*books representing differnt types of families (sic.)*” would make their playroom more culturally sensitive. Thus, it appears that some play therapists would benefit from training or information on where to locate such culturally sensitive materials. Additionally, play therapists may benefit from education on how to navigate the exploration of local or inexpensive resources such as online social stories or local libraries.

### *Dramatic Play Materials*

The use of culturally sensitive food items and/or dishes is supported by Gil and Drewes (2005) and O’Connor (2005), who all believed that these items are easily accessible in local food markets. These types of recommendations were apparently appreciated and known, as a majority of participants (74%) reported having culturally sensitive dishes. In fact, 33% reported having eating/cooking utensils. The results also support Gil and Drewes’ beliefs that acquiring materials locally allowed that item to reflect the local culture. Many responding play therapists reported purchasing materials personally and some using local resources to overcome the perceived barrier of availability of culturally sensitive materials. Garza and Bratton (2005) discussed the

subjective findings of their study on *School-based Child Centered Play Therapy with Hispanic Children*. Specifically, they acknowledged that children seemed more comfortable when noting toys and materials from their culture. Garza and Bratton explained that children would state, “you got this in Mexico!” (p. 67).

Additionally, there appeared to be a relationship between having a designated playroom and use of culturally sensitive dramatic play materials. This could suggest that having a designated playroom allows for the space required to house multiple items, such as dishes, utensils, and food items. It could also suggest that the perceived barrier of limited space was related to the individuals who did not have a designated playroom. Perhaps play therapists could benefit from knowledge about dramatic play materials that required less storage space.

#### *Dress up Clothing*

Dress up clothing was least commonly used by play therapists; only 17% reported the availability of special needs items such as a sling or crutch. These results are in direct contrast to those of Chang, Ritter, and Hays (2005) who found play therapists reported using local stores for dress up clothing, to represent local cultures. It is possible that the increase in response to this survey allowed for more clarity in how often these types of materials were used, as opposed to the qualitative themes identified by Chang, Ritter, and Hays. It is possible that responding play therapists did not utilize medical equipment due to storage issues or lack of availability at conventional stores. Alternatively, some play therapists may not have viewed special needs items such as crutches as “dress up clothes.”

Even though O’Connor (2005) supported the use of culturally sensitive materials such as adaptive devices or crutches in the playroom, many responding play therapists reported lack of storage as a barrier to utilizing such materials in their playrooms. For example, one participant stated he or she lacked “*storage space for enough diverse toys that represent current clients.*”

This could indicate that, while those materials are available through local merchants, the storage necessary for multiple sets of dress up clothes could be a prohibitive factor for many. Another barrier noted was the environment in which the therapy was provided. An individual reported that “*space (P.T. practiced at client's home or school makes having a good variety of play material challenging)*” could limit the ability to use a variety of culturally sensitive materials. It is possible that some play therapists may view culturally sensitive materials as additional materials for the playroom, not as substitutions for more conventional play therapy materials. These additional materials could require more storage space than some play therapist may have access to.

Overall, it appeared that many play therapists in this study do not include culturally sensitive dress up clothing in their playrooms. Also noted was the lack of relationship between the use of culturally sensitive dress up clothing and education, status as a play therapist, and designated playroom. Thus, it can be concluded that many did not use culturally sensitive dress up clothing and it is not related to their training, space available or additional certifications as a registered play therapist.

#### *Dolls, s, and Dollhouse Materials*

The vast majority of play therapists (94%) reported the use of culturally sensitive dolls, dollhouses, and dollhouse materials. These materials have enjoyed a long history of recommendations by historical play therapists such as Axline (1947). These findings suggest that play therapists understand the value of these materials and feel comfortable using them. However, some play therapists noted barriers to availability of certain dolls and dollhouse materials. Other play therapists reported overcoming these barriers by asking others for the location, availability, or resources used to obtain dolls and dollhouse materials. Similarly, play



therapists could feel more comfortable with the use of dolls due to Landreth's (2002) recommendation that dolls be included in a playroom.

African American dolls were reportedly available to most play therapists (83%). Only 23 play therapists reported not having any culturally sensitive dolls and only 20 play therapists claimed that they had no dollhouse or materials available or used in their playrooms. Participants also reported having dolls for the dollhouse with multiple sexes, representing grandparents, extended family members, or blended families ( $n=289$ ). These findings support the recommendations for multiple dolls that are noted in play therapy literature. For example, in *The suitcase playroom*, Cassel (1972) recommended, "two families of five members each, one set black and one set white..." Cassel noted the limitations of therapists needing to provide therapy in a variety of places, but believed one could still provide a variety of dolls and figures representative of the community (e.g., police, firefighter, mail carrier) Perhaps these types of early recommendations made this category more accessible, or maybe there is wider availability of such dolls at local stores. This finding supported Chang, Ritter, and Hays (2005) who found a large number of respondents had ethnic dolls, sand tray items, and puppets. Diverse sand tray items such diverse landscapes (i.e. cactus), religious (i.e. Hindu gods and Buddhas) and families may be purchased online through online stores such as [www.childtherapytoys.com](http://www.childtherapytoys.com), which may also increase the likelihood of their inclusion in a playroom.

Findings indicated that there was a relationship between having a dollhouse and (a) having a designated playroom and (b) certification as a registered play therapist. Specifically, 81% of play therapists reported having a designated playroom, which was related to the use or availability of a dollhouse and/or materials. There was also a relationship between having a dollhouse and/or materials and an individual's status as a registered play therapist, indicating that registered play therapists were more likely to use or have a dollhouse available than play

therapists who were not registered play therapists. These findings could be attributed to the space required to house dollhouses and dollhouse materials. The purchasing of such costly items could also indicate the therapist's dedication to the field of play therapy. Perhaps, if one invested the money in such materials he or she would be more likely to deliver therapy through the method of play therapy. Such findings may indicate a commitment to the field, as indicated by those who have sought out the additional certifications as registered play therapists. Lambert et al. (2005) reported individuals who primarily identified themselves as play therapists were more likely to belong to the play therapy association than those who identify as experts in mental health or experts in community counseling. They also reported that play therapists were more likely to obtain and maintain training/education around play therapy issues. Specifically, when Lambert, et al. examined play therapy continuing education differences between members of the American Counseling Association and members of the Association for Play Therapy, they reported that play therapists received 88.29 to 118.64 more hours in play therapy training than those therapists who were members of the American Counseling Association only.

Even though participating play therapists reported using dolls, dollhouses, and dollhouse materials, some still perceived access and availability as a barrier to implementing culturally sensitive play therapy with the use of dolls, dollhouses, and dollhouse materials. Play therapists desired more diversity in dollhouse materials; this was summarized by an individual who reported, "*...more variety of dollhouse people.*" Some play therapists still identified barriers to finding specific cultural items, such as "*...toys/dolls to address the issue of being biracial*" and "*Finding materials that accurately reflect culture like dolls with skin tones that look like clients.*" Another play therapist wished for more "*...dollhouse furniture appropriate for other cultures.*" This perceived barrier was addressed by O'Connor (2005) who recommended looking to the community where the child lives to ensure that the material is representative of the child's

cultural experiences or surroundings. O'Connor suggested that a simple piece of felt could be drawn on for a Navajo design, which could be an inexpensive addition to a culturally sensitive dollhouse. Even with the recommendations from play therapists such as O'Connor, my participants still wished for dollhouse varieties such as "different types of dollhouses (sizes, type of residence, etc.)." This continues to indicate the need for more diverse dollhouse materials or the need for education on how one could acquire or purchase such products. One play therapist believed that the perceived barrier was overcome by trying "... *to have toys that are colored neutrally, for example my dollhouse is plain wood, rather than pink.*" In support of cost effective and space saving options, Landreth, Ray, and Bratton (2009) have recommended the use of a cardboard box lid as an alternative to a dollhouse, simply explaining that one could draw designated rooms with a marker. These types of recommendations could explain the higher numbers of participants who reported using dollhouse materials, while not directly addressing the desire for more diversity in dollhouse materials.

The findings indicated that play therapists use culturally sensitive dolls, dollhouses, and dollhouse materials, but do not perceive that available dollhouse materials are representative of a variety of cultures. These findings also suggest the need to be educated on where diverse materials may be obtained. It is possible too that vendors are still not manufacturing such materials or making them readily available in the United States. Finally, these comments signify that play therapists understand the importance of having culturally sensitive dolls, dollhouses, and dollhouse materials and they continue to seek out such materials.

### *Puppets*

Surprisingly, 100 play therapists conveyed having no culturally sensitive puppets. This unexpected result is in contrast to the findings of Chang, Ritter, and Hays (2005), who found that play therapists believed that puppets were an important part of a culturally sensitive playroom.

Perhaps play therapists believed that puppets are an important part of culturally sensitive playrooms, but perceived barriers prevent the participants from acquiring culturally sensitive puppets.

Using an analysis of variance to determine the between group differences for clients' ethnicity and their use of culturally sensitive materials, only one of the 10 culturally sensitive play therapy categories indicated significance—puppets ( $F=8.77, p=0.003$ ). This indicated that there were differences in the use of culturally sensitive puppets among clients of different ethnic backgrounds..

Play therapists qualitatively noted that their clientele was not diverse but instead made up of primarily similar clients as evidenced by one who reported "*Clientele is mostly upper middle class*" and another who reported "*Lack of diverse clientele.*" Additionally, one indicated, "*I simply don't have a diverse clientele. I would get more if I had the client base for it. As it is, I'm not going to spend money (my resources) on items that will not be used. If my clients become more diverse, I would change my toys accordingly.*" This is in contradiction to the qualitative findings of Chang, Ritter, and Hays (2005) who found a main qualitative theme of increased numbers of ethnic minority clients seeking services. In the qualitative portion of their study, play therapists reported a perceived increase in diverse clientele presenting for play therapy. These difference in findings could be explained by the manner in which play therapists were asked about their experiences, with the Chang, Ritter, and Hays (2005) survey asking about trends noted while this survey explored barriers to including culturally sensitive materials within the playroom. Also, play therapists may have wanted to explain qualitatively why they did not have materials inquired about quantitatively.

The findings in this study suggest that costs for materials may exclude many play therapists from including a variety of culturally sensitive puppets in their playrooms. One could

purchase a diverse package of puppets (including one puppet representing each ethnicity) or play therapists could spend approximately the same amount for a single puppet of a specific diversity. However, recommendations for inexpensive puppets have been made by Nims (2007) who discussed a technique used as part of an integrated play therapy technique wherein he made a puppet of “neutral-colored material stitched together.” Then the child was allowed to draw a face with markers. In this case, Nims discussed using the neutral puppet to allow the child to draw expressions representative of the child’s current feelings. This technique reportedly allowed the child to then discuss the reason for the expressed emotion and how that emotion may change. These types of recommendations could offer alternatives for play therapists who perceive costs to be a barrier to using culturally sensitive puppets. Perhaps these findings also suggest that play therapists need education on more cost effective ways of incorporating culturally sensitive materials into their playrooms.

### *Sand Tray Materials*

A large percentage (86%) of play therapists reported having sand tray materials. A large number of participating play therapists had the following available for use: religious figures and symbols (72%), landscape figures (75%), and African American figures (66%), These findings also support the work previously done by Ritter, Chang, and Hays (2005) who found the majority of play therapists reported the inclusion of sand tray items in their playrooms.

Axline (1947) supported the use of sand tray materials with children. This support by a founding figure in the play therapy field could contribute to the large number of participants who reported the use of sand tray materials. While Axline did not specifically address culturally sensitive sand tray materials, she did endorse and recommend sand tray work. She discussed the wide and varied materials used for sand tray materials, for example using dolls, soldiers, and animals. Additionally, she believed children were able to use their imagination with sand, explaining they

may bury materials, use it for aggressive play, and it was relatively safe. Axline's praise for sand tray materials may allow current play therapists to feel comfortable seeking out and utilizing such materials.

Play therapists in this study reported that they used sand tray materials, but also commented on the need for more culturally sensitive sand tray materials. While most reported some type of culturally sensitive sand tray materials, one still reported a desire for "...*varying religious figures from world religions for sand play*" and "...*sandtray diverse religious material.*" Alternatively, some play therapists use sand tray therapy as their primary mode of treatment, as one play therapist reported, "*I have diverse materials in my my (sic.) sand tray work which is my primary treatment mode.*" This comment suggested that individuals who use sand tray as a primary mode of treatment may not include other categories of culturally sensitive play therapy materials. However, those play therapists may still actively engage in culturally sensitive play therapy. These findings may suggest a need for more education about culturally sensitive items in trainings specific to sand tray therapy. The use of culturally sensitive materials was also supported by Rousseau, Benoit, Lacroix and Gauthier (2009) in their work with multiethnic preschool children. Their work focused on children's mental health during the aftermath of a tsunami. Rousseau, Benoit, Lacroix, and Gauthier offered children traditional sand tray miniatures, but also thought that cultural miniatures, such as religious symbols, variety of housing types, figures dressed in national costumes, and numerous national flags were beneficial in allowing the children to recreate their experiences.

The findings also suggest that there is a relationship between having a designated playroom and the use of culturally sensitive sand tray materials. More specifically, the relationship between having a designated playroom and use of culturally sensitive play therapy

was explored, finding significance with sand tray materials. This finding suggests the use of a sand tray requires space, which was identified as a barrier to implementing culturally sensitive play therapy. A play therapist who reported moving from site to site and perceived this as a barrier to using some materials, explained, “*play therapy room at outpatient clinic does not have materials. I buy my own items for my offices at schools where I work most of the time.*” One play therapist also summarized play therapists working in space-limited schools as a perceived barrier by stating, “*space available at schools is limited.*” While another simply stated, “*no play tx (sic.) room,*” which was similarly expressed by another who stated, “*not having a Play Room.*” (sic.)

Thus, play therapists are using culturally sensitive sand tray items, and there appears to be a relationship between the use of sand tray materials and having a designated playroom. This finding is supported by play therapists’ comments that they are limited in their culturally sensitive materials by space constraints and availability. However, there appears to be no relationship between the use of sand tray materials and space availability and this may suggest that if play therapists had bigger playrooms and more education then perhaps they would use more culturally sensitive sand tray materials.

### *Musical Instruments*

The findings show almost half of responding play therapists reported having no culturally sensitive musical instruments and many reported barriers to using culturally sensitive musical instruments. However, there appears to be no relationship between education, status as play therapists, or having a designated playroom and the use of musical instruments. These findings indicated that play therapists are not using musical instruments, even though there have been recommendations on how to use culturally sensitive musical instruments. For example, Kranz, Ramirez, Flores-Torres, Steele, and Lund (2005) have recommended musical instruments and musical items such as CDs in a playroom used to work with first generation Mexican-American

children. Despite those types of specific recommendations, a large number of participants reported no instruments; this could be due to shared space as reported by one who stated, *“I don't have a set up where I can have musical instruments in the playroom.”* Alternatively, some play therapists reported the clients served did not use culturally diverse musical instruments. As one play therapist summarized, *“I work with African American children but their culture doesn't involve musical instruments, kaftians ect (sic.) that one thinks of from Africa.”* Additionally, it was noted that in Axline's (1947) discussion of materials recommended in the playroom, no mention of musical instruments was included, which could also explain the lack of inclusion in participants' playrooms. However, Garza and Bratton (2005) recommended toys and materials, including musical items, for use with Hispanic children. The items suggested by Garza and Bratton included musical instruments such as bongos and maracas. However, they admitted that many items were authentic and purchased in Mexico making them potentially difficult to locate in the United States, which also supports the findings of this study and suggests that some play therapists have a difficult time locating culturally diverse materials.

#### *Overview Summary*

Overall findings indicated that play therapists in this study believed that culturally sensitive play therapy was useful and they provided materials that they perceived to be necessary for positive outcomes for their clients. Play therapists indicated agreement that culturally sensitive play therapy is useful and beneficial, and it is necessary to have culturally sensitive materials in the play therapy room in order to engage children from diverse backgrounds. Their beliefs about culturally sensitive play therapy were supported by the finding that the majority of play therapists indicated that they use or had available some culturally sensitive art and craft materials, dolls, dollhouse and/or materials, sand tray, dramatic play, books, and puppets. However, play therapists reported perceived barriers to implementing culturally sensitive play



therapy, including costs, storage, and availability. Some play therapists chose not to indicate how or if they overcame those barriers, but the reason for the lack of response is unclear (i.e., are they still faced with those barriers or did they simply choose not to answer the item).

Landreth, Ray, and Bratton (2009) acknowledged that a playroom with all the appointed toys is desirable, but also stated, “we never accept the excuse that there is no space for play therapy” (p. 283). They recommended that mobile play therapists or those limited by space refer to Landreth’s (2002) recommendations for a “tote bag playroom.” Overall, most play therapists ( $n=310$ ) responded in the CSPTS that they had a designated playroom, while fewer ( $n=75$ ) did not. Perhaps those who have a designated playroom have more space for culturally sensitive materials than those who do not.

Findings suggest that play therapists using culturally sensitive materials are aware of the Association for Play Therapy’s (2009) recommendations of awareness of personal cultural identity, obtaining continuous cultural knowledge, and displaying culturally appropriate practices. It is clear from the responses given by participating play therapists that they are providing a variety of culturally sensitive materials in their playrooms. These findings supported the work of Cates, Paone, Packman, and Margolis (2006) who reported that having “culturally sensitive arts and crafts, toys, dolls, and games” from five major ethnic groups in the playroom could be beneficial. A responding play therapist summarized this well in the statement, “*Having the tools in the playroom necessary for the child to tell their story from their unique cultural perspective.*”

Even with findings suggesting that play therapists were using culturally sensitive materials, it was clear that individuals thought that more trainings on such topics were needed, as best expressed by one participant who stated, “*I think we need more workshops addressing this issue. Maybe even have a packet that new clinicians are given when they start using play therapy*

(sic.).” However, with the exception of books, there was little relationship between the use of culturally sensitive materials and education or training. Perhaps workshops are not beneficial training forums for such topics, and more research is required to determine how to meet the needs of practicing play therapists.

### **Limitations of the Study**

The *Culturally Sensitive Play Therapy Survey* (CSPTS) had limitations in the following areas: survey design, data collection, and sampling. Although this survey was designed specifically for use in this online study and was subjected to an expert panel of registered play therapists who were also members of APT, Granello and Wheaton (2004) described the four limitations of online surveys as: (a) sample representation, (b) response rate, (c) measurement errors, and (d) difficulties with technology. Further elaborating on the sample representations, Lyons, Cude, Lawrence, and Gutter (2005) reported that limited participation or regional participation could result in questionable generalization for a study. Although these limitations may have been present, the size of the sample and procedures used to develop content validity in the survey minimized potential limitations.

Cantrell and Lupinacci (2007) reported that another limitation to online surveys is allowing for skipping of questions, which they believed resulted in incomplete surveys and unusable data. Based on their findings, items on the CSPTS were written as forced responses, except for the open-ended questions. Additionally, the survey was designed so that individuals could not return to a question once they had entered an answer. This also prompted some individuals to provide information in item 41 that asked for comments on anything that they thought would be important for me to know about the delivery of culturally sensitive play therapy at their work site or additional information that they wished to add, such as, “*Didn’t think of it earlier but storage and display. My site does not lend itself to that.*” Play therapists

were also asked to complete the survey via an online survey company, which may have prevented some from completing the survey, due to lack of internet access or limited understanding or familiarity with online surveys.

The data were collected from members of the Association for Play Therapy (APT) who held at least a Master's degree (list provided by the APT). This sample may not be representative of most play therapists in the field who are not members of APT; the participants in this study may have more continuing education or commitment to the field of play therapy. Lambert, LeBlanc, Mullen, Ray, Baggerly, White, and Kaplan (2005) discovered that members of the Association of Play Therapy (APT) were more likely to acquire training in play therapy than members of the American Counseling Association, which could be due to their homogeneous specialty in play therapy. Due to their specialized area of play therapy, however, it could be that they were biased in favor of culturally sensitive materials. While this contributes to some sampling bias, the population of the study was designed to be that of play therapists who were members of the APT. Additionally, Lonsdale, Hodge, and Rose (2006) reported members of an association might respond more readily than a non-homogeneous group, so it is also possible that the responding play therapists had a greater interest in using play therapy with diverse populations.

This survey also asked about a sensitive topic, which may have been in part the reason for the low response rate. Recommendations made by Cantrell and Lupinacci (2007) included allowing participants to complete sensitive surveys online in order to decrease the social response bias and researcher influence bias. Additionally, Lyons et al. (2005) found that online surveys created a perceived social distance, thereby cultivating responses that are, in fact, more open. This survey was online and anonymous which would have minimized any sensitivity issues.

The final limitation of the survey was the timing. The survey was distributed shortly after the Memorial Day holiday in 2011, which may have prevented some from receiving the online survey at a convenient or less busy time. Because the online survey was distributed during the summer months, university faculty members or school counselors may not have been at their respective worksites to receive the email requesting participation.

### **Implications for Play Therapists**

This study aimed to increase understanding about culturally sensitive play therapy, the materials used, and the barriers encountered by play therapists in the field. Additionally, the study sought to examine play therapists' beliefs regarding culturally sensitive play therapy, and their avenues to overcoming barriers encountered, adding to the knowledge base obtained by Ritter and Chang (2002), who surveyed members of the Association for Play Therapy with the *Multicultural Counseling Competence and Training Survey* (Holcomb-McCoy & Myers, 1999). The results of this study may allow play therapists to gain an appreciation for items that are available and used by other play therapists in the field. Additionally, play therapists may have increased their awareness regarding the universality of barriers to implementing culturally sensitive play therapy as encountered by other play therapists. Next, the professionals may find enlightenment in the avenues others have pursued in overcoming their identified barriers to implementing culturally sensitive play therapy.

Finally, play therapy educators may regard the additional comments given in this survey as requests by play therapists to include such topics in workshops or courses. Some of the comments or requests received were:

*"...survey, it was thought provoking and gave me ideas on expanding my practice"*

*"Experiential and didactic workshops"*

*“I think we need more workshops addressing this issue. Maybe even have a packet that new clinicians are given when they start using play therapy.”*

*“I would be interested in hearing what others say.”*

As play therapists commented on wanting more information on this topic, it would also be beneficial to prepare new clinicians with information on how to gain access to culturally sensitive materials and how to use the materials in a clinically sound manner. In addition, considerations for education regarding the barriers that newer play therapists may encounter when opting to use certain materials and how others before them have overcome said obstacles would be beneficial for the field.

### **Implications for Future Research**

Future research should include outcome studies to understand the effectiveness of culturally sensitive materials in play therapy. Additionally, the field of play therapy could benefit from a greater understanding of how play therapists incorporate culturally sensitive materials into their play therapy. Participants also commented on the need for education around culturally sensitive materials. This could include how one utilizes materials, how one locates materials, and which materials are cost effective. Additionally, qualitative studies could be aimed at understanding how resources are allocated in environments that offer play therapy services, so that the association could advocate for a better use of those funds.

Due to the nature of this exploratory study, more information is needed on the qualitative statements given by play therapists. Specifically, a richer explanation of how much money or resources are made available to play therapists and who determines how those resources are distributed could further direct the educational needs in the field. It could be that play therapists are in need of education on ways to advocate for play therapy as a beneficial therapy or play therapists need education on where to obtain more cost effective materials.

A clinical study to examine the benefit of having said materials in a playroom could strengthen the literature base as well. Outcome studies directed at the effectiveness of utilizing culturally sensitive materials with specific populations could provide direction for play therapists. It is acknowledged that one-size-fits-all approach is not the answer, finding out which materials are most used and show promising effects would be beneficial. Whereas many play therapists stated that they used or had the materials available, it was unclear as to how they were using the materials in the playroom, if one was available.

### **Summary**

The results of this study describe culturally sensitive play therapy, as defined by members of the Association for Play Therapy. The study also describes play therapists' formal play therapy training, their beliefs regarding culturally sensitive play therapy, and their perceived barriers and methods used to overcome those perceived barriers to implementing culturally sensitive play therapy. Additionally, this study examined if there were relationships between the use or availability of culturally sensitive play therapy materials and the following: level of their education, their formal play therapy training, their formal multicultural training, and having a designated playroom.

The results of the survey found that many respondents, who were largely female, Caucasian, and child-centered in theoretical orientation, did not take play therapy course work from an accredited university or college; instead, they attended workshops, special institutions, and read play therapy literature. However, the findings did suggest that most play therapists had coursework in multicultural counseling. Results also showed that overall play therapists received formally educated in multicultural counseling, attended play therapy workshops, read literature, or attend a special institutes, but fewer received graduate level play therapy training. Thus, the

Association for Play Therapy, educators, and vendors may assist play therapists by offering more information on culturally sensitive play therapy through those forums.

These findings showed that play therapists participating in this study are dedicated to the field and often seek out education around issues they feel important. Overall, the participants agreed that culturally sensitive play therapy is useful, beneficial, and necessary to engage children from diverse backgrounds. However, they requested more information on culturally sensitive play therapy and the materials used to provide such therapy. They also believed that networking was an avenue to overcome perceived barriers, such as learning more about culturally sensitive play therapy.

The findings of this study show that play therapists are interested in learning more about culturally sensitive materials. Clearly, play therapists are using culturally sensitive materials, however, some continued to face obstacles to incorporating culturally sensitive materials into their playrooms. While some play therapists reported overcoming barriers to implementing culturally sensitive play therapy, others remain burdened by costs, and lack of access, and want more information. Many play therapists reported that they were able to overcome these perceived barriers. Some of the more common methods used to overcome those barriers were through continued education, purchasing materials personally, and networking for ideas on uses, availability, and additional resources.

Additionally, play therapy could benefit from additional research on culturally sensitive play therapy, how it is provided, how resources are allocated, and outcome studies. Obviously, participants in this study were using culturally sensitive materials in their playrooms, but more information is needed on what they are doing with those materials. Play therapists reported costs as a barrier; perhaps more research could qualitatively examine how those resources are allocated to determine how to assist play therapist in advocating for the use of culturally

sensitive materials. Also researchers could explore the effectiveness of cost effective or homemade materials. Finally, studies could investigate child outcomes when culturally sensitive materials are used in play therapy.

Many play therapists reported that they believed that culturally sensitive play therapy was useful, beneficial, and necessary to engage children from diverse backgrounds. This study augmented previous studies by providing play therapists with the opportunity to explain their perceived barriers to providing culturally sensitive play therapy; specifically, they believed that lack of funds, availability, and space to store such materials limited their use of culturally sensitive play therapy. However, participants in this study were using some culturally sensitive materials, even when faced with barriers to providing those materials. Another addition to the body of literature provided by the findings of this study was that play therapists sought out education, networked and purchased materials themselves to overcome perceived barriers to culturally sensitive play therapy. Participants also requested more information on culturally sensitive materials, and through continued research, the field of play therapy could provide play therapists with appropriate guidance on how to best incorporate culturally sensitive play therapy.



## REFERENCES

- Abrams, L., Post, P., Algozzine, B., Miller, T., Ryan, S., Gomory, T., et al. (2006). Clinical experiences of play therapists: does race/ethnicity matter? *International Journal of Play Therapy, 15*(2), 11-34.
- American Academy of Pediatrics. (2007). The importance of play in promoting healthy child development and maintaining strong parent-child bonds. *Pediatrics, 119*(1), 182-192.
- Association for Play Therapy. (2009). *Play therapy best practices*. Retrieved from <http://www.a4pt.org/download.cfm?ID=28051>
- Association for Play Therapy. (2011). Programs and publications. Retrieved from <http://www.a4pt.org/ps.programspublications.cfm?ID=2384#anchor23380>
- Association for Play Therapy. (2010). RPT/S Credentialing Program.
- Association for Play Therapy, Inc. (2006). BYLAWS.
- Astramovich, R. (1999). Play therapy theories: A comparison of three approaches. *National Conference of the Association for Counselor Education and Supervision*. New Orleans, LA.
- Axline, V. (1947). *Play therapy*. New York, NY: Ballantine Books.
- Axline, V. (1950). Entering the child's world via play experiences. *Progressive Education, 27*, 68-75.
- Axline, V. (1964). *Dibs in search of self*. New York, NY: Ballantine Books.
- Baggerly, J., & Bratton, S. (2010). Building a firm foundation in play therapy research: response to Phillips. *International Journal of Play Therapy, 19*(1), 26-38.
- Bainum, C., Schneider, M., & Stone, M. (2006). An Adlerian model for sandtray therapy. *The Journal of Individual Psychology, 62*(1), 36-46.

- Berting, T. (2009, September). Directive or nondirective play therapy? *Play Therapy*, pp. 23-25.
- Bradway, K. (2006). What is sandplay?. *Journal of Sandplay Therapy*, (15)2, 7.
- Botha, E., & Dunn, M. (2009). A board game as gestalt assessment tool for the child in middle childhood years. *South African Journal of Psychology*, 39(2), 253-262.
- Burns, B., & I. (n.d.). (personal communication, April, 2011).
- Burroughs, M., Wagner, W., & Johnson, J. (1997). Treatment with children of divorce: A comparison of two types of therapy. *Journal of Divorce and Remarriage*, 27, 83-99.
- Cantrell, M. & Lupinacci, P. (2007). Methodological issues in online data collection. *Journal of Advanced Nursing*, 60(5), 544-549.
- Cassell, S. (1972). The suitcase playroom. *Psychotherapy: Theory, research and practice*, 9(4), 346-348.
- Cates, J., Packman, J., Paone, T., & Margolis, D. (2006). Effective parent consultation in play therapy. *International Journal of Play Therapy*, 15, 87-100.
- Chang, C., Ritter, K., & Hays, D. (2005). Multicultural trends and toys in play therapy. *International Journal of Play Therapy*, 14(2), 69-85.
- Chau, I., & Landreth, G. (1997). Filial therapy with chinese parents: effects on parental empathic interactions, parental acceptance of child and parental stress. *International Journal of Play Therapy*, 6(2), 75-92.
- Chow, R. (2010, September). Cultural diversity and play therapy. Association for Play Therapy Mining Report.
- Coleman, V., Parmer, T., & Barker, S. (1993). Play therapy for multicultural populations: guidelines for mental health professionals. *International Journal of Play Therapy*, 2(1), 63-74.

- Constantino, G., Malgady, R., & Rogler, L. (1986). Cuento therapy: A culturally sensitive modality for Puerto Rican children. *Journal of Consulting and Clinical Psychology*, 54(5), 639-645.
- Dogra, A., & Veeraraghaven, V. (1994). A study of psychological intervention of children with aggressive conduct disorder. *Journal of Clinical Psychology*, 21, 28-32.
- Fall, M., Drew, D., Chute, A., & More, A. (2007). The voices of registered play therapists as supervisors. *International Journal of Play Therapy*, 16(2), 133-146.
- Freud, A. (1946). *The psycho-analytical treatment of children*. (N. Procter-Gregg, Trans.) London, England: Imago Publishing Co. Ltd.
- Freud, S. (1909/1955). *The case of "Little Hans" and the "Rat Man"*. London, England: Hogarth Press.
- Garza, Y., & Bratton, S. (2005). School-based child-centered play therapy with Hispanic children: outcomes and cultural considerations. *International Journal of Play Therapy*, 14(1), 51-79.
- Garza, Y., Kinsworthy, S., & Watts, R. (2009). Child-parent relationship training as experienced by Hispanic parents: A phenomenological study. *International Journal of Play Therapy*, 18(4), 217-228.
- Gil, E. (1994). *Play in family therapy*. New York, NY: The Guilford Press.
- Gil, E., & Drewes, A. (2005). *Cultural issues in play therapy*. New York, NY: The Guilford Press.
- Ginott, H. (1959). The theory and practice of therapeutic intervention in child treatment. *Journal of Consulting Psychology*, 23, 160-166.
- Glover, G., & Landreth, G. (2000). Filial therapy with Native Americans on the flathead reservation. *International Journal of Play Therapy*, 9(2), 57-80.

- Granello, D., & Wheaton, J. (2004). Online data collection: strategies for research. *Journal of Counseling & Development*, 82, 387-393.
- Green, E. (2008). Reenvisioning Jungian analytical play therapy with child sexual assault survivors. *International Journal of Play Therapy*, 17(2), 102-121.
- Grskovic, J., & Goetze, H. (2008). Short-term filial therapy with German mothers: findings from a controlled study. *International Journal of Play Therapy*, 17(1), 39-51.
- Hammer, C., & Weiss, A. (1999). Guiding language development: how African American mothers and their infants structure play interactions. *Journal of Speech, Language, and Hearing Research*, 42, 1219-1233.
- Hinman, C. (2003). Multicultural considerations in the delivery of play therapy services. *International Journal of Play Therapy*, 12(2), 107-122.
- Joiner, K., & Landreth, G. (2005). Play therapy instruction: A model based on objectives developed by the delphi technique. *International Journal of Play Therapy*, 14(2), 49-68.
- Jones, K., Casado, M., & Robinson, E. (2003). Structured play therapy: A model for choosing topics and activities. *International Journal of Play Therapy*, 12(1), 31-47.
- Kao, S., & Landreth, G. (1997). Evaluating the impact of child-centered play therapy training. *International Journal of Play Therapy*, 6(2), 1-20.
- Kazdin, A., Holland, L., & Crowley, M. (1997). Family experience of barriers to treatment and premature termination from child therapy. *Journal of Consulting and Clinical Psychology*, 65(3), 453-463.
- Kidron, M., & Landreth, G. (2010). Intensive child parent relationship therapy with Israeli parents in Israel. *International Journal of Play Therapy*, 19(2), 64-78.
- Klein, M. (1955). The psychoanalytic play technique. *American Journal of Orthopsychiatry*, 25, 223-237.

- Knell, S. (1993a). *Cognitive-behavioral play therapy*. Northvale, NJ: Jason Aronson.
- Knell, S. (1993b). To show and not tell: Cognitive-behavioral play therapy. In T. Kottman, & C. Schaefer (Eds.), *Play therapy in action: A casebook for practitioners*. (pp. 169-208). Northvale, NJ: Jason Aronson.
- Knell, S. (1994). Cognitive-behavioral play therapy. In K. O'Connor, & C. Schaefer (Eds.), *Handbook of play therapy*. (pp. 111-142). New York, NY: Wiley.
- Knell, S. (1997). Cognitive-behavioral play therapy. In K. O'Connor, & L. Braverman (Eds.), *Play therapy theory and practice: A comparative presentation*. (pp. 79-99). New York, NY: Wiley.
- Kottman, T. (2001). Adlerian play therapy. *International Journal of Play Therapy*, 10(2), 1-12.
- Kottman, T. (2001). Theoretical approaches to play therapy. In T. Kottman, *Play therapy: Basics and beyond* (pp. 37-78). Alexandria, VA: American Counseling Association.
- Kottman, T., & Warlick, J. (1989). Adlerian play therapy: Practical considerations. *Individual Psychology*, 45(4), 432-446.
- Kranz, P., Ramirez, S., Flores-Torres, L., Steele, R., & Lund, R. (2005). Physical settings, materials, and related spanish terminology recommended for play therapy with first-generation mexican-american children. *Education*, (126)1, 93-97.
- Lambert, S., LeBlanc, M., Mullen, J., Ray, D., Baggerly, J., White, J., et al. (2005). Learning more about those who play in session: The national play therapy in counseling practices project (phase I). *International Journal of Play Therapy*, 14(2), 7-23.
- Landreth, G. (1993). Child-centered play therapy. *Elementary School Guidance & Counseling*, 28(1), 17-30.
- Landreth, G. (2002). *Play therapy the art of the relationship* (2nd ed.). New York, NY: Routledge.

- Landreth, G., Ray, D., & Bratton, S. (2009). Play Therapy in Elementary School. *Psychology in the Schools*, 46(3), 281-289. doi: 10.1002/pits.20374.
- Lee, M., & Landreth, G. (2003). Filial therapy with immigrant Korean parents in the United States. *International Journal of Play Therapy*, 12(2), 67-85.
- Levy, D. (1938). "Release therapy" in young children. *Psychiatry: Journal for the study of interpersonal process*, 1, 387-390.
- Lyons, A., Cude, B., Lawrence, F., & Gutter, M. (2005). Conducting research online: challenges facing researchers in family and consumer sciences. *Family and Consumer Sciences Research Journal*, 33(4), 341-356.
- McCalla, C. (1994). A comparison of three play therapy theories: Psychoanalytical, Jungian and Client-centered. *International Journal of Play Therapy*, 3(1), 1-10.
- Mendell, A. (1983). Play therapy with children of divorced parents. In C. Schaefer, & K. O'Connor (Eds.), *Handbook of play therapy* (pp. 320-354). New York, NY:Wiley.
- Morrison, M. (2009). Adlerian play therapy with a traumatized boy. *The Journal of Individual Psychology*, 65(1), 57-68.
- Moustakas, C. (1959). *Psychotherapy with children: The living relationship*. New York, NY: Harper & Row.
- Nims, D. (2007). Integrating play therapy techniques into solution-focused brief therapy. *International Journal of Play Therapy*, 16(1), 54-68. doi:10.1037/1555-6824.16.1.54
- Oaklander, V. (1993). Interview with Violet Oaklander, author of windows to our children. (C. Campbell, Interviewer) *Elementary School Guidance & Counseling*, 28(1), 52-62.
- Oaklander, V. (2001). Gestalt play therapy. *International Journal of Play Therapy*, 10(2), 45-55.

- O'Connor, K. (2005). Addressing diversity issues in play therapy. *Professional Psychology, 36*(5), 566-573.
- Peery, J. (2002). Archetype and object: Primary deintegration and primary love in analytical play therapy with young children. *Journal of Analytical Psychology, 47*, 407-420.
- Perez, R., Ramirez, S., & Kranz, P. (2007). Adjusting limit setting in play therapy with first-generation Mexican American children. *Journal of Instructional Psychology, 34*(1), 22-27.
- Phillips, R., & Landreth, G. (1995). Play therapists on play therapy I: A report of methods, demographics and professional practices. *International Journal of Play Therapy, 4*(1), 1-26.
- Rasmussen, L., & Cunningham, C. (1995). Focused play therapy and non-directive play therapy: Can they be integrated? *Journal of Child Sexual Abuse, 4*(1), 1-20.
- Ray, D., Blanco, P., Sullivan, J., & Holliman, R. (2009). An exploratory study of child-centered play therapy with aggressive children. *International Journal of Play Therapy, 18*(3), 162-175.
- Ritter, K., & Chang, C. (2002). Play therapists' self-perceived multicultural competence and adequacy of training. *International Journal of Play Therapy, 11*(1), 103-113.
- Rousseau, C., Benoit, M., Lacroix, L., & Gauthier, M. Evaluation of a sandplay program for preschoolers in a multiethnic neighborhood. *Journal of Child Psychology and Psychiatry, 50*(6), 743-750. doi:10.1111/j.1469-7610.2008.02003.x
- Ryan, S., Gomory, T., & Lacasse, J. (2002). Who are we? examining the results of the association for play therapy membership survey. *International Journal of Play Therapy, 11*(2), 11-41.

- Shen, Y.-J. (2008). Reasons for school counselors' use or nonuse of play therapy: An exploratory study. *Journal of Creativity in Mental Health, 3*(1), 30-43.
- Solis, C., Meyers, J., & Varjas, K. (2004). A qualitative case study of the process and impact of filial therapy with an African American parent. *International Journal of Play Therapy, 13*(2), 99-118.
- Springer, J., Phillips, J., Phillips, L., Cannady, L., & Kerst-Harris, E. (1992). CODA: A creative therapy program for children's families affected by abuse of alcohol or other drugs. *Journal of Community Psychology, 20*, 55-74.
- Sue, D. (1991). A diversity perspective on contextualism. *Journal of Counseling & Development, 70*, 300-301.
- Sue, D. (2003). Dismantling the myth of a color-blind society. *Black Issues in Higher Education, 20*(19), 106.
- Sue, D. (2004). Whiteness and ethnocentric monoculturalism: Making the "invisible" visible. *American Psychologist, November*, 761-769.
- Swank, J. (2008). The use of games: A therapeutic tool with children and families. *International Journal of Play Therapy, 17*(2), 154-167.
- Sweeney, D., Minnix, G., & Homeyer, L. (2003). Using sand tray therapy in lifestyle analysis. *Journal of Individual Psychology, 59*(4), 376-387.
- Tyndall-Lind, A., Landreth, G., & Giordano, M. (2001). Intensive group play therapy with child witnesses of domestic violence. *International Journal of Play Therapy, 10*(1), 53-83.
- US Census Bureau. (2010). *Reported internet usage for households by selected householder characteristics: 2009*. U.S. Department of Commerce Economics and Statistics Administration.



- US Census Bureau. (2011). Religion. Retrieved from <http://www.census.gov/prod/www/religion.htm>
- VanderGast, T., Post, P., & Kascak-Miller, T. (2010). Graduate training in child-parent relationship therapy with a multicultural immersion experience: giving away the skills. *International Journal of Play Therapy, 19*(4), 198-208. doi: 10.1037/a0021010.
- Watts, R., & Garza, Y. (2008). Using children's drawings to facilitate the acting "as if" technique. *The Journal of Individual Psychology., 64*(1), 113-118.
- Willock, B. (1983). Play therapy with aggressive, acting-out child. In C. Schaefer, & K. O'Connor (Eds.), *Handbook of play therapy* (pp. 386-411). New York, NY:Wiley.
- Wilson, P., Petticrew, M., Calnan, M., & Nazareth, I. (2010). Effects of a financial incentive on health researchers' response to an online survey: a randomized controlled trial. *Journal of Medical Internet Research, 12*(2), e13. doi:10.2196/jmir.1251.
- Yuen, T., Landreth, G., & Baggerly, J. (2002). Filial therapy with immigrant chinese families. *International Journal of Play Therapy, 11*(2), 63-90.

## APPENDICES

## Appendix A

### Association for Play Therapy Mailing List Agreement



## Mailing List Rental Agreement Association for Play Therapy

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

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

Select Type of List	APT Approved Providers	Others
<input type="checkbox"/> Mailing Addresses	\$50.00 / per 1,000	\$100.00 / per 1,000
<input checked="" type="checkbox"/> Email Addresses	\$75.00 / per 1,000	\$150.00 / per 1,000
<input type="checkbox"/> Both Addresses	\$100.00 / per 1,000	\$200.00 / per 1,000

- The rental fee schedule above includes ground shipping charges if the list is mailed to Renter. Other shipping options are available and, if applicable, at additional cost to Renter. Note: Most Renters prefer that the list be transmitted electronically as an Excel attachment.
- Payment of rental fee may be made by check, money order, credit card (only Mastercard or Visa), and valid institutional purchase order. If credit card, Renter must provide this information:  
 Credit Card: \_\_\_\_\_ MasterCard \_\_\_\_\_ Visa  
 Credit Card account number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
 Amount authorized: \$ \_\_\_\_\_ Name on Credit Card: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_
- The submission of purchase orders represents a guarantee and promise that that the institution will immediately forward payment upon receipt of an invoice and mailing list from APT. Purchase orders net 30 days.
- Rental orders faxed to APT are accepted only if paid by credit card or accompanying purchase order with sample piece.
- APT reserves the right to reject any rental request.
- APT strives to maintain an accurate and complete list but cannot and does not guarantee such to Renter.

Renter is asked to provide the following information to APT:

- Date list ordered: 5-25-11 Date list required: \_\_\_\_\_ APT CE Provider # \_\_\_\_\_
- Name of Renter: Krystal M Vaughn
- Billing/Shipping Address: 7809 Cohn Street, New Orleans, LA 70118
- Telephone: 504 864 8367 Email: KVaughn@tulane.edu
- Geographic area (complete US list will be sent unless specified): U.S.
- Sequence Desired (by Zip Code, alphabetical, etc.): \_\_\_\_\_
- Method of Delivery (by email as Excel attachment, ground shipping, etc.): Excel
- Format Desired (pressure sensitive labels, Excel attachment, etc.): Excel; (Individual with Master's Degree (+))

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

Renter Name (print): Krystal Vaughn Date: 5-25-11  
 Renter Signature: KVaughn

**For office use only:**

Date Received: \_\_\_\_\_ Total Sent: \_\_\_\_\_ Total Cost: \_\_\_\_\_ Date Mailed: \_\_\_\_\_  
 Rev. 2006, 2008, 2009

Appendix B

Institutional Review Board Application

**APPLICATION FOR CONDUCTING RESEARCH  
INVOLVING HUMAN SUBJECTS**

<i>For office use only</i>
Protocol No _____
Date received: _____

**A. FACE PAGE**

<b>PROTOCOL TITLE:</b> Play Therapists' Perspectives on Culturally Sensitive Play Therapy		
<b>ALTERNATE TITLE:</b> Culturally Sensitive Play Therapy: Materials, Beliefs and Barriers.		
<b>TYPE OF REVIEW:</b> <input checked="" type="checkbox"/> NEW <input type="checkbox"/> RENEWAL If renewal, are there substantive changes? Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>Principal Investigator:</b> Louis V. Paradise New investigator: <input type="checkbox"/>	<b>Department:</b> Department of Educational Leadership, Counseling, & Foundations	<b>University Affiliation:</b> <input checked="" type="checkbox"/> Professor <input type="checkbox"/> Associate Professor <input type="checkbox"/> Assistant Professor <input type="checkbox"/> Instructor <input type="checkbox"/> Other: (Graduate students cannot serve as PI)
<b>Campus Address:</b> Department of Educational Leadership, Counseling, & Foundations University of New Orleans New Orleans, LA 70148	<b>Phone:</b> 504.280.6026 (o) 504.952.3039 (m) <b>Preferred e-mail:</b> <a href="mailto:lparadis@uno.edu">lparadis@uno.edu</a>	
<b>Co-Investigator:</b> Krystal Vaughn New investigator: <input checked="" type="checkbox"/>	<b>Department:</b> Department of Educational Leadership, Counseling, & Foundations	<b>University Affiliation:</b> <input type="checkbox"/> Faculty <input type="checkbox"/> Staff <input checked="" type="checkbox"/> Graduate Student <input type="checkbox"/> Undergraduate Student <input type="checkbox"/> Other:
<b>Campus Address:</b> Department of Educational Leadership, Counseling, & Foundations University of New Orleans New Orleans, LA 70148	<b>Phone:</b> 504-864-8367 <b>Preferred e-mail:</b> kmvaughn@my.uno.edu	
<b>Co-Investigator:</b> New investigator: <input type="checkbox"/>	<b>Department:</b>	<b>University Affiliation:</b> <input type="checkbox"/> Faculty <input type="checkbox"/> Staff

Campus Address:	Phone:	<input type="checkbox"/> Graduate Student
	Preferred e-mail:	<input type="checkbox"/> Undergraduate Student <input type="checkbox"/> Other:

Note: New investigators must submit a copy of their human subjects certification (<http://phrp.nihtraining.com/users/login.php>)



## B. Project Description

1. Provide an abstract of your project (do not exceed 250 words).

The Association for Play Therapy (2009) promotes play therapists' awareness of personal cultural identity, obtaining continuous cultural knowledge, and displaying culturally appropriate practices. Play therapy research includes studies on working with culturally diverse populations. Founding play therapists, such as Virginia Axline (1948), made recommendations for toys that should be included in the playroom. However, it remains unknown if practicing play therapists are conducting therapy with diverse populations with culturally specific toys or the recommended traditional toys. Therefore, this study aims to gain a deeper understanding of how play therapists define and conduct culturally sensitive play therapy and the materials used in the playroom. An instrument was not available to measure said issues, so the *Culturally Sensitive Play Therapy Survey* was developed for this study. The survey consists of 41 items, 39 quantitative and 2 qualitative. The potential participants' email addresses will be obtained from the Association for Play Therapy. Approximately 1,767 emails requesting voluntary participation will be sent out to professional members. The email will describe the purpose of the study, explain the IRB process, and provide a link to the survey on Qualtrics™. The survey will ask for demographic information, which will be used as independent variables for later comparisons among groups. The survey will ask for training, beliefs about culturally sensitive play therapy, perceived barriers, materials used in delivering culturally sensitive play therapy, and the definition of culturally sensitive play therapy, which will be used as dependent variables. The findings will assist with play therapy education and future research.

2. Provide a **brief** description of the **background, purpose, and design** of your research. Avoid using technical terms and jargon. Be sure to list all of the **means you will use to collect data** (e.g., instruments measures, tests, questionnaires, surveys, interview schedules, focus group questions, observations). Provide a short description of the tests, instruments, or measures and **attach copies of all instruments and questionnaires** for review. Descriptions should be at least 1 page and include citations.



The Association for Play Therapy has recommended that play therapists become more culturally aware. Experts in the field published recommendations on how one should or could work with a child from a specific type of family, whether divorced, ethnically diverse, or otherwise dissimilar from mainstream America (e.g., O'Connor, 2005; Gil & Drewes, 2005). Historically, experts in the field have published recommendations for how a therapist should stock a playroom (e.g., Axline, 1948; Kottman, 2001; Landreth, 2002). However, few studies have examined how therapists define culturally sensitive play therapy or support those play therapists in meeting the needs of diverse clients, but instead give general recommendations for working with specific populations.

The purpose of this study is to understand play therapists' definition of culturally sensitive play therapy, beliefs about culturally sensitive play therapy, materials used to deliver culturally sensitive play therapy, and perceived barriers of implementing culturally sensitive play therapy. Additional purposes of this study are to examine the relationship between populations served and materials available in the playroom and to determine within group differences among play therapists based on sex, age, type of licensure, formal multicultural, and play therapy training.

Participants in this study will be play therapists who are members of the Association of Play Therapy. The Association of Play Therapy is an interdisciplinary association that promotes the value of play, play therapy, and credentialed play therapists (Association of Play Therapy *Bylaws*, 2006). The play therapist participants should meet the criteria of: (a) utilized play therapy within the past year; and (b) at minimum a master's degree. A list of potential participants will be requested from the Association of Play Therapy by completing the "Mailing List Rental Agreement" (see Appendix A). The mailing list rented from the association will list play

therapists' email addresses.

I developed the *Culturally Sensitivity Play Therapy Survey* for my study. It is a 41-question survey containing the following sections: personal information, training and preparedness, beliefs about culturally sensitive play therapy, perceived barriers, materials used in delivering culturally sensitive play therapy, and the definition of culturally sensitive play therapy. The last question ask if the participant would like to add any additional information.

Data analysis for this study will use: descriptive statistics, chisquare tests, and correlational analysis. The one qualitative question will be examined with constant comparative analysis.

#### C. Data Collection

1. Total **number of participants** that you plan to include/enroll in your study: Approximately 1,767
2. Age range of participants you plan to include / enroll in your study. 23 to 90
3. Will you recruit participants from any of the following groups? (check all that apply)
  - Minors (persons under the age of 18)**
  - Cognitively or psychologically impaired individuals**
  - Prisoners or parolees**
  - Specific medical population:**
  - Elderly**
  - Pregnant women**
  - Minority populations**
  - UNO students/employees**

**If you checked any of the boxes in #3**, describe how you will provide the **special protections** to which these participants may be entitled under federal regulations. (See information on vulnerable populations at: <http://www.hhs.gov/ohrp/policy/populations/index.html>).

4. Will the recruitment of participants and/or data collection involve any of the following?:
  - Audiotapes, videotapes, photographs**
  - Electronic communications (e.g., e-mail, internet)**
  - Archival data that is not publicly available.**
  - Focus group**

**If you checked any of the boxes in #4**, describe how the media will be used (e.g., coded and then destroyed, kept for possible publication or broadcast, etc.).

5. Does the proposed research require that you **deceive** participants in any way?  Yes  No

If yes, describe the type of **deception** you will use, why deception is necessary, and provide a copy of the debriefing script.

6. Describe how you will **recruit** participants and inform them about their role in the study. Please attach copies of advertisements, flyers, website postings, recruitment letters, oral or written scripts, or other materials used for this purpose.

Participants will be recruited via email (made available through the Association of Play Therapy mailing list agreement). Please see attached recruitment letter.

7. Project Start Date: May 23, 2011 Project End Date: November 1, 2011

\* Projects lasting more than 12 months must receive continuation approval before the end of the project.

## D. Funding Source

1. Have you received any source of **funding** for the proposed research (federal, state, private, corporate, or religious organization support)?  Yes  No

2. Is this project currently **consideration** for funding (e.g., under review)?  Yes  No

If your response is “yes” to either 1 or 2, please indicate any source(s) of **funding** for the proposed research (e.g., NIH, NSF, departmental funds, private foundations or corporations).

Graduate Enhancement Fund from the University of New Orleans, Department of Educational Leadership, Counseling, & Foundations

3. Do you or the funding source(s) have any potential for financial or professional benefit from the outcome of this study?  Yes  No

If yes, please explain.

## E. Risks to Participants

1. Consider to both the **actual and potential** risks to the participants that could reasonably be expected to occur during the course of the study. Check all that apply.

- Disclosure of the participants’ responses may place the participant at risk of **criminal or civil liability**.
- Disclosure of the participants’ responses may be damaging to their **financial standing, employability, or reputation**.
- Participants may encounter **physical risk**.
- Participants may be subjected to **stress** beyond that ordinarily encountered in daily life.
- Participants may be asked to disclose information that they might consider **personal or sensitive**.
- Participants may be asked to reveal **personal information that cannot be anonymous and/or there may be a limit to the confidentiality that can be guaranteed due to particular circumstances or procedures used in the study** (e.g., focus group or surveys submitted via email).
- Participants may be presented with materials that they may consider **offensive, threatening, or degrading** or they may encounter other forms of **psychological or social risk**.
- An individual’s participation will be reported to an instructor so that the individual can receive **research or extra credit**.
- As a result of this research, a **permanent record** will be created that will contain information

(identifiers) that could reveal a participant's identity

If you checked any of these risks, discuss the risk below. Describe the steps you will take to **minimize risk** to the participant.

Due to the nature of the study, participants will be asked about their beliefs regarding culturally sensitive materials used in play therapy and their perceived barriers to using said materials. I plan to explain the study, risk involved and then those who choose not to participate may do so. I also plan to use Qualtrics™, an online survey program, which will allow me to provide a link to the survey then participants will not be asked for identifiable information once the link is accessed.

## F. Informed Consent

1. Describe the procedures you will use to **obtain and document informed consent and/or assent**. The informed consent will be made available in the recruitment email. Completing the survey will serve as their consent to participate in the study. There will be no direct benefits for participation; however, the findings may benefit clinicians in the field of play therapy. Participants will be informed that participation is voluntary and they may withdraw from the study at any time without consequence. Refusal or withdrawal will not result in a penalty or loss of benefits of any kind. Participants will be given the researchers contact information if they have any questions concerning this study.

2. **Attach copies of the forms that you will use.** The UNO Human Subjects website has additional information on sample forms and letters for obtaining informed consent. (*in the case of secondary data, please attach original informed consent or describe below why it has not been included.*) Fully justify any request for a waiver of written consent or parental consent for minors. **All consent forms must be on current UNO letterhead and contain the 8 elements of consent:**

(<http://www.humansubjects.uno.edu/8%20elements%20of%20consent.doc>)

## G. Data Use

1. How will these data be used? Check all that apply.

- |  |   |
|--|---|
| <input checked="" type="checkbox"/> Dissertation             | <input checked="" type="checkbox"/> Publication/journal article   |
| <input type="checkbox"/> Thesis                              | <input type="checkbox"/> Results released to participants/parents |
| <input type="checkbox"/> Undergraduate honors thesis         | <input type="checkbox"/> Results released to employer/school      |
| <input checked="" type="checkbox"/> Conference/presentations | <input type="checkbox"/> Results released to agency/organization  |
| <input type="checkbox"/> Other:                              |   |

2. Describe the steps you will take to ensure the confidentiality of the participants and data. Indicate how you will safeguard data that includes identifying or potentially identifying information (e.g., coding). Indicate when identifiers will be separated or removed from the data. Also, indicate where and how you will store the data and how long you plan to retain it. Describe how you will dispose of it (e.g., erasing tapes; shredding data). Be sure to include all types of data collected (e.g., audiotape, videotape, and questionnaire/survey).

Once the email addresses are loaded into Qualtrics™, the survey will not ask for any identifiable information. The data will be maintained for one year, then electronically deleted and/or shredded.

**Signature Page**

**Protocol Title:**

Play Therapists' Perspectives on Culturally Sensitive Play Therapy

## H. Principal Investigator's Assurance

I certify that the information provided in this application is complete and correct.

I understand that as Principal Investigator, I have ultimate responsibility for the conduct of the study, the ethical performance of the project, the protection of the rights and welfare of human subjects, and strict adherence to any stipulations imposed by the IRB.

I agree to comply with all UNO policies and procedures, as well as with all applicable federal, state, and local laws regarding the protection of human subjects in research, including, but not limited to, the following:

- performing the project by qualified personnel according to the approved protocol,
- implementing **no** changes in the approved protocol or consent form without **prior** UNO IRB approval (except in an emergency, if necessary to safeguard the well-being of human subjects),
- obtaining the legally effective informed consent from human subjects or their legally responsible representative, and using only the currently approved, stamped consent form with human subjects,
- **promptly reporting significant or untoward adverse effects to the UNO IRB in writing within 5 working days of occurrence.**

If I will be unavailable to direct this research personally, as when on sabbatical leave or vacation, I will arrange for a co-investigator to assume direct responsibility in my absence. Either this person is named as a co-investigator in this application, or I will advise UNO IRB by letter, in advance of such arrangements.

**I also agree and understand that informed consent/assent records of the participants must be kept for at least three (3) years after the completion of the research.**

Principal Investigator Name: (Print)

Signature:

Date:

Co-Principal Investigator Name: (Print)

Signature:

Date:

Co-Principal Investigator Name: (Print)

Signature:

Date:

**University Committee for the Protection  
of Human Subjects in Research**

University of New Orleans

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*Campus Correspondence*

Principal Investigator: Louis V Paradise

Co-Investigator: Krystal Vaughn

Date: May 24, 2011

Protocol Title: "Play Therapists' Perspectives on Culturally Sensitive Play  
Therapy"

IRB#: 07May11

The IRB has deemed that the research and procedures described in this protocol application are exempt from federal regulations under 45 CFR 46.101 category 2, due to the fact that any disclosure of the human subjects' responses outside the research would not 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, Ph.D., Chair  
UNO Committee for the Protection of Human Subjects in Research

Appendix C

Consent Letter Requesting Voluntary Participation

Dear Play Therapist:

I am a graduate student under the direction of Dr. Louis Paradise in the Department of Leadership, Counseling, & Foundations at the University of New Orleans. I am conducting an exploratory research study to explore play therapist perceptions of culturally sensitive play therapy. I have developed a survey (*Culturally Sensitive Play Therapy Survey*) that asks play therapists to respond to questions about their use of culturally sensitive play therapy materials, their beliefs regarding culturally sensitive play therapy, their perceived barriers to using culturally sensitive play therapy materials, and their definition of culturally sensitive play therapy. I plan to use the data from the survey to assist play therapists in educating future play therapists. I also plan to use the data to understand how play therapists define culturally sensitive play therapy and what materials are used to deliver culturally sensitive play therapy. Your answers on this survey will provide important information regarding the use (or lack of use) of culturally sensitive play therapy. Data may be helpful to not only play therapists looking for ways to implement culturally sensitive play therapy but also play therapy educators.

I am requesting your participation, which will involve approximately fifteen minutes of your time. Your participation in this study is voluntary, and you may choose to withdraw from the study at any time. The results of the research study may be published, but your name will not be used. The survey is anonymous.

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.

Please follow the link below to find the Qualtrics™ survey. Please be as honest as possible when answering the questions to ensure proper results.

[\\${!://SurveyLink}](#)

If you are not connected automatically, then you can cut-and-paste the link into the address box on your web browser and then press enter.

Completion of the questionnaire will be your consent to participate, you may withdraw your consent and terminate participation at any time without consequence. The risks associated with this study are minimal. Due to the nature of the subject matter may induce some discomfort. Also, some individuals may tire while answering the questions.

If you have any questions concerning the research study, please email me at [kmvaughn@my.uno.edu](mailto:kmvaughn@my.uno.edu) or call Dr. Paradise at (504) 280-6026. If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, please contact Dr. Paradise at (504) 280-6026 or Dr. Ann O'Hanlon at the University of New Orleans (504) 280-6501.

Thank you very much for your time and help.

Krystal Vaughn, LPC-S, M.S.  
Doctoral Candidate  
University of New Orleans



## Appendix D

### Culturally Sensitive Play Therapy Survey

## Play Therapy

Q1 Sex

Male (1)

Female (2)

Q2 Age

- 18 (1)
- 19 (2)
- 20 (3)
- 21 (4)
- 22 (5)
- 23 (6)
- 24 (7)
- 25 (8)
- 26 (9)
- 27 (10)
- 28 (11)
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- 86 (69)
- 87 (70)
- 88 (71)
- 89 (72)
- 90 (73)
- 91 (74)
- 92 (75)
- 93 (76)
- 94 (77)
- 95 (78)
- 96 (79)
- 97 (80)
- 98 (81)
- 99 (82)

Q3 Ethnicity

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

Q4 Please indicate the approximate percentage of ethnic diversity of your clients (Total should equal 100%)

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

Q5 Mental Health Credential/License(s)

- Licensed Marriage and Family Therapist (LMFT) (1)
- Licensed Professional Counselor (LPC) (2)
- Licensed Clinical Social Worker (LCSW) (3)
- Licensed School Psychologist (4)
- Licensed Psychologist (5)
- Other (6)

Q6 Do you have a designated play therapy room at your work site?

- Yes (1)
- No (2)

Q7 Status as a Play Therapist

- Under supervision for Registered Play Therapist (RPT) credentials (1)
- Registered Play Therapist (RPT) (2)
- Registered Play Therapist Supervisor (RPT-S) (3)
- Other (4)

Q8 What is your theoretical orientation?

- Child-Centered (1)
- Cognitive Behavioral (2)
- Adlerian (3)
- Gestalt (4)
- Psychoanalytic (5)
- Jungian (6)
- Other (7)

Q9 Highest mental health degree earned

- Master's (1)
- Master's +30 (2)
- Doctorate (3)

Q10 Total number of years practicing as a mental health professional

- 1 (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 (7)
- 8 (8)
- 9 (9)
- 10 (10)
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- 43 (43)
- 44 (44)

- 45 (45)
- 46 (46)
- 47 (47)
- 48 (48)
- 49 (49)
- 50 (50)

Q11 Approximate number of graduate level courses that you have taken in play therapy from an accredited university or college?

- 0 course (1)
- 1 course (2)
- 2 courses (3)
- 3 courses (4)
- 4+ courses (5)

Q12 Approximate number of graduate level courses that you have taken in multicultural counseling from an accredited university or college?

- 0 courses (1)
- 1 course (2)
- 2 courses (3)
- 3 courses (4)
- 4+ courses (5)

Q13 Approximate number of play therapy workshops or special institutes you have attended in the past two years from all sources.

- 0 play therapy workshops or special institutes (1)
- 1 play therapy workshops or special institutes (2)
- 2 play therapy workshops or special institutes (3)
- 3 play therapy workshops or special institutes (4)
- 4+ play therapy workshops or special institutes (5)

Q14 I keep current on the latest play therapy techniques by attending conferences, conventions, and presentations.

- Strongly Disagree (1)
- Disagree (2)
- Somewhat Disagree (3)
- Neither Agree nor Disagree (4)
- Somewhat Agree (5)
- Agree (6)
- Strongly Agree (7)



Q15 I keep current on the latest play therapy techniques by reading play therapy literature (books, journals, newsletters, etc.).

- Strongly Disagree (1)
- Disagree (2)
- Somewhat Disagree (3)
- Neither Agree nor Disagree (4)
- Somewhat Agree (5)
- Agree (6)
- Strongly Agree (7)

Q16 I believe there is a relationship between culturally sensitive play therapy and a positive outcome for my clients.

- Strongly Disagree (1)
- Disagree (2)
- Somewhat Disagree (3)
- Neither Agree nor Disagree (4)
- Somewhat Agree (5)
- Agree (6)
- Strongly Agree (7)

Q17 Culturally sensitive play therapy is useful for my clients.

- Strongly Disagree (1)
- Disagree (2)
- Somewhat Disagree (3)
- Neither Agree nor Disagree (4)
- Somewhat Agree (5)
- Agree (6)
- Strongly Agree (7)

Q18 Culturally sensitive play therapy is not necessary for a positive therapeutic outcome for my clients.

- Strongly Disagree (1)
- Disagree (2)
- Somewhat Disagree (3)
- Neither Agree nor Disagree (4)
- Somewhat Agree (5)
- Agree (6)
- Strongly Agree (7)

Q19 It is necessary to have culturally sensitive materials in the play therapy room in order to engage children from diverse backgrounds in play therapy.

- Strongly Disagree (1)
- Disagree (2)
- Somewhat Disagree (3)
- Neither Agree nor Disagree (4)
- Somewhat Agree (5)
- Agree (6)
- Strongly Agree (7)

Q20 I wish I had more culturally sensitive materials for use in the play therapy room.

- Strongly Disagree (1)
- Disagree (2)
- Somewhat Disagree (3)
- Neither Agree nor Disagree (4)
- Somewhat Agree (5)
- Agree (6)
- Strongly Agree (7)

Q21 I do not use culturally sensitive play therapy materials because they are unnecessary based on my theoretical orientation.

- Strongly Disagree (1)
- Disagree (2)
- Somewhat Disagree (3)
- Neither Agree nor Disagree (4)
- Somewhat Agree (5)
- Agree (6)
- Strongly Agree (7)

Q22 What additional materials, if any, do you believe would make your playroom more culturally sensitive?

- Item 1 (1)
- Item 2 (2)
- Item 3 (3)

Q23 I do not use culturally sensitive play therapy materials with my clients because I do not have enough materials in the play therapy room.

- Strongly Disagree (1)
- Disagree (2)
- Somewhat Disagree (3)
- Neither Agree nor Disagree (4)
- Somewhat Agree (5)
- Agree (6)
- Strongly Agree (7)

Q24 I do not use culturally sensitive play therapy materials with my clients because I do not feel adequately trained in culturally sensitive play therapy.

- Strongly Disagree (1)
- Disagree (2)
- Somewhat Disagree (3)
- Neither Agree nor Disagree (4)
- Somewhat Agree (5)
- Agree (6)
- Strongly Agree (7)

Q25 I do not use culturally sensitive play therapy materials because they are difficult to find.

- Strongly Disagree (1)
- Disagree (2)
- Somewhat Disagree (3)
- Neither Agree nor Disagree (4)
- Somewhat Agree (5)
- Agree (6)
- Strongly Agree (7)

Q26 I do not use culturally sensitive play therapy materials because I cannot afford them.

- Strongly Disagree (1)
- Disagree (2)
- Somewhat Disagree (3)
- Neither Agree nor Disagree (4)
- Somewhat Agree (5)
- Agree (6)
- Strongly Agree (7)

Q27 I do not use culturally sensitive play therapy materials because I do not control the materials in the playroom.

- Strongly Disagree (1)
- Disagree (2)
- Somewhat Disagree (3)
- Neither Agree nor Disagree (4)
- Somewhat Agree (5)
- Agree (6)
- Strongly Agree (7)

Q28 Please identify the top three most frequent barriers to implementing culturally sensitive play therapy that you have experienced in your work site.

- Barrier 1 (1)
- Barrier 2 (2)
- Barrier 3 (3)

Q29 What strategies, if any, did you employ to address the above identified barriers?

- Strategy 1 (1)
- Strategy 2 (2)
- Strategy 3 (3)

Q30 Which culturally sensitive art and craft materials do you use or have available to your clients? (Please check all that apply).

- Clay (1)
- Multicultural crayons (representing various skin tones) (2)
- Multicultural pencils (representing various skin tones) (3)
- Multicultural markers (representing various skin tones) (4)
- Multicultural fabrics (i.e., kente cloth, batik cloth, or leather) (5)
- Origami paper (for artwork or folding) (6)
- Native American impression for clay (7)
- Other (8)
- None (9)

Q31 Which culturally sensitive books do you use or have available to your clients? (please check all that apply)

- African American themed (e.g., Amazing Grace) (1)
- Asian American themed (e.g., Dumpling Soup) (2)
- Hispanic themed (e.g., Too Many Tamales) (3)
- Native American themed (e.g., Mama, Do You Love Me?) (4)
- Multicultural (e.g., Different Just Like Me) (5)
- Disabilities (e.g., Someone Special Just Like You) (6)
- Diverse family makeup (e.g., Heather Has Two Mommies) (7)
- Other (8)
- None (9)

Q32 Which culturally sensitive board games do you use or have available to your clients? (please check all that apply)

- African American themed (1)
- Asian American themed (2)
- Hispanic themed (3)
- Native American themed (4)
- Multicultural themed (5)
- Disability themed (6)
- Diverse family makeup (7)
- Other (8)
- None (9)

Q33 Which culturally sensitive dramatic play materials do you use or have available to your clients? (please check all that apply)

- Dishes (e.g., gender neutral) (1)
- Eating/cooking utensils (e.g., chopsticks) (2)
- Pots and pans (e.g., wok or tortilla press) (3)
- Food items (e.g., sushi or taco) (4)
- Ethnic rugs (5)
- Other (6)
- None (7)

Q34 Which culturally sensitive dress up clothes do you use or have available to your clients? (please check all that apply).

- African American clothing (e.g., Kaftan) (1)
- Asian American clothing (e.g., Kimono) (2)
- Hispanic clothing (e.g., Sombrero) (3)
- Native American clothing (e.g., buckskin) (4)
- Multicultural clothing (5)
- Special needs (e.g., sling, crutch, etc.) (6)
- Other (7)
- None (8)

Q35 Which culturally sensitive dolls do you use or have available to your clients? (please check all that apply).

- African American dolls (1)
- Asian American dolls (2)
- Hispanic dolls (3)
- Native American dolls (4)
- Multicultural dolls (5)
- Special needs dolls (6)
- Fabrics for dressing (7)
- Other (8)
- None (9)

Q36 Which culturally sensitive dollhouse and/or materials do you use or have available to your clients? (please check all that apply)

- African American dolls (1)
- Asian American dolls (2)
- Hispanic dolls (3)
- Native American dolls (4)
- Multicultural dolls (5)
- Special needs dolls (6)
- Multiple houses (7)
- Multiple sexes (representing grandparents, extended family members, or blended families) (8)
- Multiple dolls (representing same-sex parents) (9)
- Special Needs Equipment (e.g., wheelchair) (10)
- Other (11)
- None (12)

Q37 Which culturally sensitive puppets do you use or have available to your clients? (please check all that apply)

- African American puppets (1)
- Asian American puppets (2)
- Hispanic puppets (3)
- Native American puppets (4)
- Multicultural puppets (5)
- Special needs puppets (6)
- Occupational puppets (e.g., clergy, postal worker, doctor, firefighter, construction worker, etc.) (7)
- Other (8)
- None (9)

Q38 Which culturally sensitive sandtray materials do you use or have available to your clients? (please check all that apply)

- Religious figures and symbols (1)
- Landscape figures (2)
- African American figures (3)
- Asian American figures (4)
- Hispanic American figures (5)
- Native American figures (6)
- Multicultural figures (7)
- Special needs figures (8)
- Other (9)
- None (10)

Q39 Which culturally sensitive musical instruments do you use or have available to your clients? (e.g., Chilean rainstick, den den drum, maracas, or rice shaker) (Please check all that apply)

- African musical instrument/s (1)
- Asian music instrument/s (2)
- Hispanic music instrument/s (3)
- Native American music instrument/s (4)
- Multicultural music instrument/s (5)
- Other (6)
- None (7)

Q40 How do you define culturally sensitive play therapy?

Q41 Please comment on anything that you think is important for me to know about the delivery of culturally sensitive play therapy at your work-site or any additional information that you would like to add?

## VITA

Krystal Vaughn earned a Bachelor of Science in Psychology with a minor in substance abuse studies from Northwestern State University and a master's degree in Counseling Psychology from Louisiana State University-Shreveport. In 2012, she earned a Doctor of Philosophy degree in Counselor Education from the University of New Orleans.

Krystal is a Licensed Professional Counselor-Supervisor (LPC-S). Krystal has also served on the board of Louisiana Association for Counselor Educators and Supervisors (LACES). Krystal was also a member of the Association of Play Therapy's Leadership Academy in 2011.

Krystal has been a faculty member at Tulane University in the Child Psychiatry since 2008. Her areas of interest include early childhood mental health consultation, school readiness, and play therapy outcome research.