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The Adult Public's Perception of the Utility of Play Therapy

A dissertation proposal submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy in Counselor Education and Supervision

by

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ABSTRACT

Children communicate through symbolism and play as toys are children's words and play is their language (Landreth, 2012; Oaklander, 1988; Piaget, 1951; Ray, 2016). Play therapists facilitate developmentally appropriate support for children (Landreth, 2012). Often parents are unaware of the importance of play in children's counseling (Brumfield & Christensen, 2011; Landreth, Bratton, Kellam, & Blackard, 2006).

Since adults often make decisions for children, it is important to know adults' perceptions of play therapy utility. There is little research on parents' knowledge of mental health services especially research specific to play therapy (Gallo, Comer, & Barlow, 2013; O'Connor & Langer, 2018). Literature does support that if parents are knowledgeable about mental health service options, they are more likely to take their children to therapy (e.g., Cunningham et al., 2008), and adults' mental health literacy improves with information (e.g., Jorm, 2000). A literature review revealed no research specific to play therapy literacy or the general adult public. This dissertation focuses on the adult public's perception of the utility of play therapy and whether information about play therapy changes perceptions.

Through Amazon Mechanical Turk, 298 participants completed a survey involving a play therapy utility instrument before and after receiving information about play therapy. Prior to receiving information, participants believed play therapy to be useful to very useful. Initially, female participants indicated play therapy was more useful than male participants. The more confidence in their knowledge of play therapy, the more useful the participant viewed play therapy initially. With more play therapy literacy education, the more individuals may value, select, or recommend play therapy. In the present study, participants' ratings of the utility of play therapy did increase significantly after viewing a brief educational video. The influence of the

educational experience appeared to vary by race, education level, and self-reported initial awareness of play therapy. Results suggest White individuals and those who have never heard of play therapy will be most impacted by educational play therapy outreach.

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DEDICATION

I would like to dedicate my dissertation to all the clients and their families that allowed me to walk with them in their journeys. Furthermore, I would like to dedicate this work to play therapists, play therapists in training, counselor educators who train students to work with children, researchers, and all members of the public who advocate for children's needs.

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CHAPTER I: INTRODUCTION

The purpose of this initial chapter is to explain the need for the study and illuminate the purpose of the study. Also, the main research questions and terminology are provided. Lastly, a brief overview of each chapter of the dissertation is discussed.

Need for the Study

Play is a significant part of children's lives and development. Children naturally communicate through symbolism and play (Landreth, 2012; Oaklander, 1988; Piaget, 1951; Ray, 2016). Landreth (2012) described children's communication through symbolism: "Toys are children's words and play is their language" (p. 11). Since children communicate through play, play therapists need to cultivate play rather than talk therapy. Play therapists facilitate therapeutic relationships and provide toys so children can express themselves (Landreth, 2012). When children express themselves through play, they learn about their world.

Children experience stress from experiences in their world. Children's brains grow rapidly which makes them especially vulnerable to trauma (De Bellis & Zisk, 2014). Many children experience direct or vicarious trauma (ILO, 2017; United Nations Children's Fund [UNICEF], 2017). Children may need therapy to help them process these troubling experiences; however, children's therapy should be different than therapy for adults. Play, rather than talk therapy, is most appropriate for children and preadolescents as their prefrontal cortexes are not developed until their mid-20s (Goodman, Reed, & Athey-Lloyd, 2015; Piaget, 1951; Stewart et al., 2016). While any person under the age of 25 may benefit from play therapy, children who have experienced trauma and stress may benefit the most. Play therapy may provide children with a healing experience in which they may play out trauma and stress.

Since children are minors, adults are often responsible for making decisions about children's mental health services. Many people in the public who might need to know about play therapy are parents, so research about parents' knowledge will be explored. Some parents do not know that play is a vital part of children's counseling (Brumfield & Christensen, 2011; Landreth, Bratton, Kellam, & Blackard, 2006). This is problematic because parents are often the people who make service decisions for children. If parents are knowledgeable about mental health service options, they are more likely to take their children to therapy (Corkum, Rimer, & Schachar, 1999; Cunningham et al., 2008; Johnston, Siepp, Hommersen, Hoza, & Fine, 2005); perhaps this same trend would apply for play therapy such as if parents knew more about play therapy maybe they would be more willing to take their children to play therapy. More research is needed about parents' knowledge of mental health services and play therapy services (Gallo, Comer, & Barlow, 2013; O'Connor & Langer, 2018). There are even further limitations in the available research. The few studies on parent preferences for children's mental health treatments tend to focus on medications, not therapy or play therapy (e.g., Bradley, McGrath, Brannen, & Bagnell, 2010; Chavira, Stein, Bailey, & Stein, 2003; Jaycox et al., 2006). Many people in the adult public may eventually become parents, may need to make decisions about children's mental health services, or may share their perceptions of play therapy with friends and family. This shows the importance and need for research that addresses the adult public's, not just parents', perception of the utility of play therapy specifically.

There is an additional need for research that addresses the influence of play therapy information on adults' perceptions of play therapy utility. This needed research could build upon the existing research which supports that adult public's general mental health literacy is improved through contact with mental health information (Christensen & Griffiths, 2000;

Corrigan et al., 2001; Jorm, 2000; Lauber et al., 2005). This shows the importance and need for research that addresses the adult public's, not just parents', perception of the utility of play therapy specifically and how play therapy information specifically may influence perceptions of the utility of play therapy.

Purpose of the Present Study

The purpose of this dissertation is to learn about the adult public's perception of the utility of play therapy and to explore whether exposure to information about play therapy can change the adult public's perceptions of play therapy utility. An additional purpose is to explore the relationship of these perceptions and participants' demographic variables. These findings will support future implications. Once play therapists know more about the adult public's perception of the utility of play therapy, they will better know if a brief educational intervention is effective and which groups of people are more influenced by the education. Once misconceptions about and lack of awareness of play therapy are addressed through education, the adult public can make informed choices about the utilization of play therapy.

Research Questions

Members of the adult public answer questions on an Internet based form. This quantitative data will be collected and analyzed to address the research questions. The following research (R) questions will guide this study.

R1: What is the initial perception of the utility of play therapy?

R2: Does this initial perception of the utility of play therapy differ significantly by various demographics: sex, race, level of education, salary, description of population in area of living, primary resource for learning mental health information, therapy usage, parent or not, have a

child or not, and self-reported level of awareness of play therapy prior to exposure to information?

R3: Does exposure to information about play therapy significantly change perceived utility of play therapy services?

R4: If there is a change in perception of the utility of play therapy, does this change significantly by demographics: sex, race, level of education, salary, description of population in area of living, primary resource for learning mental health information, therapy usage, parent or not, have a child or not, and self-reported level of awareness of play therapy prior to exposure to information?

Definitions of Terms

Amazon Mechanical Turk (MTurk) – MTurk was created in 2005 and is a crowdsourcing platform (Beymer, Holloway, & Grov, 2018; Sheehan & Pittman 2016). MTurk is used to recruit workers to complete tasks through the Internet (Amazon Mechanical Turk [MTurk], 2019; Litman, 2015). MTurk workers' demographic information is comparable to the general population of survey respondents and it is more diverse than college student populations (Andersen & Lau, 2018; Brañas-Garza, Capraro, & Rascón-Ramírez, 2018; Cunningham et al., 2017; Follmer, Sperling, & Suen, 2017; Goodman & Paolacci, 2017; Kan & Drummey, 2018; Shank, 2016; Sheehan, 2018). MTurk will be used to recruit participants to complete the survey.

Association for Play Therapy (APT) – APT is a national professional society which was established in 1982 and is based in Clovis, California (APT, 2019a). APT's (2019a) mission is the following:

...to promote the value of play, play therapy, and credentialed play therapists. This is accomplished by advancing the psychosocial development and mental health of all people through play and play therapy by promoting and supporting those programs, services, and related activities that promote the: (a) Public understanding and appreciation of play and play

therapy, (b) Effective practice of play therapy through research, education and training, and support, (c) Recognition, incorporation, and preservation of diversity in play and play therapy, and (d) Development and maintenance of a strong professional organization that satisfies this mission. (n.p.)

The current study focuses on the adult public understanding and appreciation of play therapy.

Approved Center of Play Therapy Education Program – APT (2019b) bestows this designation to institutions of higher education offering Master’s or Doctoral degrees in the mental health field that meet APT’s criteria to grow the credibility of play therapy.

APT Type I Provider – APT (2019c) explained that a Type I provider may:

...offer unlimited play therapy educational programs with unlimited number of continuing education credit hours within the designated approval period. There are three different approval periods awarded by APT at its discretion: 1-year, 2-year, and 5-year. Approval Period is contingent upon applicant demonstrating a solid understanding of Provider standards as outlined in the Approved Provider Criteria and Standards. (p. 2)

APT Type II Provider – APT explained that APT Type II providers “may offer play therapy training at one event that neither extends beyond five (5) consecutive days nor offers more than 25 hours of play therapy credit” (2019c, p. 2).

Feeling reflection – This is a technique play therapists uses to help the child feel understood (Landreth, 2012). For example, the play therapist may say, “You feel proud.”

Human Intelligence Task (HIT) – HITs are small jobs posted by requesters or researchers for MTurk employees to complete online (Sheehan & Pittman, 2016). In this study, the survey is considered a HIT.

Micro-batching – This MTurk feature is used to improve sample representativeness (Litman, Robinson, & Abberbock, 2017). Micro-batching improves sample representativeness, and it allows requesters to break tasks or HITs in to smaller segments and indicate time intervals for the HIT launching (Litman et al., 2017). This helps prevent bias and prevent requesters from only sampling MTurk workers on a specific day at a specific time (Litman et al., 2017). For instance,

it helps reduce range restriction from selecting people who are off work and like completing requests on Monday mornings.

Perception – Perception is defined as “a belief or opinion, often held by many people and based on how things seem” (Cambridge Dictionary, n.d., n.p.) and as “the way that someone thinks and feels about a company, product, service, etc” (Cambridge Dictionary, n.d., n.p.). In this study, it is the beliefs and attitudes the adult public has about play therapy and mental health services.

Play therapy –APT (2019a) defines play therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (n.p.). To make the definition more readable, the study used the following definition in the survey. Play therapy is a relationship between a child and a trained play therapist (Landreth, 2012). The play therapist provides toys and facilitates a safe relationship for the child to express and explore who they are (feelings, thoughts, experiences, and behaviors) through play (Landreth, 2012). Play is the child's natural way to communicate, grow, and develop (Landreth, 2012). “Toys are children's words and play is their language” (Landreth, 2012, p. 156).

Registered Play TherapistTM (RPT) – APT (2019g) explained that individuals who hold the RPT credential completed the following:

...have provided APT with documentation that they have a) a mental health graduate or higher degree; b) been licensed by the applicable state licensing or certification authority; c) completed a minimum number of hours of general clinical experience and supervision; d) completed a minimum number of hours of play therapy training and supervision; and e) completed the requisite continuing education hours (n.p.).

Registered Play Therapy-SupervisorTM (RPT-S) – The RPT-S credential signifies a RPT with additional supervision training. APT (2019e) explained that to transition from being a RPT to a RPT-S, applicants must

(1) Hold or have held an RPT credential issued by APT for three consecutive years in good standing. (2) Be approved by your state mental health board to supervise others/interns (whether or not you choose to supervise towards licensure or just towards APT credentialing). (3) Hold a clinical mental health license for three consecutive years in good standing and without conditions. (4) Completed 3,000 hours of direct clinical experience after obtaining your clinical, independent license. (5) Complete 500 hours of direct play therapy experience after obtaining your RPT credential. (6) Complete 6 hours of play therapy specific supervisor instruction sponsored by an APT Approved Provider or through a graduate play therapy course shown on a transcript. (7) Complete 24 hours of clinical supervisor instruction (academic instruction on how to supervise). This is not required to be play therapy specific. (p. 22)

APT explained that their credentials help the public to identify those with specialized training and experience in play therapy (APTc, 2019). To renew the RPT-S, 3 hours of supervision training must be completed every 3-year continuing education cycle (APTc, 2019).

School Based-Registered Play TherapistTM (SB-RPT) – SB-RPT are school counselors or school psychologists

who have provided APT with documentation that they have a) a mental health graduate or higher degree; b) been licensed or certified as a school counselor or school psychologist by the applicable state licensing or certification authority; c) completed a minimum number of hours of general clinical experience and supervision; d) completed a minimum number of hours of play therapy training and supervision; and e) completed the requisite continuing education hours. (APTc, 2019, n.p.)

Tracking – Landreth (2012) stated, “Tracking responses put into words what the therapist sees and observes the child doing” (p. 191). For example, the play therapist may say, “You are putting that there.” Tracking reflections help the play therapists communicate to the child that they are interested in the child and are paying attention to the child’s play (Landreth, 2012).

TurkPrime - TurkPrime is a website powered by CloudResearch (2019) that uses the MTurk application programming interface (API) and additional tools and provides its own graphical user

interface (GUI) (Litman et al., 2017). TurkPrime allows researchers additional features to filter MTurk employees and change the rate of MTurk data collection (Litman et al., 2017).

Utility – It is “The state of being useful...beneficial” (Oxford University Press, n.d., n.p.).

Brief Overview of Dissertation

This dissertation is composed of five chapters. The first chapter includes an introduction, an explanation of the need for the study, the purpose of the present study, a brief overview of the research questions, and a list of definitions. The second chapter is a review of the literature. Specifically, it entails a review of the history of play therapy, the value of play therapy, and a review of literature that indicates a need for mental health services for children. Also, it entails a discussion of the public’s preferred ways to receive mental health information, a review of barriers to parents receiving information about mental health services, mental health literacy information, and resources to inform parents about play therapy. The third chapter includes the research questions, background information on Amazon Mechanical Turk, participant recruitment and selection criteria, and information about the procedure, information about data collection, information about the instrument, and the approach for statistical data analyses. The fourth chapter includes information about the demographic descriptive statistics, internal consistency reliability, statistical assumptions, and analytic results. The fifth chapter includes a discussion on the interpretation of findings, limitations and possible confounds, and ideas for future research.

CHAPTER II: REVIEW OF THE LITERATURE

The purpose of this chapter is to review relevant literature. The history of play therapy, the value of play therapy, and the need for play therapy services are discussed. Also, the chapter entails a review of parents' preferred avenues to receive mental health information, and a review of barriers that influence parents receiving information about mental health services. Lastly, it includes a review of mental health literacy and a review of resources for the adult public to learn more about play therapy.

History of Play Therapy

The first pioneers of children's mental health noted children's play. In 1762, Rousseau (1762/2004) was the first person documented to have encouraged others to study children's play (Lebo, 1955). In *Emile*, Rousseau (1762/2004) noted that children are not tiny adults. This was an important remark because it evoked the idea that children need services that differ than those for adults. Rousseau (1762/2004) recommended that a child's teacher play like a child in order to understand his pupil better. Rousseau was not alone in noticing the benefits of learning about children through being close to children. Sigmund Freud also became interested in children's development, and created theories based on his observations of children (Freud, 1908). Freud (1909) published the first child mental health case of Little Hans, who had a phobia of horses. Sigmund Freud noted Little Hans' verbal statements and some play, and recognized challenges of using psychoanalysis with children (Freud, 1909). For example, Freud (1909) noted that children have trouble describing their anxieties with words and that there was a need for a parent or someone who knew the child well to interpret a child's statements. While Sigmund Freud began the conversation of psychoanalysis with children, Von Hug-Hellmuth furthered the discussion. Von Hug-Hellmuth (1921) appeared to be the first therapist to emphasize play with

child analysis; however, she never specified a specific play technique (Klein 1955; Landreth, 2012). Instead Von Hug-Hellmuth (1921) emphasized the importance of building a trusting relationship with the child's parents as they are in charge of bringing the child to services. Rousseau, Freud, and Von Hug-Hellmuth were just the beginning of therapists' interest in children's development and their play.

Psychoanalytic Play Therapy

Initially, therapeutic work with children was rooted in a psychoanalytic framework (Homeyer & DeFrance, 2005). In 1926, Melanie Klein with her British colleagues created the psychoanalytic play technique which later became known as the English school of psychoanalysis (Klein, 1955). Melanie Klein (1955) used play to make interpretations and analyze children under the age of 6 years old. Not only did Klein acknowledge children's need for play in mental health services, she incorporated this awareness in her work. Klein (1955) explained that children express their feelings and defenses in play through symbolism, similarly to how adults do through the psychoanalytic method of free association. At first, Klein (1955) worked with children in their homes. She began to recognize the need for children's privacy and the influence of family members in the home setting. Later she used a play room in which each child had their own locked drawer with their own toys (Klein, 1955). These toys were only known by the analyst and the child, similar to an adult's free association (Klein, 1955). Klein continually compared and linked children's therapy and adult's therapy. Ultimately, she believed that play work with children was especially important as she believed it was the root to adult mental health issues (Klein, 1955). Klein's work was very significant in the development of modern day play therapy, yet she was not the only revolutionary female at the time.

Anna Freud and Klein had similar yet different approaches and philosophies. Anna Freud (1947) explained that her approach differed from Klein's; Anna Freud viewed psychoanalysis as only appropriate for "little neurotic delinquent[s]" (p. 14) with "infantile neurosis" (p. 3), and Klein viewed psychoanalysis as appropriate for the "normal child" (p. 3). Anna Freud emphasized developing a strong attachment with a child is vital as the child must project thoughts and feelings, such as those they have for their parents, on to the therapist (Freud, 1947). Anna Freud believed that projection or transference is necessary to conduct analysis and argued that Klein's method of simply interpreting play, rather than transference in the relationship, was not adequate (Freud, 1947). Regardless of the specific differences between their processes, both Klein and Anna Freud believed play was a child's natural form of expression and both strived facilitate children's ability to express self appropriately through uncovering the past (Landreth, 2012). These psychoanalytic therapists provided a platform for many more approaches to begin.

Release Play Therapy

Around 1933, a major shift occurred in play therapy and some therapists began to use a release format of the psychoanalytic framework (Homeyer & DeFrance, 2005). David Levy (1938, 1939) developed release play therapy for children who had experienced a specific anxiety provoking event. In release play, a limited number of toys are provided, and the therapeutic relationship is considered indicative of relationships outside of the therapeutic relationship (Lebo, 1955). Levy did not make interpretations rather he selected toys, primarily dolls, to recreate the scene that was stressful for the child (Rogers, 1939). During release play the child is no longer in the passive role of experiencing an event, but is in control when playing out the

scene (Levy, 1938, 1939). Levy's (1938, 1939) approach gives the child control to play out a new response to the scenario which is empowering for the child.

Grove Hambridge (1955) worked to preserve Levy's work and improve it. Hambridge (1955) expanded Levy's release therapy and developed structured play therapy in which he was more directive with recreating events and applied a more specific structure of independent sequences of play: (1) structured play, then free play; (2) structured play, then free play, and then repeat the same structured play; and (3) structured play, free play, and new structured play. More generally, Hambridge's (1955) structured play was initiated by a therapist facilitating different anxiety provoking scenes and then stepping back so the child can play out what would happen next. This was always followed by free play in which the child further played out and processed the event (Hambridge, 1955). While this approach was more prescriptive and directive, it still allowed children free play to process their feelings and change their play responses.

Relationship Play Therapy

The next significant development in play therapy was relationship therapy, which was developed in 1933 (Landreth, 2012; Homeyer & DeFrance, 2005). The philosophical basis for Jesse Taft's (1933) and Frederick Allen's (1934) relationship therapy was developed from Otto Rank's (1936) work (Taft, 1933). Allen (1934, 1942), the 1934 president of The American Orthopsychiatry Association, emphasized that children under the age of 10-years-old relate to others through play. Allen (1934) explained that developing the therapeutic relationship is very important since it is in this relationship that the child experiences himself in the present and feels safe enough to be expressive. Relationship therapy differed from psychoanalytic therapy in that it emphasized the therapeutic relationship, placed emphasis in the present, and did not seek to

interpret past experiences (Allen, 1934; Taft, 1933). In relationship therapy, the therapist is present focused and does not dictate the play, only joins in the child's play when invited (Allen, 1934; Taft, 1933). Therapists with a relational approach focus on the therapeutic alliance as an agent of change in the present moment rather than on being directive, analytic, prescriptive, and focused on the past.

Nondirective Therapy

While relationship therapy began as a separate movement, it later was merged with nondirective therapy (Lebo, 1955). Carl Rogers created nondirective therapy later known as client-centered therapy (Rogers, 1951) which is now known as person-centered therapy or child-centered therapy (Landreth, 2012). Nondirective therapists work to provide experiences that facilitate the client's self-awareness and decision making. Through nondirective therapists accepting their clients, their clients in turn begin to accept themselves and begin to face their true self, not the self that others want them to be or who they would like to be (Rogers, 1961).

Rogers (1961) explained that genuineness is an important component:

I do not need to be uneasy as to whether my own feelings are 'therapeutic.' What I am and what I feel are good enough to be a basis for therapy, if I can transparently *be* what I am and what I feel in relationship to him [the client]. Then perhaps he can be what he is, openly and without fear. (p. 67)

Also this therapeutic process involves the therapist trusting the client as well as not telling the client what to do. Nondirective therapists view the client as having a tendency towards growth (Axline, 1947b; Landreth, 2012; Lebo, 1955; Rogers, 1939, 1942). Rogers (1961) acknowledged that it can be challenging for younger children to engage in this therapeutic process with verbalization, so various mediums can be used to facilitate children expressing their feelings freely.

Creative Approaches with Children

There are several creative approaches that can assist clients in this process towards growth. Rogers (1939, 1942, 1961) explained that similarly to Levy's cathartic play scenarios, children can play with expressive therapies such as drawing, carving soap, dancing, writing poetry, cutting on and constructing with cardboard, retelling folk tales (changes from the original tale are noted), and creating puppet shows. These mediums allow the child to release energy and alter thoughts and feelings. Margaret Lowenfeld (1939, 1979) created another creative technique called "The World" technique for sandtray (Lowenfeld, 1939, p. 68). Children above the age of 4 years-old make their world by selecting figures and placing them in the sand anyway they wish (Lowenfeld, 1939). This method allows for comparison of trays that represent how the child was feeling during each session (Lowenfeld, 1939). During these creative processes, children self-soothe, release emotions, and gain new perspectives in a supportive, therapeutic relationship. Facilitated by the therapeutic relationship, these expressive activities help the client freely express self and begin to gain self-insight (Rogers, 1942). To facilitate this relationship, a client-centered therapist upholds three core conditions: congruence (authentic, no professional facade), unconditional positive regard (positive acceptance of the totality of the client), and empathic understanding (understanding the client's feelings) (Rogers, 1980). The therapist who facilitates these creative approaches abides by nondirective, client-centered conditions, which were not specifically or formally described regarding working with children, a child-centered approach, until Virginia Axline's work.

Child-Centered Play Therapy

Virginia Axline (1947a, 1947b) was one of Rogers' students who applied his philosophy to working with children and play therapy and outlined eight principles of play therapy (Landreth, 2012). In her principles, Axline (1947b) explained that in nondirective play therapy, the child self-directs play, plays with which ever toy is desired, expresses emotions, and grows in self-awareness; the therapist accepts the child and does not focus on a disorder. This is vital as it communicates to the child that they are cared for just as they are and are not a problem that needs to be fixed. In a well-equipped playroom, a nondirective therapist facilitates a secure, warm relationship in which a child can express himself in his own way and time (Axline, 1947b). Child-centered play therapists do not try to rush children and they trust children's tendency toward growth in a safe relationship and environment. Axline (1964) demonstrated this work through her case study, *Dibs in Search of Self*, which is still one of the best-selling child psychotherapy books (Homeyer & DeFrance, 2005). Axline's principles and book provided guidelines and a case example to teach others about child-centered play therapy.

Later Developments in Play Therapy

Soon, other developments occurred in the field of play therapy. Emphasis on which children could benefit from play therapy began to change. Clark Moustakas (1951) wrote about how situational play therapy could be used with "normal children" going through everyday stressful situations such as a sibling being born, not just as a remedial approach (p. 225). This preventative approach could benefit the child's mental health. Moustakas (1951) believed situational play therapy allowed children to play and process their feelings rather than repress them and perhaps eventually becoming more serious issues. Soon after parents were being trained in basic child-centered techniques and philosophy to create a systemic family change.

Bernard Guerney (1964) and Louise Guerney (1997) developed filial therapy, which involved parents being trained in a model of the child-centered play therapy and supported in a weekly group in conducting play sessions with their own children. Next training for play therapist began to improve. For instance, Garry Landreth (1991) advocated for child-centered play therapy and wrote a textbook to aid in training new counselors. As awareness about play therapy spread, many theoretical perspectives applied their own lenses to play therapy.

Play Therapy Theoretical Perspectives

At about the same point in time, other play therapy theoretical perspectives began to evolve from other theoretical perspectives typically used with adults. Derived from Adler's (1927) individual psychology with adults, Adlerian play therapy developed appears to have been developed by Kottman (1987, 2001). From Gestalt therapy (Perls, 1947) with adults, Gestalt play therapy developed by Oaklander (1988, 2001), and Blom (2006) later wrote a Gestalt play therapy handbook. Derived from Jungian therapy or Jungian analysis (Jung, 1960) with adults, Jungian play therapy appeared to be developed by Allan (1998) and was continued by Green (2014). Rooted in cognitive theory (Rush, Khatami, & Beck, 1975) for adults, cognitive behavioral play therapy began with Knell (Knell & Moore, 1990; Knell, 1993). While there are a variety of play therapy perspectives, child-centered play therapy is the most researched and widely used play therapy perspective (Lambert et al., 2007; Ray, 2016). With these new theoretical play therapy perspectives developing, there was much growth in play therapy during the late 1980s and 1990s.

Formalization of Play Therapy

Naturally with so much interest, a formal organization of play therapy arose. In 1982, Charles Schaefer and Kevin O'Connor founded the international Association for Play Therapy

(APT) (Johnson, 2016). Soon state branches were made, the *International Journal of Play Therapy* was developed, the creation of the credentials Registered Play Therapist (RPT) and Registered Play Therapist Supervisor (RPT-S), and a list of APT approved continuing education providers was published. Later School-Based Registered Play Therapist (SB-RPT) were created. Even a formal definition of play therapy was created. The APT defines play therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development (APT, 2019a, n.p.). This formalization of play therapy likely helped to build its credibility.

The interest in play therapy continues to grow. APT's membership has grown every year since December 1998 (APT, 2020). On December 31, 1998 APT had 3,346 members and on December 31, 2019 APT had 7,518 members (APT, 2020). This shows therapists' growing awareness about play therapy and a commitment to obtaining specialized training, supervision, and education to work specifically with children. In addition to growth in membership, play therapy educational centers are growing rapidly. For instance, in 2011 there were 17 approved centers, 197 Type I providers, 20 Type II providers, and in 2019 there were 30 approved centers, 345 Type I providers, 8 Type II providers (APT, 2020). APT increased online educational opportunities through the APT E-Learning Center (APT, 2020). This allows therapists in rural areas to also have access. APT provides education opportunities at an international scale through conferences. APT conference registration attendance has not grown steadily since 1998; however, overall it has grown over time increasing from 963 registrants in 1998 to 1293 registrants in 2019 (APT, 2020). Similarly, the number of APT branches have not grown consistently but have grown overall from 31 branches in 1998 to 42 branches in 2019 (APT,

2020). This growth in branches makes sense as RPTS/S and SB-RPT numbers have increased. On December 31, 2019 there were 2,442 RPT, 1,910 RPT-S, 29 SB-RPT, which totals to 4,381 RPT/S or SB-RPT (APT, 2020). While RPTS/S and SB-RPT numbers have increased, this number is relatively small when compared to the total number of counselors, school counselors, clinical social workers, and clinical psychologists.

Value of Play Therapy

Play therapy is valuable for children and preadolescents. Play therapy is developmentally appropriate as play is children's natural form of communication (Axline, 1947b; Klein, 1955; Landreth, 2012; Stewart, Field, & Echterling, 2016). Furthermore, play therapy is informed by neuroscience (e.g., Field et al., 2015; Luke, Miller, & McAuliffe, 2019; Siegal & Bryson, 2012), which is becoming increasingly important in terms of understanding the benefits of various therapeutic approaches and techniques.

Developmentally Based

Play is children's language (Axline, 1947b; Klein, 1955; Landreth, 2012; Stewart, Field, & Echterling, 2016). In the 20th century, many developmental theorists explained that play was an important part of childhood (Erikson, 1963; Freud, 1947; Gesell, Ilg, Learned, & Ames, 1943; Greenspan & Benderly, 1997; Greenspan & Salmon, 1997; Kohlberg, 1987; Piaget, 1951; Vygotsky, 1966). The ability to verbally communicate comes from the left hemisphere of the brain, which develops later than the right hemisphere, which houses emotional response (Perryman, Blisard, & Moss, 2019; Piaget, 1951; Ray, 2016). Therefore, children's cognitive development supersedes their verbal abilities (Piaget, 1951) and children primarily communicate through symbolism and play (Oaklander, 1988; Piaget, 1951; Ray, 2016). Since the prefrontal cortex is one of the last regions of the brain to develop, and is not fully developed until a

persons' mid-20s, play, rather than talk therapy, is most appropriate for children and preadolescents (Goodman, Reed, & Athey-Lloyd, 2015; Stewart et al., 2016). Play therapy aids the therapist in meeting children where they are developmentally.

Evidence-Based

Specific formats of play therapy such as Theraplay, Adlerian play therapy, child parent relationship therapy, filial family therapy, and child-centered play therapy are evidence-based according to the National Registry of Evidence-Based Programs and Practices on the Substance Abuse and Mental Health Services Administration website (APT, 2019f). There are three programs of play-based interventions that support their effectiveness: Child-Parent Psychotherapy, Incredible Years, and Parent-Child Interaction Therapy (APT, 2019f). Ray and McCullough (2016) wrote an evidence play therapy statement, which APT released, and referenced research supporting play therapy's effectiveness for children 3 to 12-years-old with disruptive behaviors, internalized problems, academic and language concerns, relationship stress, trauma, and impairment and medical concerns. Play therapy's effectiveness with children is supported by research.

Neuroscience Informed

A working knowledge of neuroscience is becoming crucial for mental health professionals as they consider best practices for therapeutic approaches (Beeson & Field, 2017; Perryman et al., 2019). In 2013, the neurocounseling movement began (Russell-Chapin, 2016). Russell-Chapin (2016) defined neurocounseling as "the integration of neuroscience into the practice of counseling by teaching and illustrating the physiological underpinnings of many of our mental health concerns" (p. 93). Play therapy can be supported by neuroscience.

During play the neuropeptide oxytocin is released, which helps build a trusting relationship between the play therapist and the child (Bartz, Zaki, Bolger, & Ochsner, 2011; Stewart et al., 2016). Also during play, mirror neurons aid in the counselor connecting and empathizing with the child's emotions, or in other words the play therapist's right hemisphere connects with the child's right hemisphere to help establish a secure attachment (Field et al., 2015; Iacoboni, 2012; Schore, 2012; Stewart et al., 2016). It is important for therapists to connect with children's right hemisphere through reflecting children's emotions, as children's right hemisphere develops before the left hemisphere (Chiron et al., 1997; De Kovel, Lisgo, Fisher, & Francks, 2018; Mento, Suppiej, Altoè, & Bisiacchi, 2010). This later developing left hemisphere is where language is processed in the Broca region (Rauch et al., 1996). Play is children's language because language processing in the left hemisphere does not develop as fast as the right hemisphere, which processes emotions. For change to occur, the therapist needs to address the child's emotions. Cozolino (2010) explained that to enhance neuroplasticity or create new neural pathways emotional arousal needs to be at a certain level. In child-directed play, the child naturally plays in their own "sweet spot" for learning and connecting (Stewart et al., 2016, p. 5). When the child is not over or under stimulated and is in this "window of tolerance," the child is self-regulated (Gaskill & Perry, 2014; Siegel, 1999, p. 253). The safety created by the skilled play therapist and the playroom provide the therapeutic space for this work.

Hemisphere Integration

The counselor's reflections paired with the child's play facilitates integration of affect and cognition in a way that honors the child's world while also fostering a more healthful narrative (Cozolino, 2010; Stewart et al., 2016). This relational connection in a safe, therapeutic

relationship allows the amygdala to produce safety responses which allows maladaptive somatic markers to be unlearned and new patterns to be tried; furthermore, with practice the child learns how to self-regulate (Gaskill & Perry, 2014; Stewart et al., 2016). This evidence of neuroplasticity, the main neurophysiological process in therapeutic change, may require many repetitions, at frequent intervals, and at appropriate amounts of intensity (Kleim & Jones, 2008), within the safety of the relationship with the play therapist.

A connection with a play therapist can help children who are struggling with regulation and integration (Field et al., 2015; Siegal & Bryson, 2012). As previously mentioned, the left hemisphere of the brain primarily processes language and is logistical, and the right hemisphere primarily processes emotion (Perryman et al., 2019). Through experiences in this therapeutic relationship, children's emotional right hemisphere and their logical left hemisphere can become integrated, which helps children balance between rigidity and chaos (Field et al., 2015; Luke et al., 2019; Siegal & Bryson, 2012). This is crucial because children need both sides of their brain working well together to effectively problem solve, form meaningful relationships, and regulate.

Bottom and Top of Brain Considerations

In addition to right and left hemisphere considerations, there are also bottom and top of the brain considerations. Information is processed in the brain through top [of the brain]-down and bottom [of the brain]-up attention (Buschman & Miller, 2007; Foltz, Diekamp, & Güntürkün, 2004). The voluntary top-down attention or stimulus-driven attention originates in the prefrontal cortex and moves down the brain; it involves knowledge about the current task (Buschman & Miller, 2007; Pinto, Leij, Sligte, Lamme, & Scholte, 2013). The rapid bottom-up attention or goal-oriented attention originates in the brainstem and moves upward; it involves emotional arousal (Buschman & Miller, 2007; Pinto et al., 2013). Top-down attention is

sustained and is where people usually place their attention as compared to bottom-up attention that is usually transiently captured (Pinto et al., 2013). Research findings by Pinto et al. (2013) suggest that top-down and bottom-up attention are two independent attention systems in which tasks are not correlated, and they have different links to consciousness. These are important considerations as the way the brain processes different types of information informs play therapists work with children.

When working with children with trauma, directive play therapist will often need to use bottom-up (somatosensory) activities to help the child first to regulate before top-down activities (Gaskill & Perry, 2014). To help children regulate, play therapists can connect with a child's right hemisphere, where traumatic implicit unconscious memories are stored, before the child creates a new narrative with the left hemisphere (Badenoch, 2018). Bottom-up and right hemisphere interventions involve somatosensory activities such as walking, drawling, dancing, listening to music, using clay, and using a sandtray (Gaskill & Perry, 2014; Perryman et al., 2019). In order to provide nondirective bottom-up and right hemisphere interventions, play therapists provide a rhythmic, consistent pattern to promote safety (Gaskill & Perry, 2014) such as keeping the session at the agreed upon time, facilitating a consistent warm relationship, giving a 5-minute time warning, and being consistent with ending the session. Play therapist facilitate the quick, automatic bottom-up attention through techniques rooted in the here-and-now such as feeling reflections and tracking behavior to help children gain awareness of their affect and behavior (Stewart et al., 2016). In play therapy, the top-down principle occurs when children gain awareness of their strengths, abilities, and emotions (Stewart et al., 2016). Activities such as writing a story, poetry, or narrative help stimulate the left hemisphere (Perryman et al., 2019). Play therapists promote the top-down attention through tracking statements and reflections such

as about the child's decision making, efforts, and creativity (Stewart et al., 2016). Brain and cognition research on top-down and bottom-up attention helped inform play therapists on how to meet children's needs and have helped support work that play therapist already discovered anecdotally.

Therapeutic Change

Therapeutic change can be explained through a neuroscience lens. If children have a prior stressful experience and a trauma-related stimulus is present, their lower brain hijacks or shifts their brain's attention to an intrusive memory and they become dysregulated (Clark & Mackay, 2015). Through play therapy, a child can have new experiences that help the child remain calm and learn to regulate during times that are not truly threatening (Clark & Mackay, 2015). In the presence of a secure attachment, the children can access their emotions through play and expressive arts and then recreate a new narrative or memory. The alteration of this memory occurs during the reconsolidation window (Eckert, 2015). Eckert (2015) defined memory reconsolidation as "the brain's innate process for fundamentally revising an existing learning and the acquired behavioral responses and/or state of mind maintained by that learning" (p. 4). Eckert (2015) emphasized that memory reconsolidation can only occur if the new information is at odds with what was learned or in other words is discrepant with what the reactivated memory expects (Eckert, 2015). For our purposes, this could mean a period of time in which the child's learned response in relation to a memory is vulnerable to changing if introduced to a new, mis-matched response. The amount of time the consolidation window is open is unclear (Bernabo & Nader, 2018); however, some findings indicate that the threshold for plasticity begins approximately 10 minutes after the memory retrieval (Schiller et al., 2013) and lasts for 4 and 6 hours (Duvarci, Mamou, & Nader, 2006; Pedreira & Maldonado, 2003). It is

important for children to have a supportive, corrective emotional experience soon after the stressful memory is recalled. Memory reconsolidation simply supports how children's thoughts, feelings, and behaviors can change through a safe relationship and experience.

Children's Need for Mental Health Services

During early development, children's brains as well as the rest of their bodies are rapidly growing and are particularly vulnerable to trauma (De Bellis & Zisk, 2014). Unfortunately, there are many traumatic adversities children may face. Green et al. (2010) found that the most reported childhood adversities were parental divorce, family violence, family financial issues, and parental mental illness. Children experience direct or vicarious trauma at school and in their homes as well as from armed conflicts and natural disasters (International Labour Organization [ILO], 2017; UNICEF, 2017). Untreated, such childhood trauma can result in adulthood issues mental health issues (Nurius, Logan-Greene, & Green, 2012) such as depression (Chung, Mathew, Elo, Coyne, & Culhane, 2008; Merrick et al., 2017; Waite & Shewokis, 2012), mood and anxiety disorders (Douglas et al., 2010), posttraumatic stress disorder (PTSD) (LeardMann, Smith, & Ryan, 2010; Wu, Schairer, Dellor, & Grella, 2010), suicide attempts (Merrick et al., 2017; Sachs-Ericsson, Rushing, Stanley, & Sheffler, 2016) and other health concerns.

Children around the world experience violence at home. For example, UNICEF (2017) reported that children from the poorest and wealthiest households aged 2 to 4-years-old were equally likely to experience violent discipline. Experiencing violence can impact children's emotional development (UNICEF, 2017). For instance, when data from 44 countries was analyzed, UNICEF (2017) found that children aged 36 to 59 months who experienced physical punishment in the last month were less likely to reach social-emotional development milestones. Sometimes children witness violence, instead of directly experiencing it. For instance, more than

half of children under 5-years-old in Afghanistan live with a mother who was a victim of sexual, emotional, or physical intimate partner violence in the last 6 months (UNICEF, 2017). Many children experience sexual violence directly; Across the world, 9 million girls who were 15 to 19-years-old were forced to engage in sexual acts or sexual intercourse in the last year. Some girls do not receive the support they need. For instance, only 1% of girls who had experienced forced sex sought professional help, and girls most frequently report perpetrators to be current or former partners or someone they knew (UNICEF, 2017). Men and sexual minoritized groups are not represented well in these statistics as there is limited data (UNICEF, 2017; Wolf, Prabhu, & Carello, 2019). This findings illustrate the prevalence of childhood trauma in daily life across the globe and the need for play therapy.

In addition to experiencing violence at home, children worldwide experience violence at school. For instance, one in two school-aged children who are between the ages of 6 and 17 years (732 million children) live in countries in which corporal punishment is not fully prohibited (UNICEF, 2017). Furthermore across 14 countries between 1991 and December 2016, there were 59 school shootings in which there was at least one reported fatality, and 43 (almost 3 in 4) of these shootings occurred in the United States (UNICEF, 2017). In 2016 across 18 countries, there were almost 500 verified school attacks or threats (UNICEF, 2017). In addition to school shootings and threats, many children experience bullying at school. Across the world, there are 130 million students aged 13 to 15-years-old who reported being bullied about monthly (UNICEF, 2017). These findings illuminate the frequency of violence children experience worldwide and the need for children to have a safe, therapeutic relationship to process these troubling events.

Play therapy is beneficial for children who have experienced a wide range of stressful and traumatic situations as well as for prevention (APT, 2019h; Ray, 2017). These stress inducing situations such as child abuse, exposure to war, terrorism, bullying, vehicle accidents, and other forms of community or domestic violence can lead to distress and higher rates of symptomology that meets diagnostic criteria (De Bellis & Zisk, 2014). The Children's Mental Health and Emotional or Behavioral Disorders Project (2018) explained that during children's school years, 13% of students aged 8 to 15- years-old have a diagnosable mental disorder. Furthermore, students who experience emotional and coping issues may be at greater risk of youth incarceration (U.S. Surgeon General, 2001). Rather than wait for severe symptomology, Perryman and Bowers (2018) advocated for a preventative play therapy approach in which children's emotional, social, and behavioral issues are identified early before becoming more significant issues (Perryman & Bowers, 2018). Unfortunately, many children with emotional or behavior difficulties do not receive mental health services or medication for severe symptomology or prevention (Simon, Pastor, Reuben, Huang, & Goldstrom, 2015). This is especially alarming since mental disorder cases that begin by age 14 are half of all lifetime mental health cases (Children's Mental Health and Emotional or Behavioral Disorders Project, 2018). If children receive play therapy to aid in their healing, they may be able to avoid the manifestation of this childhood trauma later in life.

Untreated issues from traumatic childhood experiences can impact adulthood. Those that experience high adverse childhood experiences (ACE) (Felitti et al., 1998) tend to report adulthood mental health issues (Nurius et al., 2012), depression (Chung et al., 2008; Merrick et al., 2017; Waite & Shewokis, 2012), mood and anxiety disorders (Douglas et al., 2010), anxiety (Green et al., 2010), posttraumatic stress disorder (PTSD) (LeardMann et al., 2010; Wu et al.,

2010), schizotypal personality disorder (Lentz, Robinson, & Bolton, 2010), multiple psychiatric problems (Lu, Mueser, Rosenberg, & Jankowski, 2008), visual and auditory hallucinations (Shevlin et al., 2011), suicidal ideation (Afifi et al., 2008), and suicide attempts (Merrick et al., 2017; Sachs-Ericsson et al., 2016). Also, those with ACE tend to report adulthood issues of disruptive behaviors (Green et al., 2010), moderate to heavy drinking and drug use (Forster, Grigsby, Rogers, & Benjamin, 2018; Merrick et al., 2017), being convicted of sex offenses (Stensrud, Gilbride, and Bruinekool, 2018), homelessness (Lu et al., 2008; Wu et al., 2010), sex work (Wu et al., 2010), sexually transmitted infections (Wu et al., 2010). Furthermore, ACE are associated with adulthood sleep problems (Chapman et al., 2013), cardiovascular disease (Felitti & Williams, 1998), headaches (Anda, Tietjen, Schulman, Felitti, & Croft, 2010), chronic lung disease (Anda, Brown, Felitti, Dube, & Giles, 2008), autoimmune disease (Dube et al., 2009), obesity (Dube, Cook, & Edwards, 2010), and early death (Brown et al., 2009). This range of health and behavioral issues could potentially be avoided if children receive appropriate care as children.

Parents' Awareness and Perceptions of Play Therapy: The Need for Education

Some parents are unaware of play therapy and the importance of play in children's counseling (Brumfield & Christensen, 2011). Thus, many children are treated by therapists who lack specific training regarding child development (Carnes-Holt & Weatherford, 2013). Parents who know more about mental health service options are more likely to bring their children to services (Corkum et al., 1999; Cunningham et al., 2008; Johnston et al., 2005). Even though greater knowledge about services leads to more usage of services, there is little research on parents' knowledge of mental health services especially research that incorporates parents learning more about play therapy and availability of these services (Gallo et al., 2013; O'Connor

& Langer, 2018). The few studies that exist on parent preferences for children's mental health treatments tend to focus on medications rather than therapy (e.g., Bradley et al., 2010; Chavira et al., 2003; Jaycox et al., 2006). It is important that parents know about developmentally appropriate, play therapy services for children so that they can make informed choices for their children's care.

Parents' Preferred Ways to Receive Mental Health Information

There is some research that indicates where parents and other members of the adult public receive information about their child's mental health care. For instance, the adult public seek information about health and mental health from doctors, mental health providers, family members, and the Internet (Clarke et al., 2016; Cutilli, 2010; Rains, 2007). Even though adults use the Internet, they tend to trust healthcare professionals more (Cutilli, 2010; O'Connor & Langer, 2018). The places the adult public receive their information may influence their perceptions of play therapy utility.

The type of healthcare professionals parents' ask about children's mental health services appears to be related to if the parents' child has received mental health services or not. Findings of a study conducted by O'Connor and Langer (2018) indicated that parents of children between the ages of 4 and 17 who received mental health services self-reported they were more likely to trust and choose mental health providers first, pediatricians second, and psychiatrists third. It seems that it is important for parents to build relationships with therapists to seek information about therapy from a trained professional. Building relationships with parents is something play therapists are taught to do. Play therapists are trained to build a relationship with a child's parent, listen to the parent's concerns, describe play therapy, and describe the parents' role in supporting the child's process (Landreth, 2012; Killough-McGuire & McGuire, 2013). It makes sense that

parents with children in therapy would know more about services. O'Connor & Langer (2018) found that parents who had a child who received mental health services had some foundational knowledge about mental health treatment as they had heard of family therapy, cognitive behavioral therapy, play therapy, and psychoanalysis. This finding indicates that these parents learned about some service options; however, not all parents have this knowledge. Parents of children who had not received mental health services shared that they would trust and choose pediatricians first and mental health providers second for information (O'Connor & Langer, 2018). It appears that parents will ask the closest specialist with whom they have a relationship.

It is important that doctors and pediatricians are informed about play therapy since some parents are going to ask them about children's mental health services. This way educated pediatricians and doctors will accurately inform parents about play therapy. APT (2019d) has recognized this importance and sells brochures to teach pediatricians about play therapy. Play therapists working to teach pediatricians and doctors about play therapy could in turn help teach parents about play therapy.

Barriers to Parents Receiving Information about Mental Health Services

Most of the available research about barriers to information about mental health services is about parents rather than the general adult public. Parents are an important demographic of the public as they are likely to make mental health service choices for children. There are many barriers that can make it more challenging for parents to receive information about mental health services or more specifically about play therapy services. There can be a lack of play therapists and play therapy information available in rural areas (Carnes-Holt & Weatherford, 2013; Hoeft, Fortney, Patel, & Unützer, 2018; Sherman et al., 2009). Parents having a lack of information about play therapy may lead to skepticism about services (Landreth, 2012; O'Connor & Langer,

2018). Furthermore, parents help-seeking for their children, perceptions of play therapy, and access to services and related information may be influenced by culture (Brumfield & Christensen, 2011; Howell & McFeeters, 2008). The adult public's mental health literacy can be improved when exposed to mental health information (Christensen & Griffiths, 2000; Corrigan et al., 2001; Jorm, 2000; Lauber et al., 2005). It is important to understand these barriers as they likely influence the adult public's perceptions of play therapy utility.

It can be especially challenging for people in rural areas to receive information about mental health care and play therapy from health professionals. In rural areas, there tend to be shortages of general pediatricians, family doctors who serve children, and pediatric subspecialists (Edelman, 2014; Sherman, Moscou, & Dang-Vu, 2009). Also, rural areas tend to lack sufficient mental healthcare overall and especially those who have training specific to working with children (Carnes-Holt & Weatherford, 2013; Hoeft et al., 2018; Sherman et al., 2014). Furthermore, mental health professionals in rural areas tend to lack access to continuing education and training for play therapy and counseling children (Carnes-Holt & Weatherford, 2013). Parents especially in rural areas who do not have enough information available may be skeptical of play therapy services.

If parents are skeptical about therapy services, children may also be concerned (Landreth, 2012; O'Connor & Langer, 2018). There may be barriers to services for the child if parents feel disrespected by the counselor or if parents doubt the utility of services (Kerkorian, McKay, & Bannon, 2006). If parents are open to the process, their child will likely be more engaged in services (O'Connor & Langer, 2018). Parents may view play therapy as developmentally appropriate for their child, but may not understand what play therapy is (Brumfield &

Christensen, 2011). Parents discomfort with services may subside if they are informed and the play therapist routinely checks-in with the parent about their concerns.

Another barrier to parents being given developmental and neurological information about their children may in part stem from a lack of this training in mental health counselors programs (Carnes-Holt & Weatherford, 2013). For counselors to become play therapists, they must acquire additional training, obtain state licensure, and supervision from a RPT-S (APT, 2019a). It may be challenging for counselors to pursue supervision from a RPT-S and to experience specialized training which are necessary to be competent in play therapy and to communicate this expertise to parents of children who need mental health services (Carnes-Holt & Weatherford, 2013). Specialized training is of the utmost important. The 2014 *American Counseling Association (ACA) Code of Ethics* mandates in section C.2 that counselors practice in specialty areas only after appropriate training, education, and supervised experiences. This professional competence protects others from harm (ACA, 2014). In addition to specialized training, specialized credentials help communicate areas of expertise to the adult public.

One barrier is that relatively few therapist have specialized credentials such as RPT/S or SB-RPT. In contrasting the number of credentialed play therapists to other mental health clinicians, it is hard to determine exactly how many mental health therapists (e.g., clinical social workers, psychologist, school counselor, counselors) there are in the United States. Considering social workers, Salsburg et al. (2017) explained that according to the 2015 American Community Survey there were 850,00 social workers, and further indicated that there were approximately 350,000 licensed social workers in 2015. There is no master list of social workers nor a list of social workers by state (Salsburg, 2017). The Clinical Social Worker Association (CSWA) lists 524 members on its publically available directory (CSWA, 2019). The discrepancy in numbers is

likely due to the fact that CSWA is a specialized organization and not all clinical social workers are members of CSWA. Looking at psychologists, the 2015 American Psychological Association (APA) Survey of Psychology Health Services Providers (HSP) surveyed United States licensed, doctoral-level psychologists. The survey identified 100,305 people meeting this criterion (APA, 2016). Based off the psychologists' emails on record with APA and state licensure board records, 29,902 psychologists were identified to have APA membership and 15,693 did not have an APA membership (APA, 2016). On the survey, 44.8% of psychologists reported working in private practice and 85.9% reported working in settings that require licensure (APA, 2016). Also 34.3% of psychologists reported frequently or very frequently working with adolescents 13 to 18 years-old, 23% of psychologists reported frequently or very frequently working with children under 13-years-old, and 50% of psychologists reported never providing services to children. Looking at school counselors, there are approximately 36,000 American School Counselor Association (ASCA) members of the in the United States and territory associations (ASCA, 2019). Perhaps the clearest comparison of mental health clinicians comes from the Department of Labor's Bureau of Labor Statistics (BLS) 2016-2017 in United States. At that time, the BLS reported 577,030 mental health professionals (139,820 mental health counselors, 166,000 clinical and counseling psychologists, 112,040 mental health and substance abuse social workers, 91,040 substance abuse counselors, 25,250 psychiatrists, 42,880 marriage and family therapists (Grohol, 2019). It is notable that play therapists were not included among those listed.

Regarding play therapists, as mentioned previously in 2019, there were 2,442 RPT, 1,910 RPT-S, 29 SB-RPT, which totals to 4,381 RPT/S or SB-RPT (APT, 2020). So out of the 577,030 mental health professionals (Grohol, 2019) only 4,381 have a RPT/S or SB-RPT (APT,

2020). This would indicate that only .76% of mental health professionals are RPT/S or SB-RPT. RPT/S or SB-RPT being such a small segment of the mental health profession, may present a barrier to children receiving play therapy services. The small numbers likely result in limited visibility which may also make it more challenging for the adult public to be exposed to play therapy and to learn about its utility.

Similarly to parents, teachers and school administrators are also members of the adult public that influence children's mental health services as some children receive play therapy services in school settings. Play therapy can help the children benefit from the learning experiences offered in schools (Landreth 2012). However, teachers may be resistant to children leaving their class to "play" (Landreth, Ray, & Bratton, 2009). This can be a barrier to services if teachers and school administrators are not supportive of students receiving play therapy services at school. At the beginning of the school year, play therapist can avoid some potential barriers through teaching school personnel about play therapy. Play therapists can point out that play therapy services for their students with emotional and behavior struggles can in turn support the teacher (Landreth et al., 2009). Every 3-5 sessions, a play therapists should consult with teachers in order to learn about the child's progress in class and to gradually teach the teacher more about play therapy (Landreth et al., 2009). At the end of the school year, play therapist are encouraged to provide visual representation of children's progress in a way that protects confidentially to school administration and teachers (Landreth et al., 2009). Play therapists building relationships with school personnel can create open communication and inform their perceptions of play therapy utility.

Culture also may influence help-seeking behaviors, perceptions of play therapy, and access to information and services. Howell and McFeeters (2008) found that urban and rural

Hispanic and urban Black children receive less mental health services than rural and urban White children. For more in depth findings that are specific to play therapy, Brumfield and Christensen (2011) conducted a qualitative study. Brumfield and Christensen (2011) learned more about Black parents of children whose children have received counseling and a few whose children received play therapy. These parents believed that a parents' cultural identity impacts their view of play therapy (Brumfield & Christensen, 2011). They believed that play is an important part of developmental learning and how children have a release of stress and express themselves (Brumfield & Christensen, 2011). Parents noted that they wanted more information about play therapy resources (Brumfield & Christensen, 2011). They indicated that their perceptions of play therapy were directly influenced by their perception of the play therapists' competence (Brumfield & Christensen, 2011). Furthermore, parents may not speak the same language as the play therapist. Hispanic children are the fastest growing group of people in the population and are often at-risk for school success; it is likely that parents may speak Spanish (Garza & Bratton, 2005). Play therapists may need to have a translator, which may alter the parents' view of the perception of play therapy. Various aspects of culture appear to influence views of the adult public's perception of play therapy.

Mental Health Literacy

Therapists and the adult public have different beliefs about treatment and the cause of mental health disorders (Jorm, 2000). Much of the adult public cannot recognize mental health disorders and do not know how to label symptomology (Jorm, 2000). This is problematic because the adult public is lacking in knowledge about mental health issues or mental health literacy. Mental health literacy is "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (Jorm et al., 1997, p. 182). Jorm (2012) acknowledged

that this definition is from a Western scientific conceptualization and that cultural considerations for mental health care need to be taken in to account. Furthermore, Jorm (2012) explained that mental health literacy entails:

(a) knowledge of how to prevent mental disorders, (b) recognition of when a disorder is developing, (c) knowledge of help-seeking options and treatments available, (d) knowledge of effective self-help strategies for milder problems, and (e) first aid skills to support others who are developing a mental disorder or are in a mental health crisis. (p. 231)

When the adult public knows less about mental health disorders and symptomology, the adult public tends to use mental health services less (Jorm, 2000) and to have report more stigma about services (Corrigan et al., 2001). Even university students especially those majoring in economics, philosophy, and natural sciences tend to lack mental health information literacy (Lauber et al., 2005). The adult public's mental health literacy is improved through contact with mental health information (Christensen & Griffiths, 2000; Corrigan et al., 2001; Jorm, 2000; Lauber et al., 2005). These opportunities must be created for the adult public to learn about mental health. The Internet is a platform in which the adult public can learn about mental health service options (Christensen & Griffiths, 2000). The adult public's lack of mental health literacy likely means that the adult public does not have much play therapy mental health literacy.

Play Therapy Mental Health Literacy Internet Resources to Inform the Adult Public

There are many play therapy mental health literacy resources available on the Internet. One resource is the APT (2019a) website page entitled About APT, which informs the reader through videos and text resources about what play therapy is, why it is developmentally appropriate for children, how it is supported by research, how to find a registered play therapist, and more. Also, the APT (2019d) website has free brochures available that explain play therapy to parents in English, Spanish, and French as well as a the before mentioned brochure designed

to teach pediatricians about play therapy for 5 dollars for a package of 25 brochures. Another publicly, easily accessible resource is the University of North Texas' Center for Play Therapy (2019) website, which has a video to explain play therapy to a child and a video to explain play therapy to an adult.

Summary

To summarize, the adult public's perceptions of the utility of play therapy may be influenced by several barriers. Often there is a lack of play therapist and play therapy information in rural areas (Carnes-Holt & Weatherford, 2013; Hoeft et al., 2018; Sherman et al., 2014) and in general which may lead to skepticism about services (Landreth, 2012; O'Connor & Langer, 2018), misconceptions, or a lack of awareness about play therapy's utility. Also, culture can influence help-seeking and perceptions of play therapy (Brumfield & Christensen, 2011; Howell & McFeeters, 2008). While the public is not mental health literate, exposure to mental health information can improve it (Corrigan et al., 2001; Christensen & Griffiths, 2000; Lauber et al., 2005; Jorm, 2000). These barriers may be addressed in part by educational resources specific to the utility of play therapy.

CHAPTER III: RESEARCH METHOD AND PROCEDURE

The main purpose of the current study is to learn about the public's perception of the utility of play therapy and to determine whether information about play therapy changes these perceptions. A play therapy utility instrument, that is under development, was used to measure the adult public's perception of how useful play therapy is in facilitating children's growth. Also, the study will explore if once participants are exposed to information about play therapy if they would consider recommending play therapy services in the future. This study is not designed to measure the guardian's satisfaction with a specific child's actual usage of play therapy services.

Research Questions

Given the background presented above, this study investigated the following research questions (R). Since this is an exploratory study and there is not previous play therapy utility research to inform the hypotheses, there is not a clear idea of what the initial perception of the utility of play therapy will be.

R1: What is the initial perception of the utility of play therapy?

R2: Does this initial perception of the utility of play therapy differ significantly by various demographics: sex, race, level of education, salary, description of population in area of living, primary resource for learning mental health information, therapy usage, parent or not, have a child or not, and self-reported level of awareness of play therapy prior to exposure to information?

R3: Does exposure to information about play therapy significantly change perceived utility of play therapy services?

R4: If there is a change in perception of the utility of play therapy, does this change significantly

by demographics: sex, race, level of education, salary, description of population in area of living, primary resource for learning mental health information, therapy usage, parent or not, have a child or not, and self-reported level of awareness of play therapy prior to exposure to information?

Amazon Mechanical Turk

Amazon Mechanical Turk (MTurk) is one of the largest and one of the first crowdsourcing platforms, originating in 2005 (Beymer, Holloway, & Grov, 2018; Sheehan & Pittman, 2016). Crowdsourcing entails paying online workers small amounts of money for completing short tasks and is a way to collect large amounts of data (Sumner, Farris, & Holman, 2019). More specifically, MTurk is a marketplace that requires human intelligence as the workforce and the workers can complete tasks at their own convenience through the Internet (MTurk, 2019). The name, Mechanical Turk, was derived from an invention of Wolfgang von Kempelen, an inventor in the eighteenth century, who created what was believed to be a chess-playing artificial intelligence; however, in actuality it was a human chess master controlling the movements (MTurk, 2019). So, the name MTurk is called an “Artificial Artificial Intelligence” (MTurk, 2019, n.p.). On MTurk, there are “requesters” or researchers or individuals seeking information (Sheehan & Pittman, 2016, p. 2). These requesters post small “Human Intelligence Tasks” (HITs) for “workers,” MTurk employees, to select and complete online (Sheehan & Pittman, 2016, p. 2). There were 15,000 published papers that referenced MTurk between 2015 and 2016 and there is a large increase of its usage in social science research (Bohannon, 2016; Chandler & Shapiro, 2016).

MTurk is a low-cost, rapid method of collecting data from a variety of special populations. One of the most appealing advantages is that through MTurk requesters have

access to specialized populations and minoritized groups (Arch & Carr, 2017; Chan & Holosko, 2016; Cunningham, Godinho, & Kushnir, 2017; Dworkin, Hessel, Gliske, & Rudi, 2016; Goodman & Paolacci, 2017; Shank, 2016). Furthermore, MTurk workers' demographic information is comparable to the general population of survey respondents and it is more diverse than college student populations (Andersen & Lau, 2018; Brañas-Garza, Capraro, & Rascón-Ramírez, 2018; Cunningham et al., 2017; Follmer, Sperling, & Suen, 2017; Goodman & Paolacci, 2017; Kan & Drummey, 2018; Shank, 2016; Sheehan, 2018). Another outstanding aspect about MTurk is that requesters can recruit workers quickly (Bohannon, 2016; Cunningham et al., 2017; Goodman & Paolacci, 2017). Using MTurk, a requester can obtain a large amount of data in short time for a reasonable cost when compared to other online methods (Andersen & Lau, 2018; Bernstein & Calamia, 2018; Boas, Christenson, & Glick, 2018; Chandler & Kapelner, 2013; Dworkin et al., 2016; Goodman & Paolacci, 2017; Kan & Drummey, 2018; Walters, Christakis, & Wright, 2018). When compared to other avenues for research, MTurk has better quality data with little missing data and better at attention checks (Andersen & Lau, 2018; Boas et al., 2018; Dworkin et al., 2016; Hauser & Schwarz, 2016).

Despite workers' veracity of responses not being able to be assured and concerns about range restriction of the sample, there are many best practices that researchers can use (Arch & Carr, 2017; Azzam & Jacobson, 2013; Buchanan, 2018; Chandler & Paolacci, 2017; Follmer, Sperling, & Suen, 2017; Kan & Drummey, 2018; Sheehan, 2018). When best practices are implemented, research conducted with MTurk was shown to be reliable and valid, and it can provide reproduction studies (Goodman & Paolacci, 2017; Kan & Drummey, 2018; Sheehan, 2018; Stewart, Chandler, & Paolacci, 2017). To promote quality research, researchers may select high-reputation workers or workers who have completed 100 HITs and received at least a

95% approval rating or fewer than 5% of completed tasks had disapproval ratings from requesters (Bentley, 2018; Cunningham et al., 2017; Goodman & Paolacci, 2017; Kan & Drumme, 2018). Also, researchers may include attention checks (Beymer et al., 2018; Follmer, Sperling, & Suen, 2017; Sheehan, 2018), micro-batch (Litman et al., 2017), and provide fair pay for the workers' time (Andersen & Lau, 2018; Liu & Sundar, 2018; Sheehan, 2018; Shank, 2016; Vaughan, 2018; Walters et al., 2018).

TurkPrime is a website powered by CloudResearch (2019) that uses the MTurk application programming interface (API) and additional tools and provides its own graphical user interface (GUI) (Litman et al., 2017). TurkPrime allows researchers additional features to filter MTurk employees and change the rate of MTurk data collection (Litman et al., 2017). For a small fee that is based on the sample size, TurkPrime allows researchers to filter participants who have already completed the study. This helps researchers to avoid blocking quality workers for mistakenly taking a survey more than once.

It is imperative to know Amazon's rules and terms of service (Sheehan, 2018). More specifically, requesters should make sure to abide by the *Guidelines for Academic Requesters* (2019), which is regularly updated by MTurk workers and academics (Goodman & Paolacci, 2017). The contributors to the *Guidelines for Academic Requesters* (2019) outlined ethical obligations for MTurk researchers: "clearly identify yourself," "provide reasonable time estimates," "approve work as soon as possible," "maintain worker privacy," "abide by terms of AMT [Amazon's MTurk] Terms of Service," "ensure conditions for rejecting work are clear and fair," "do not blocking workers to avoid duplicate subjects," "maintaining responsive line of communication with Turkers," and "pay a fair wage" (n.p.). The reason requesters may not block workers to avoid duplicate subjects is because the block indicates a bad-faith worker and

leads to suspension from MTurk (Guidelines of Academic Requesters, 2019). Lastly, requesters need to also follow general guidelines for research for their institution and their Institutional Review Board such as including a withdrawal-without-prejudice option for workers (Gleibs, 2017; Sheehan, 2018).

Participants

Participants were 298 MTurk workers who were above the age 18 and had at least an MTurk satisfaction rating of 95%. Participants were recruited through MTurk and participation was voluntary. Participants were not punished for withdrawing from the study. Some participants received counseling or other mental health services before. Participants will be technology savvy as they are MTurk workers.

Of the 298 participants, 167 (56.04%) were male, 130 (43.62%) were female, and 1 (.34%) was nonbinary / third gender. Participants' ages were between 18 years and 80 years with most participants' ages being between 31 years and 50 years. One hundred and ninety-eight (66.4%) participants identified as White while the remaining 33.56% identified as non-White. Please refer to Chapter Four for more detailed descriptions of the sample.

Procedure

Before commencing the study, necessary approvals were received. Approval to begin the study was obtained from the dissertation committee and exemption status was granted by the University of Arkansas Institutional Review Board Human Use Committee (IRB) (See Appendix A for IRB approval letter). After these approvals, the survey was posted on MTurk for people above the age of eighteen from the public who have at least a satisfaction rating of 95%.

Participants were recruited through MTurk or TurkPrime using standard MTurk recruiting procedures. From MTurk or TurkPrime, participants selected a link to an online

Google Form survey. All participants received informed consent to participate in the study. Respondents completed an online self-report survey that included demographic information, questions pertaining to usage of mental health and play therapy services, and a 1:25 minute video. Participants were asked to respond to a Likert scale instrument before and after watching a video that provided information about play therapy. For the purposes of determining response quality, control questions, such as “What drink was mentioned in the video?” were inserted into the survey.

Participants were compensated with 90 United States cents which corresponds to minimum wage for anticipated time needed to complete the survey. MTurk rewarded participants from a fund that was pre-established. When an attention check question was answered incorrectly, the participant was not paid and their work was not included in the data set. Collected data was analyzed using statistical analysis software to determine the relationships between variables related to the research purpose. As this project consisted of anonymous self-report, the risk of harm was no greater than what would normally be present in everyday computer use. In case a participant was troubled by the study, the National Alliance on Mental Illness (NAMI) crisis service helpline phone number and hours of operation, the NAMI crisis after-hours text line, and the NAMI (2019) website for more information were listed.

Responses were kept as anonymous as the technologies/systems utilized allowed. MTurk supplies each worker a unique work identification (ID) code which is a semi-random alphanumeric string. All data the researcher received was associated with this ID. While the primary researcher may view the worker’s ID, the primary researcher does not know the person’s name associated with the ID. Workers entered their ID at the beginning of the survey and their secret code consisting of the last four characters of their ID at the end of the survey. This secret

code served as a control question and indicated that it was indeed a person, not a machine taking the survey. Once the researcher confirmed that the ID and secret code are a match, the ID and code were deleted to create de-identified data.

G (Google) Suite, which includes Google Forms and Google Sheets as well as MTurk work to protect data. Google Forms and MTurk provide the same level of protection of personal data used for Amazon.com services such as those that protect credit card information (Litman, 2015). MTurk and G Suite provide end-to-end encryption through Hypertext Transfer Protocol Secure (HTTPS) which indicates that data shared between users and websites is being transmitted securely using a Transport Security Layer (TLS) protocol (Amazon Payments, 2019; Google, 2019). TLS uses cryptographic system that creates public and private keys and website users can view encryption certificate authority through clicking the lock symbol next to the HTTPS web address (Amazon Payments, 2019; Google, 2019). MTurk and G Suite use a https web address rather than a http to indicate this TLS protection (Amazon Payments, 2019). In 2013 for message communication, Google Suites doubled the length of the TLS encryption keys with a Rivest-Shamir-Adleman (RSA) algorithm to 2048 bits and the keys are changed every few weeks (Google, 2019). Also, G Suite uses Perfect Forward Secrecy (PFS) to accompany the HTTPS; even if someone had access to the originally used secret key, in the future they would not be able to decrypt or leak any of the original HTTPS session (Higgins, 2013). Furthermore, Internet Protocol (IP) addresses were masked or removed. The researcher used a Virtual Privacy Network (VPN) for protection between a device and a server to protect data when it was downloaded (Rasmussen, 2019).

Data Collection

The study was posted on MTurk and TurkPrime. Once MTurk workers selected the HIT on MTurk or TurkPrime, they clicked a link to the Google Form online survey. The data was password protected by at least two password walls. The participants' names were not associated with the data, only the participants' MTurk ID which was deleted to de-identify data. The first two batches of 50 participants were collected with MTurk and the rest of the participants were collected through TurkPrime which allows for more research filtering of MTurk employees. TurkPrime was used to avoid collecting data from the same participant twice. The larger batch of about 250 participants' data was collected through automated micro-batching, a feature of TurkPrime which slows down data collection to increase sample representativeness (Litman et al., 2017). Once the data was collected, the data was cleaned. Any participant's data that did not have the correct answer to the attention check questions were not included in the data set. Seven participants' data were set aside: 4 participants missed the attention check question and 3 participants had already taken the survey so their second time taking it was set aside. The participants who took the survey twice were paid twice even though their second set of data was set aside as the researcher accepted responsibility for not adequately filtering them out and worked to abide by the *Guidelines for Academic Requesters* (2019). Many of the demographic variables were aggregated to create more equal sized groups for the Analysis of Variance (ANOVAs). For instance, race was aggregated as White and non-White. Another example is that many participants typed in their own profession rather than selecting an available category, so the unique occupations were sorted in to existing categories and new categories such as the service industry were created. Statistical packages such as Excel with Analysis ToolPak and Statistical Analysis System (SAS) were used to organize and analyze the data.

Instrument

As there is not a measure for play therapy utility in the literature, the Play Therapy Utility Measure is under exploratory development as part of this study. The instrument created for the present study is a 14-item self-report questionnaire that measures perception of what situations play therapy can be used to facilitate growth and attitudes of developmental appropriateness for children on a 5-point Likert scale: (1) *strongly disagree*, (2) *disagree*, (3) *neutral*, (4) *agree*, (5) *strongly agree*. In greater detail, the instrument measures the utility of play therapy which is the degree to which a participant perceives play therapy to be developmentally appropriate for children and facilitates children's growth in developing social, emotional, cognitive, and behavioral skills interacting with or adapting to one's environment. The play therapy utility instrument scale score range is 1 to 5. The scale score was found by taking the average of possible response items if answered 1 on all items ($14/14 = 1$) and then taking the average of response items if answered 5 on all items ($70/14 = 5$). Lower scores indicate that participants do not view play therapy as useful and higher scores indicate that participants view play therapy as very useful. Participants answered the instrument before and after viewing a video about play therapy. The definition of play therapy presented before the instrument and the instrument items have a Flesch-Kincaid Grade Level of 8.8 or below. To see the whole survey that includes the instrument, view Appendix C.

Approach for Statistical Analyses

In this section, a data analysis approach is described. First preliminary analyses were conducted. Next primary analyses were conducted to address the research questions.

Statistical Approach for Preliminary Analyses

Descriptive statistics and the internal consistency of the instrument were investigated prior to conducting the primary analyses. Inter-correlations among each of the samplings of the scales were also conducted to explore the relationships among variables and to ensure that each represented similar findings.

Statistical Approach for Primary Analyses

This section contains the data analysis approach selected to address the primary research questions.

R1: What is the initial perception of the utility of play therapy?

For R1, a CI was used to estimate the average initial perception of participants.

R2: Does this initial perception of the utility of play therapy differ significantly by various demographics such as age, gender, race, having children, education level, and experience with therapy?

Between-subjects analysis of variance (ANOVA) analyses were used to address R2.

R3: Does exposure to information about play therapy significantly change perceived utility of play therapy services?

If all statistical assumptions are held, a pre-post comparison and a paired/dependent two-sample *t*-test will be used to address R3.

R4: If there is a change in perception of the utility of play therapy, does this change significantly by demographic variables?

Between-subjects ANOVA analyses were used to address R4.

Summary

In this chapter, the research procedure and methodology were explained. The research questions were described. MTurk as a research tool was explained. The participant selection, study procedures, and data collection process were shared. The purpose for the play therapy utility instrument was explained. Lastly the statistical approaches for addressing each research questions was described.

CHAPTER IV: FINDINGS

The following chapter has five sections. The first section provides the demographic descriptive statistics. The second section addresses the internal consistency reliability of the instrument. The third section addresses the statistical assumptions for the primary analyses. The fourth section reports analytic results from the research questions outlined in Chapter Three. The final section is a summary of the findings in this study.

Demographic Descriptive Statistics

Participants were 298 MTurkers who were between 18 and 80 years of age with most participants having an age between 31 and 50 years-old (See Table 4.1).

Table 4.1: *Sample Demographic: Age*

<i>Age Range</i>	<i>Frequency</i>	<i>Percent</i>	<i>Cumulative Frequency</i>	<i>Cumulative Percent</i>
18-30	53	17.79	53	17.79
31-40	120	40.27	173	58.05
41-50	72	24.16	245	82.21
51-80	53	17.79	298	100

There were 167 (56.04%) male participants, 130 (43.62%) female participants, and 1 (.34%) nonbinary / third gender participants (See Table 4.2).

Table 4.2: *Sample Demographic: Sex*

<i>Sex</i>	<i>Frequency</i>	<i>Percent</i>	<i>Cumulative Frequency</i>	<i>Cumulative Percent</i>
Male	167	56.04	167	56.04
Female	130	43.62	297	99.66
Nonbinary / Third gender	1	.34	298	100

There were 198 (66.44%) White participants and 100 (33.56%) non-White participants (See Table 4.3). See Appendix D for more detail on participants' race.

Table 4.3: *Sample Demographic: Race*

<i>Race</i>	<i>Frequency</i>	<i>Percent</i>	<i>Cumulative Frequency</i>	<i>Cumulative Percent</i>
White	198	66.44	198	66.44
Non-White	100	33.56	298	100

There was a range of the reported highest level of school completed: 57 (19.13%) high school or less education (less than high school diploma or high school diploma or equivalent), 54 (18.12%) Associate's or vocational degree (e.g., AA, AGS or equivalent, completion of 60 semester credit hours at a college / university, or vocational / technical school certificate, 141 (47.32%) Bachelor's degree (e.g., BS, BFA), 46 (15.44%) Master's, Doctoral or terminal degree in field (e.g., MA, MS, Med, MAT, PhD, EdD, JD, or DNP) (See Table 4.4).

Table 4.4: *Sample Demographic: Highest level of School Completed*

<i>Degree</i>	<i>Frequency</i>	<i>Percent</i>	<i>Cumulative Frequency</i>	<i>Cumulative Percent</i>
High School or Less Education	57	19.13	57	19.13
Associate or Vocational Degree	54	18.12	111	37.25
Bachelor's Degree	141	47.32	252	84.56
Master's, Doctoral, or Terminal Degree	46	15.44	298	100

Participants had many areas of current work / study with 131 (43.96%) working in business management, marketing, computer and information sciences, and related support services, 51 (17.11%) working in science, technology, engineering, and mathematics (STEM), 25 (8.39%) service industry, 25 (8.39%) working in education, 15 (5.03%) working in architecture and related services such as construction and skilled labor, 12 (5.03%) working in humanities (not

related to mental health), 9 (3.02%) working in physical health professions and related programs (e.g., nursing, athletic trainer, pre-veterinary studies, nutrition), 9 (3.02%) working in visual and performing arts (e.g., art history, drama, fashion apparel design, game design, music) 3 (1.01%) working in mental health professions (e.g., counselor, school counselor, social work, psychology, psychiatry), 6 (2.01%) public service such as law and security, and 6 (2.01%) homemaker and unemployed (See Table 4.5). Since many participants self-identified by typing in their occupation rather than selecting an existing work category, these unique responses were sorted into existing and additional categories.

Table 4.5: *Sample Demographic: Areas of Current Work / Study*

<i>Areas of Work / Study</i>	<i>Frequency</i>	<i>Percent</i>	<i>Cumulative Frequency</i>	<i>Cumulative Percent</i>
Business Management, Marketing, Computer and Information Sciences, and Related Support Services	131	43.96	131	43.96
Science, Technology, Engineering, and Mathematics (STEM)	51	17.11	182	61.07
Service Industry	25	8.39	207	69.46
Education	25	8.39	232	77.85
Architecture and Related Services	15	5.03	247	82.89
Humanities (NOT related to mental health)	12	4.03	259	86.91
Physical Health Professions and Related Programs	9	3.02	268	89.93
Visual and Performing Arts	9	3.02	277	92.95
Agriculture and Related Sciences	6	2.01	283	94.97
Homemaker / Unemployed	6	2.01	289	96.98
Public Service	6	2.01	295	98.99
Mental Health Professions	3	1.01	298	100

Participants had combined family income (or household income) category with 119 participants (40.07%) having \$0-\$39,999, 112 participants (37.71%) having \$40,000-\$79,999, and 66 participants (22.22%) having \$80,000 or more (See Table 4.6).

Table 4.6: *Sample Demographic: Combined Family Income*

<i>Income</i>	<i>Frequency</i>	<i>Percent</i>	<i>Cumulative Frequency</i>	<i>Cumulative Percent</i>
\$39,999 or Less	119	40.07	119	40.07
\$40,000- \$79,999	112	37.71	231	77.78
\$80,000 or more	66	22.22	297	100

Participants described the area in which they live: 118 (39.4%) urban, 121 (40.6%) suburban, and 59 (19.8%) rural (See Table 4.7).

Table 4.7: *Sample Demographic: Areas of Living*

<i>Area of Living</i>	<i>Frequency</i>	<i>Percent</i>	<i>Cumulative Frequency</i>	<i>Cumulative Percent</i>
Rural	59	19.8	59	19.8
Suburban	121	40.6	180	60.4
Urban	118	39.6	298	100

One hundred and three (34.56%) participants reported learning most about mental health from online educational resources (e.g., TedTalk(s) / YouTube / educational Internet video(s), or informational website(s)), 101 (33.89%) social resources (e.g., friend(s) or family, Facebook community groups, television / movie(s) or social media), and 85 (28.53%) professional (a mental health professional such as a school counselor, counselor, psychologist, psychiatrist, medical doctor(s) who do(es) not specialize in mental health, or course(s) / workshop(s) or

book(s)). There were nine participants whose data on mental health resources were not applicable since they reported not knowing about mental health resources or reported using various resources; the data about resource information for these participants was set aside (See Table 4.8).

Table 4.8: Sample Demographic: Primary Mental Health Informational Resource

<i>Resource</i>	<i>Frequency</i>	<i>Percent</i>	<i>Cumulative Frequency</i>	<i>Cumulative Percent</i>
Online	103	34.56	103	34.56
Educational				
Social	101	33.89	204	68.46
Professional	85	28.52	289	96.98
Not Applicable	9	3.02	298	100

Ninety-two participants (30.87%) said they had received mental health services, and 18 participants (6.04%) said they had received play therapy services. One hundred and thirty-eight participants (61.41%) said they had a close friend or family member who received mental health services and 47 (15.77%) reported they had a friend or family member who received play therapy services. This information was aggregated for data analyses. There were 105 participants (35.23%) who had not received personal mental health therapy and did not have a friend who received mental health therapy, 101 participants (33.89%) who had not received personal mental health therapy but had a friend who received mental health therapy, and 92 participants (30.87%) who had received personal mental health therapy (See Table 4.9).

Table 4.9: *Sample Demographic: Mental Health Therapy Usage*

<i>Income</i>	<i>Frequency</i>	<i>Percent</i>	<i>Cumulative Frequency</i>	<i>Cumulative Percent</i>
No Personal therapy and no friend had therapy	105	35.23	105	35.23
No Personal therapy but a friend had therapy	101	33.89	206	69.13
Had Personal Therapy	92	30.87	298	100

One hundred and fifty-three participants (51.34%) reported being a parent (See Table 4.10).

Ninety-three participants (31.21%) said they have at least one child 12-years-old or younger.

Table 4.10: *Sample Demographic: Parent*

<i>Parent</i>	<i>Frequency</i>	<i>Percent</i>	<i>Cumulative Frequency</i>	<i>Cumulative Percent</i>
Yes	153	51.34	153	51.34
No	145	48.66	145	100

Participants had varying awareness of play therapy pre-play therapy information with 58 (19.46%) reporting “I know what play therapy is,” 125 (41.95%) reporting “I have never heard of play therapy,” and 115 (38.59%) “I think I have heard of play therapy, but am unsure of what it is” (See Table 4.11).

Table 4.11: *Sample Demographic: Awareness of Play Therapy Pre-Information*

<i>Awareness</i>	<i>Frequency</i>	<i>Percent</i>	<i>Cumulative Frequency</i>	<i>Cumulative Percent</i>
I have never heard of play therapy.	125	41.95	125	43.10
I think I have heard of play therapy, but am unsure of what it is.	115	38.59	240	82.76
I know of what play therapy is.	58	19.46	290	100

Internal Consistency Reliability

Internal consistency reliability was assessed using coefficient alpha for the play therapy utility instrument. With all 14 items, the internal consistency reliability level was moderately strong for the instrument with values above .80 for both times the instrument was completed, pre and post receiving information about play therapy. Once items 3, 6, and 13 were removed due to factor loadings less than .4, the internal consistency reliability level was strong with values above .87. The removal of these items will be explained more in the below paragraphs. The standard error of measurement (SEM) was slightly higher for the post instrument completions when compared to the pre-instrument completions. The average score was slightly higher for the post instrument completion, indicating higher level of utility of play therapy (See Table 4.12).

Table 4.12: *Reliability and SEM for the Play Therapy Utility Instrument*

Timing	Number of Items	N	M	SD	Min.	Max.	Coefficient Alpha	SEM
Pre-information	14	298	4.128	.483	2.286	5.000	.811	.028
Post-information	14	298	4.22	.516	2.214	5.000	.838	.030
Pre-information	11	298	4.212	.545	2.091	5.000	.874	.032
Post-information	11	298	4.335	.565	2.000	5.000	.902	.033

A principal component analyses were conducted to determine if the play therapy utility instrument's items load as one predicted factor. Principal component analyses were conducted for the play therapy utility instrument at both pre- and post-information collections. Some traditional selection criteria, such as the Kaiser Criterion, would suggest a two-factor model. However, there are still some arguments that suggest this instrument is essentially unidimensional. There are several procedure designs that indicate the optimal level of factors for principal component analysis such as parallel factor analysis (Horn, 1965), acceleration factor and optimal coordinates (Raïche et al., 2013), and very simple structure criterion (Revelle & Rocklin, 1979). Another approach is Cattell's (1966) scree plot method which indicates that the point on the curve where the slope changes notably, sometimes called the elbow or the bend, and the components to the left of this point should be retained as significant. Through Cattell's scree plot method, a 1-factor model was selected (See Figure 4.1).



Figure 4.1: *Scree Plot Pre-Information Eigenvalues for the 11-Item Instrument*

Note: This figure shows the slope of the eigenvalues for the 11-item instrument.

On the 1-factor model, there is a high coefficient alpha with 14 items ($\alpha = .8108$) and also with 11 items ($\alpha = .8740$). On the initial analyses, items 3 (reverse coded, pre-information .31, post-information .35), 6 (reverse coded, pre-information -.06, post-information .04) and 13 (pre-information .26 and post-information .30) had factor loadings less than .4, so all three items were removed and the principal component analyses were conducted with the remaining 11 items (See Table 4.13 and Table 4.14).

Table 4.13: *1-Factor Primary Principal Components Analysis with 14-items*

	Pre	Post
Item 1	.58 *	.76 *
Item 2	.45 *	.47 *
Item 3	.31	.35
Item 4	.69 *	.71 *
Item 5	.80 *	.74 *
Item 6	-.06	.04
Item 7	.73 *	.78 *
Item 8	.79 *	.78 *
Item 9	.77 *	.76 *
Item 10	.68 *	.69 *
Item 11	.66 *	.76 *
Item 12	.66 *	.73 *
Item 13	.26	.30
Item 14	.67 *	.67 *

Items 3 and 6 were reverse coded. Values greater than .4 are flagged by "*."

Table 4.14: *1-Factor Primary Principal Components Analysis with 11-items*

	Pre		Post	
Item 1	.58	*	.76	*
Item 2	.45	*	.48	*
Item 4	.70	*	.72	*
Item 5	.80	*	.74	*
Item 7	.72	*	.78	*
Item 8	.78	*	.77	*
Item 9	.78	*	.78	*
Item 10	.69	*	.70	*
Item 11	.66	*	.77	*
Item 12	.67	*	.74	*
Item 14	.67	*	.68	*

Values greater than .4 are flagged by "*."

Pre-Information

When the instrument was given pre-information, the two largest eigenvalues were 5.201 and 1.043 (See Table 4.15). The proportion of variance accounted for (using a 1-factor solution) was .4728 (See Table 4.15). The Kaiser Criterion was considered in selecting which factors to select how many factors to retain. There were 2 eigenvalues greater than 1.0, so the Kaiser Criterion would indicate a 2-factor model. However, Cattell's scree plot method was ultimately used and indicated a 1-factor model, which was used (See Figure 4.1). The range of factor loadings of items was .45 to .80 (See Table 4.14). Item 2 had the lowest factor loading with the lowest communality of .204. It appears overall that after removal of items 3, 6, and 13 the remaining pre-information items load moderately well (See Table 4.15).

Table 4.15: *Pre-Information Eigenvalues of the Correlation Matrix for 11-items*

	Eigenvalue	Difference	Proportion	Cumulative
1	5.20094760	4.15776012	.4728	.4728
2	1.04318748	.13268812	.0948	.5676
3	.91049937	.19749211	.0828	.6504
4	.71300725	.08816922	.0648	.7152
5	.62483803	.05690189	.0568	.7720
6	.56793615	.04974297	.0516	.8237
7	.51819317	.09089469	.0471	.8708
8	.42729848	.02801912	.0388	.9096
9	.39927936	.08034080	.0363	.9459
10	.31893856	.04306403	.0290	.9749
11	.27587454		.0251	1.0000

Post-Information

When the instrument was given post-information, the two largest eigenvalues were 5.752 and 1.070 (See Table 4.16). The proportion of variance accounted for (using a 1-factor solution) was .5229 (See Table 4.16). There were 2 eigenvalues greater than 1.0, so the Kaiser Criterion would indicate a 2-factor model (See Table 4.16). However, Cattell's scree plot method was ultimately used and indicated a 1-factor model, which was used. The range of factor loadings of items was .47 to .97 (See Table 4.15). Item 2 on had the lowest factor loading with the lowest communality of .2269. It appears overall that after removal of items 3, 6, and 13 the remaining post-information items load moderately well (See Table 4.16).

Table 4.16: *Post-Information Eigenvalues of the Correlation Matrix for 11-items*

	Eigenvalue	Difference	Proportion	Cumulative
1	5.75150346	4.68115296	.5229	.5229
2	1.07035051	.24719681	.0973	.6202
3	.82315370	.20498454	.0748	.6950
4	.61816916	.07582806	.0562	.7512
5	.54234109	.06444339	.0493	.8005
6	.47789770	.04288494	.0434	.8439
7	.43501277	.04116610	.0395	.8835
8	.39384667	.05248427	.0358	.9193
9	.34136240	.02235648	.0310	.9503
10	.31900592	.09164930	.0290	.9793
11	.22735662		.0207	1.0000

Statistical Assumptions

The statistical assumptions were checked for the statistical analyses. The assumptions are addressed in relation to the research questions and analyses.

Assumptions for R1: What is the initial perception of the utility of play therapy?

A confidence interval for a population mean must meet inferential procedure assumptions of having random sampling of the data and either normality or a large sample size. For R1, normality was assessed with the Shapiro-Wilk's test. Given the relatively large sample size (i.e., > 30), all assumptions for confidence interval estimation were tenable.

Assumptions for R2: Does this initial perception of the utility of play therapy differ significantly by various demographics?

Similarly to R1, for R2, the observed pre-information data was used. The between-subjects ANOVA assumptions are independence of the data, normality, and Homogeneity of Variance (HOV) (Maxwell, Delaney, & Kelley, 2018). Independence was supported through sampling method as each participant just took the survey once. Normality was violated for all independent variables of interest: sex, race, level of education, salary, description of population in area of living, primary resource for learning mental health information, therapy usage, parent or not, have a child or not, and self-reported level of awareness of play therapy prior to exposure to information. HOV was assessed with Levene's test. HOV was met for all the independent variables of interest except for the primary resource for learning mental health information variable. Since there was only one non-binary individual in the sample, this one person was set aside for only the analyses for sex to help create more equal group sizes.

It is important to note that the ANOVA test is robust to violations to the normality assumption, moderate violations to HOV, and violations to independence of errors assumptions (Maxwell et al., 2018). Maxwell et al. (2018) robustness refers to the "extent to which a statistical method produces correct results even when its assumptions fail to hold" (p. 135). This robustness indicates that even when assumptions are not met perfectly, the actual Type I error rate is usually close to the nominal or desired value (Maxwell et al., 2018).

Assumptions for R3: Does exposure to information about play therapy significantly change perceived utility of play therapy services?

The assumptions for a dependent *t*-test are that the two groups of data are paired, no significant outliers, normality of the paired differences, and continuous data (DataNovia, 2018).

The data is paired as the same person took the play therapy utility instrument pre and post-information. For the change from pre-information to post-information, Kolmogorov-Smirnov, the goodness of fit tests for normality, was violated with p -values less than .05. The change between pre- and post-information was not normally distributed ($M = .1226$, $SD = .3038$) skewness of .2473 and kurtosis of 3.6963. There are outliers or extreme observations (See Table 4.17) and the data does not fit a normal distribution (See Figure 4.2). The data from the instrument is from a Likert scale, so it is not exactly continuous; it is quasi-interval, so it is categorical/qualitative in an ordinal nature and numeric in discrete nature.

Table 4.17: *Extreme Observations*

Lowest		Highest	
Value	Observation	Value	Observation
-1.272727	265	.818182	259
-.818182	44	.909091	27
-.727273	66	1.000000	228
-.545455	177	1.363636	296
-.545455	128	1.545455	25

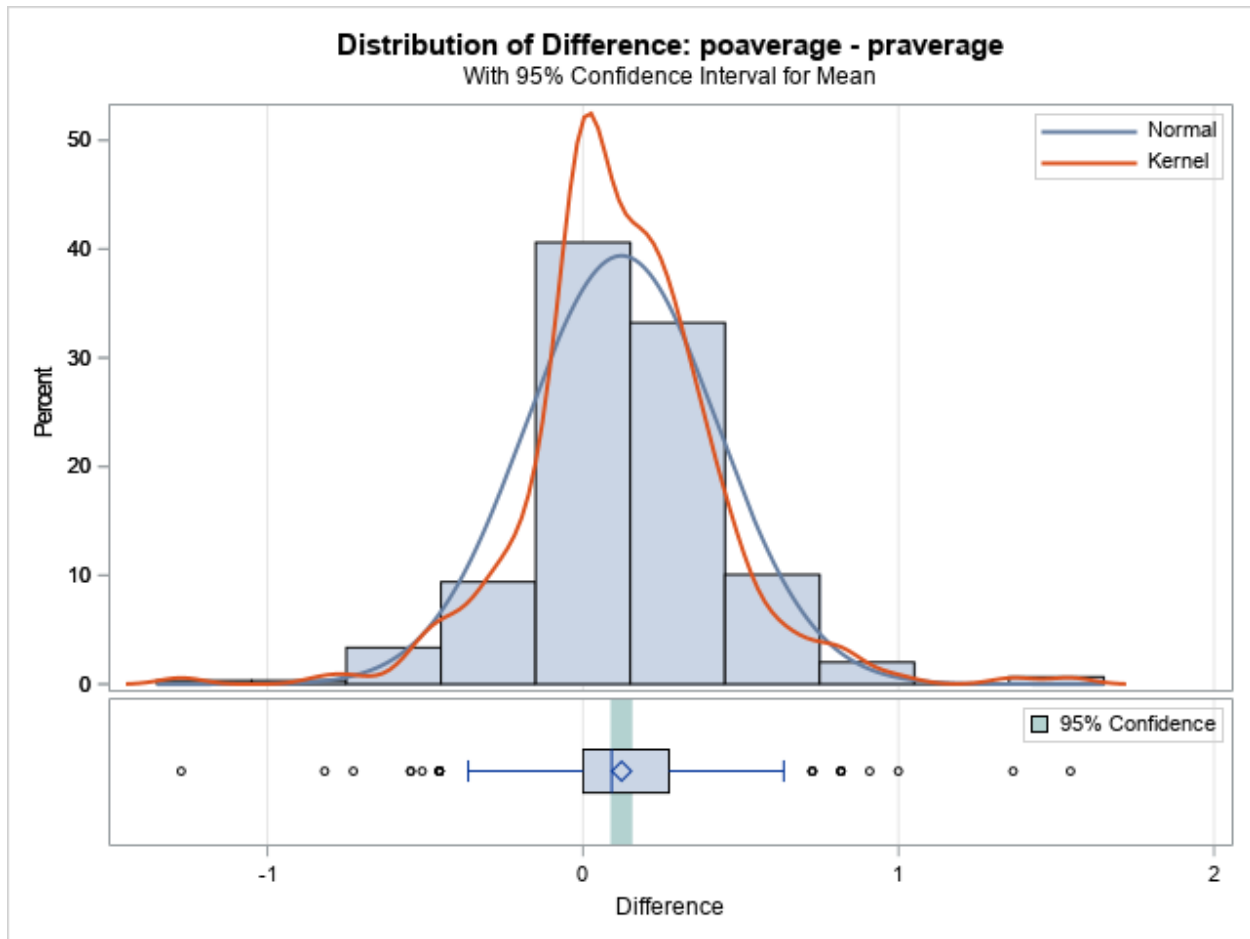


Figure 4.2: *Histogram to See Distribution*

Note. This figure shows that the data is not normally distributed.

Assumptions for R4: If there is a change in perception of the utility of play therapy, does this change significantly by demographic variables?

Independence of the data, normality, and HOV, were assessed for the ANOVA (Maxwell et al., 2018). For R4, the change in perceptions from pre-to post-information were used. The independence of the data is supported by the sampling method. Participants took the survey independently as each participant only took the survey one time. Normality of the dependent variable, change in perception from pre- to post-information, distribution was assessed with Shapiro-Wilk's test using residuals. Normality was violated for all independent

variables of interest: sex, race, level of education, salary, description of population in area of living, primary resource for learning mental health information, therapy usage, parent or not, have a child or not, and self-reported level of awareness of play therapy prior to exposure to information. HOV was assessed with the Levene's test. The HOV assumption was met for all independent variables of interest: sex, race, level of education, salary, description of population in area of living, primary resource for learning mental health information, therapy usage, parent or not, and have a child or not.

Analytic Results

The findings to the primary analyses are addressed in regard to each research question. For research questions 2 and 4, a Kruskal-Wallis' test and a Dwass, Steel, Critchlow-Flinger (DSCF) post-hoc analyses, a pairwise two-sided multiple comparison analyses, were conducted when the omnibus/overall analysis indicated significant main effects.

R1: What is the initial perception of the utility of play therapy?

Data about participants' awareness of play therapy was collected. When the participant was asked after viewing information about play therapy if the participant would recommend play therapy services in the future, 80 (26.85%) said definitely will, 101 (33.89%) said very likely, 99 (33.22%) said likely, 17 (5.70%) said not likely, and 1 (.34%) said definitely not. Even before play therapy information was presented, participants tended to view play therapy as useful. The initial perception of the utility of play therapy is $M = 4.212$, $SD = .545$, 95% CI [4.150, 4.274] with skewness of -.689 and kurtosis of .555.

R2: Does this initial perception of the utility of play therapy differ significantly by various demographics such as sex, race, having children, education level, and experience with therapy?

Since all demographic variables violated Shapiro-Wilk's test for normality, the Kruskal-Wallis' test, nonparametric alternative to the one-way ANOVA test (Maxwell et al., 2018), was used for all pre-information averages.

Sex

A Kruskal-Wallis' test indicated that female participants (Mean rank =162.35) had a significantly more positive initial perception of the utility of play therapy than male participants (Mean rank =138.61), $\chi^2(1) = 5.60, p = .02$ (See Table 4.18).

Self-reported level of awareness of play therapy prior to exposure to information

Also, a Kruskal-Wallis' test indicated a significant difference in self-reported level of awareness of play therapy prior to exposure to information, $\chi^2(2) = 9.18, p = .01$ with a mean rank of 161.81 for those who think they heard of play therapy but are unsure what it is, a mean rank of 131.75 for those who have never heard of play therapy, and a mean rank of 163.34 for those who know what play therapy is. A DSCF post-hoc analysis indicated that participants who self-reported that think they heard of play therapy but are not sure what it is (Mean rank = 161.81) were significantly different than those who had never heard of play therapy (Mean rank = 131.75), $\chi^2(2) = 9.18, p = .01$ (See Table 4.18).

Table 4.18: *Significant Findings for Research Question 2*

Variables	DF	N	Mean Rank	Chi Square	Kruskal-Wallis test for p
Sex	1			5.60	.02
Male		167	138.61		
Female		130	162.35		
Play Therapy Awareness	2			9.18	.01
I think I have heard of play therapy, but am unsure what it is.			161.81		
I have never heard of play therapy.			131.75		
I know what play therapy is.			163.34		

Not significant at the 5% significant level

Initial perception of play therapy utility does not differ significantly at the 5% significant level by race, level of education, salary, description of population in area of living, primary resource for learning mental health information, therapy usage, parent or not, and have a child or not.

R3: Does exposure to information about play therapy significantly change perceived utility of play therapy services?

A paired-samples t -test indicated there was a significant change in perceived utility of play therapy services with post-information scores ($M = 4.335$, $SD = .565$) being higher than pre-information ($M = 4.212$, $SD = .545$), $t(297) = 6.97$, $p < .0001$, $d = .4038$. This finding needs to be

interpreted with caution as there is a statistical conclusion validity threat due to the assumption violations. Nonparametric equivalent procedures confirmed the original parametric result.

R4: If there is a change in perception of the utility of play therapy, does this change significantly by demographic variables?

Since all demographic variables violated Shapiro-Wilk's test for normality, the Kruskal-Wallis' test, nonparametric alternative to the one-way ANOVA test, was used for all pre-information averages and post-information averages.

Race

A Kruskal-Wallis test indicated that White individuals (Mean rank = 157.01) perception of the utility of play therapy changed significantly more than non-White individuals (Mean rank = 134.63), $\chi^2(1) = 4.54, p = .03$.

Education level

Also, a Kruskal-Wallis test indicated change in perception of the utility of play therapy differed significantly by education level, $\chi^2(3) = 8.18, p = .04$, with a mean rank of 171.32 for those with an associate degree or vocational degree, a mean rank of 164.19 for those with a high school degree or less education, a mean rank of 139.41 for those with a terminal bachelor's degree, and a mean rank of 136.61 for those with a master's degree or higher degree. A DSCF post-hoc analysis, indicated that there were no significant findings. Since overall significance is detected and the post-hoc does not detect significance, there are differences but the differences could be complex differences between the groups. Perhaps, a combination of groups differs from another combination of groups but no two individual groups differ. So, there is evidence of group differences, but the post-hocs are unable to adequately discern where these differences are. Once the multiple pairwise comparisons occur, there may not be enough power.

Self-reported level of awareness of play therapy prior to exposure to information

Additionally, a Kruskal-Wallis test indicated change in perception of the utility of play therapy differed significantly by self-reported level of awareness of play therapy prior to exposure to information, $\chi^2(2) = 6.50, p = .04$, with a mean rank of 124.36 for those who self-reported knowing what play therapy is, mean rank of 152.42 for those who think they heard of play therapy but are not sure what it is, and a mean rank of 158.48 for those who have never heard of play therapy (See Table 4.19). A DSCF post-hoc analysis indicated that participants who self-reported that they knew what play therapy was (Mean rank = 124.36) were significantly different than those who had never heard of play therapy (Mean rank = 158.48), $\chi^2(2) = 6.50, p = .04$ (See Table 4.19).

Table 4.19: *Research Question 4: Significant Changes by Variable*

Variables	DF	N	Mean Rank	Chi Square	Kruskal-Wallis test for <i>p</i>
Race	1			4.54	.03
White		198	157.01		
Non-White		100	134.63		
Education Level	3			8.18	.04
Associate degree or vocational degree		54	171.32		
High school degree or less		57	164.19		
Terminal bachelor's degree		141	139.41		
Master's degree or higher		46	136.61		
Play Therapy Awareness	2			6.50	.04
I think I have heard of play therapy, but am unsure what it is.		115	152.42		
I have never heard of play therapy.		125	158.48		
I know what play therapy is.		58	124.36		

Not significant at the 5% significant level

A Kruskal-Wallis test indicated change in perception of the utility of play therapy differed at the 10% significance level for participants who have a child ($M = 135.22$) when compared to individuals who do not have a child ($M = 155.98$); however, at the 5% significance level having a child is not significant, $\chi^2(1) = 3.76, p = .05$. Change in perception of utility of play therapy did not differ significantly at the 5% significance level by salary, description of

population in area of living, primary resource for learning mental health information, therapy usage, parent or not, and have a child or not.

Summary of Findings

Statistical assumptions were assessed. All pre-information averages violated Shapiro-Wilk's test for normality, met Levene's test for HOV (except primary resource for learning mental health information), and met independence due to the sampling method. All the change in perceptions from pre-to post-information averages violated Shapiro-Wilk's test for normality, met HOV, and met independence. Since there are some threats to statistical conclusion validity, findings need to be interpreted cautiously. Non-parametric procedures were used to increase statistical conclusion validity.

Statistical analyses were completed to reveal findings. To address research question 1, participants' initially perceived play therapy as useful. To address research question 2, initial perception of the utility of play therapy does differ significantly by sex and self-reported awareness of play therapy prior to exposure to information. Female participants had a significantly more positive initial perception of the utility of play therapy than male participants. A DSCF post-hoc analysis indicated that participants who self-reported that think they heard of play therapy but are not sure what it is were significantly different than those who had never heard of play therapy. To address research question 3, exposure to information about play therapy did change perceived utility of play therapy services. To address research question 4, change in perception of the utility of play therapy, does this change significantly by race, education level, and self-reported awareness of play therapy prior to exposure to information. White individuals' perception of the utility of play therapy changed significantly more than non-White individuals. Change in perception of the utility of play therapy differed significantly by

education level for those with an associate degree or vocational degree, those with a high school degree or less education, those with a terminal bachelor's degree, and those with a master's degree or higher degree. While there is evidence of education level group differences, the post-hocs were unable to adequately discern where these differences were among the education levels. Lastly, participants who self-reported that they knew what play therapy was were significantly different than those who had never heard of play therapy.

CHAPTER V: DISCUSSION

In chapter five, the interpretation of the findings and implications are provided. Also, the limitations and possible confounds are shared such as limitations with demographic representativeness, the instrument being underdevelopment, and the threats to statistical conclusion validity.

Interpretation of Findings

Participants' ratings indicated that the participants tended to have a strong to very strong initial perception that play therapy is useful. Female participants tend to have higher initial ratings indicating a perception of greater utility of play therapy than did male participants. This finding is similar to findings on female participants' views of their own psychological services (not a child's services). Shy and Waehler (2009) found that female participants expected better outcomes from psychological services than male participants, and male participants expected more direction from the mental health service provider regardless of the terms than did female participants. Shy's and Waehler's (2009) findings, may inform findings in the present study. Perhaps after viewing the video, male participants would have rated play therapy more useful if the video had been less vague and provided more information on what to expect in the play therapy process. Also, pre-information, participants who self-reported that they think they heard of play therapy but are not sure what it is had a significantly higher initial perception of play therapy than those who had never heard of play therapy. Post-information, participants who self-reported that they knew what play therapy was were significantly different than those who had never heard of play therapy. It makes sense that those who do not know what play therapy is would not perceive play therapy to be as useful as someone who thinks they may know what play therapy is but is unsure. This trend may indicate that the more confident a participant feels

about their knowledge of play therapy, the more useful the participant viewed play therapy initially and after receiving play therapy information. This could indicate that with more play therapy mental health literacy education, the more members of the public will value and potentially select or recommend play therapy services. It appears that participants viewed play therapy as more useful after receiving information about play therapy. These findings align well with previous research which indicated that information improved general mental health literacy (Christensen & Griffiths, 2000; Corrigan et al., 2001; Jorm, 2000; Lauber et al., 2005). Even though, this finding must be interpreted with caution, it suggests that even brief education (about 1.5 minutes of information being shared) about play therapy can improve peoples' perceptions of play therapy utility. Perceptions of the utility of play therapy did change significantly after information was given by race, education level, and self-reported awareness of play therapy prior to exposure to information. Potentially this could indicate those who identify as White and those who have never heard of play therapy will be most impacted by educational play therapy outreach. In the future, it is important to explore ways to teach non-White individuals about play therapy utility. Since a post-hoc procedure could not differentiate where the change occurred among the levels of education, education level may not be as important to consider when targeting groups that would benefit most from play therapy information education.

Implications

The findings may have several implications for teaching the adult public about play therapy and influencing the public's perceptions of play therapy utility. This study supports that even a less than two-minute video on play therapy can influence adult members in the public's perceptions of play therapy utility. Interventions could be targeted based on settings such as medical, school, legislature, and community common spaces.

Medical Settings

The play therapy information video used in this study could be provided in English and additionally in Spanish on iPads used for intake paperwork and waiting room televisions doctors' offices. The video could be displayed with subtitles in case sound is a barrier to watching the video. This platform would allow parents to learn more about play therapy and to ask their pediatrician any questions especially if the child shows symptoms of depression and anxiety in the doctor's screening. It will be important that grants be written for any community clinics that do not have access to video playing materials. Additionally, it will be important for pediatricians to be aware of local no and low cost referrals for play therapy. Pediatricians can be given the APT brochure meant to help teach pediatricians about play therapy. Also, play therapists can show the video to hospital administration to advocate for more play therapy services for children who must stay at the hospital for long-term visits.

School Settings

The play therapy video could be used to teach school counselors and school administrators about the utility of play therapy. Additionally, the video could be shown at parent nights or through parent emails. Play therapy brochures which are available in several languages could be sent home in packets to parents. In order to provide play therapy services to more children at low or no cost, schools can partner with any local university programs for counselors in training internship site placements. Also, Teachers could watch the video to learn more about play therapy. This may increase their views of play therapy utility and in turn increase their support of children being pulled from class for play therapy services. In addition to the video, it will be important to share information about how play therapy research supports that play

therapy aids children's academics and language development (Blanco et al., 2012; Perryman et al., 2020).

Legislature

Systemic change is imperative in order to increase access to play therapy services and to advocate for families being able to select for a play therapist. Play therapists can share the video with politicians and lobbyists which may increase their views of play therapy utility. In addition to the video, it will be important to present the legislature information on financial, health, and socio-emotional impact of play therapy on communities. It will be important to share research about the effectiveness of play therapy to aid the legislature in advocating for the importance of play therapy service accessibility. This form of education and advocacy may have a large impact on children and their families access to quality play therapy care.

Community Common Spaces

The video could be used to reach other members of the adult public. Play therapy booths could be present at festivals and health fare events such as races with the video and play therapy skill demonstrations. Exhibits could be present in the children's section of public libraries with a list of local play therapists and resources. In order to intentionally reach minoritized groups, there could be outreach presentations and tabling at cultural community centers. It may be beneficial to show the video and do outreach education in retirement communities which may increase grandparents advocating for grandchildren and children in their communities. Other places to reach out with play therapy education and the video could be local gyms and churches. During the APT's play therapy week local play therapists and play therapy students could table outside of main shopping centers and show the video on iPads and distribute brochures. These small, educational interactions in a variety of settings may be enough to increase the adult

public's play therapy utility. Being intentional to select educational materials that are written in a variety of languages and being intentionally inclusive in the settings in which education is provided may help increase the play therapy utility of non-Whites in the adult public.

Limitations and Possible Confounds

There are some methodological limitations to the study. As a result, the present study's findings should be regarded as suggestive or interpreted with caution. One consideration is that while the participants' demographics are similar in many ways to the American public, it is not an exact representation. This may affect generalizability of the findings. There are some additional statistical caveats. Since there are some threats to statistical conclusion validity and since the play therapy instrument is in the beginning stage of development, findings need to be interpreted cautiously. Non-parametric procedures were used to increase statistical conclusion validity which may lead to greater interpretive assurance than would otherwise be the case.

In addition to methodological considerations there are some social considerations. The present study's finding, regarding preference for play therapy as related to information, will mainly be of use to people who have the privilege to choose mental health services for children.

Demographic Representativeness

The study's MTurk sample is compared to the general American public. Even though we do not know of which country participants are residence or citizens, MTurk workers are primarily from the United States (US) or India due to MTurk only paying workers in U.S. dollars and Rupees (Shank, 2016; Shatz, 2017; Vaughan, 2018). The main demographics were compared to US Census Bureau information. While the sample does not represent the general US population exactly, it is a close representation in many ways. This is similar to other research conducted with MTurk which indicated that MTurk workers' demographic information

is comparable to the general population of survey respondents and it is more diverse than college student populations (Cunningham et al., 2017; Follmer, Sperling, & Suen, 2017; Sheehan, 2018; Shank, 2016; Andersen, 2018; Brañas-Garza, Capraro, & Rascón-Ramírez, 2018; Kan & Drummey, 2018; Goodman & Paolacci, 2017).

Computer Savvy

MTurk participants are tech savvy members of the adult public. The US Census Bureau (2019) estimated that for a city with a population of 5,000 or more between the years of 2014 and 2018 there were 88.8% households with a computer and 80.4% of households have a broadband Internet subscription. So, most of Americans have access to the Internet and a computer which may suggest that most Americans are computer savvy to some extent.

Race

In the sample for this study, 66.44% of participants self-identify as White. The US Census Bureau (2019) estimated that for a city with a population of 5,000 or more, currently 76.5% of Americans are White alone. So, people who are White are slightly underrepresented in this study and non-White individuals are slightly more represented. Substance Abuse and Mental Health Services (SAMHA, 2015) conducted surveys and computed the overall annual average estimates for 2008 to 2012 on American adult mental health service usage over the past year; it was estimated that 17.1% of American adults who reported two or more races used mental health services who were followed by White adults (16.6%), American Indian or Alaska Native adults (15.6%), Black adults (8.6%), Hispanic adults (7.3%), and Asian adults (4.9%). Since minoritized racial groups do not use mental health services as often, often face oppression, and may benefit from mental health services, it is important to promote inclusive play therapy utility education to these populations. Additionally, it is important to highlight that according to

the Agency for Healthcare Research and Quality's (AHRQ, 2019) 2018 National Healthcare Quality and Disparities Report, "Blacks, American Indians and Alaska Natives (AI/ANs), and Native Hawaiians/Pacific Islanders (NHPs) received worse care than Whites for about 40% of quality measures" (2019, p. 1). So, it is imperative that play therapy utility be improved in the adult public which may increase advocacy and accessibility for minoritized populations.

Education

The US Census Bureau (2019) estimated that between years 2014 and 2018 for a city with a population of 5,000 or more than 87.7% of Americans who are 35 years or older are a high school graduate or higher and that 31.5% of Americans who are 35 years or older have a Bachelor's degree or higher. In this study's sample when considering all participants (18-years-old or older), 99.33% reported having a high school degree or equivalent or higher and 62.75% reported having a Bachelor's degree or higher. This study's question on age provided age ranges for the participant such as ages 31 to 40, so it is unclear how many participants were exactly 35 years of age or older to more directly compare with the census data; however, participants 31 years of age and older is a close comparison for reference. In this study's sample when considering participants who are 31-years-old or older, 99.18% reported having a high school degree or equivalent or higher and 59.18% reported having a Bachelor's degree or higher. It appears that the sample is relatively comparable with the census in regards to the percentage of people with a high school degree or equivalent or higher. It appears that compared to the census data, the sample over represents people who a Bachelor's degree or higher.

Area of Living

There were 39.6% of participants who live in urban areas, 40.6% live in suburban, and 19.8% live in rural areas. The 2010 US Census states that 71.2% of the US population live

urbanized areas, 9.5% suburban or urban clusters, and 19.3% in rural areas (Ratcliffe et al., 2016). This study's sample was representative of the general population in rural areas, but those that live in suburban areas were overrepresented and those in urban areas were under represented. This may be in part explained by a lack of definitions being provided to participants and participants using their own interpretation of what urban and suburban are defined as.

Household Income

There were 39.93% of participants whose combined household income was \$39,999 or less and 60.07% whose household income was \$40,000 or above. In 2018, 27.9% of US citizens had an annual household income of 34,999 or less (Duffin, 2019) and a median income of \$63,179 (Semega et al., 2019). Since participants in this study selected from ranges of income, a median cannot be reported for direct comparison. There were more people from annual lower household income represented than in the general population. However, it is notable that while the higher household incomes were not as well represented as in the general population, they did have some representation. Participants had combined family income (or household income) category with 119 (40.07%) having \$0-\$39,999, 112 (37.71%) \$40,000-\$79,999, 46 (15.49%) \$80,000-\$119,999, 16 (5.39%) \$120,000-\$159,999, and 4 (1.35%) \$160,000 or more (See Appendix D). These categories, though less aggregated are still not directly comparable to those found in Duffin (2019). In 2018, 27.9% of Americans reported household incomes of \$0 to \$34,999, 29.2% of Americans reported \$35,000 to 74,999, 27.4% of Americans reported, \$75,000 to \$149,999, and 15.5% 150,000 or more. So, whether the more or less aggregated data was considered, the lowest groups of household income are over represented when compared to the general population.

Instrument Under Development

Since this study was exploratory in nature it made it a challenge since much of the work is just the beginning of this area of research. There were no play therapy utility instruments found in a literature review. The play therapy utility instrument used in the present study is under development and is not well researched. It should be regarded as more of a questionnaire than as a standardized instrument. Several of the items were determined not to be useful and set aside but the items and the item ordering may have influenced the responses to the remaining items. The instrument will need further development

Statistical Conclusion Validity Threat

Since the data did not meet all statistical assumptions, there is a threat to statistical conclusion validity. The findings from this study need to be viewed with caution and may be suggestive rather than clearly indicate how play therapy information may affect the adult public's perception of play therapy. With this nonparametric data, a Type I error, rejecting a true null hypothesis or false positive, is potentially more probable. Data transformations such as a logarithmic transformation or a square root transformation (Maxwell et al., 2018) may be of use in the future.

Privilege to Choose Mental Health Provider

Many children with emotional, social, or behavioral difficulties do not receive psychological services or medication for severe symptomology or prevention (Simon, Pastor, Reuben, Huang, & Goldstrom, 2015). Therefore, children often do not receive services and it is even more rare that parents may choose the type of therapy their children receive. The reality in the US and in many other countries is that people often do not have choices in who their or their children's mental health providers are. Often children have Medicaid coverage and are assigned

to a school-based therapist who is assigned to a specific school and may have limited training in child development and play therapy. Even children of families who have more financial resources many not have the mental health literacy or time to take their children to a play therapist in their town or nearest town where there is a play therapist. Some families may need to bill insurance and not all play therapists will bill insurance as they prefer to take cash payments or may not be a part of an insurance panel. There is little to no academic research about parent's struggling to or being unable to choose their child's mental health services.

A National Public Radio article by Wolfson (2019) described the challenges parents face in trying to help their children receive mental health services. Wolfson (2019) describes a mother's experience of trying to find her daughter mental health therapist. The mother had good insurance and still was unable to find a therapist in her insurance network that could see her daughter in less than 3 months or that expressed competence in treating her symptoms. The mother found a therapist out of her insurance network and pays \$45 per session, but she knows families who pay \$200 a week for their child's therapy. Wolfson (2019) references data from the American Academy of Child and Adolescent Psychiatry that stated in the US there is only one child and adolescent psychiatrist for every 1,800 children in need. Wolfson (2019) recommended that parents ask pediatricians to screen their child for anxiety and depression. Also, Wolfson (2019) suggested low-cost resources such as community clinics which can be found at <http://findahealthcenter.hrsa.gov/> and contacting school counselors. This article illuminated that those with good insurance and monetary privilege are struggling to meet their children's mental health needs, so we know that those with less privilege are meeting many barriers to obtaining mental health services for their children.

The present study primarily could aid people who have the privilege to make choices to choose their mental health provider for their child. An area of future research could be to study the usefulness of play therapy educational materials to educate key decision makers in government and program developers that could impact policy development and change. These individuals are key in the potential choices that less privileged individuals are offered.

Future Research

Future research has the potential to expand and improve the current investigation. Research could replicate the present study to determine if results remain consistent. Also, the educational component of the research could be varied in the future. A researcher could investigate differences in different formats of play therapy information (e.g., video, reading, graphical information, asynchronous interaction with a play therapist, or a playful, creative intervention experience in-person or virtually) on play therapy utility. Potentially such findings would inform play therapists on the best ways to display information to different groups of people in the general public.

The current study's results found that self-identified White participants were most influenced by the educational materials. This may have been due to the nature of the materials or the interaction between a person's characteristics and materials, rather than to characteristics of the participant. In the future, researchers' samples could be broadened to resemble demographics or to enable generalization. Future research could include more minoritized groups and more international groups both as participants and as models in video materials. Additionally, it would be important to see if play therapy information not marketed to White English speaking individuals would increase minoritized individuals' perceptions of play therapy more than the materials used in the present study. This study only provided the English version

of the play therapy video, and there is a Spanish version available that could be used in future research. Also all actors in the video appeared to be White, so it will be important to have more representation of other groups in future videos. The film being more inclusive in casting and having a variety of settings such as increasing representation of a variety of races, abilities, cultures, and social economic standing may allow the video to be beneficial for more people.

The play therapy utility scale is in beginning stages of development. Psychometric research could be conducted to further develop the play therapy utility scale and build validity and reliability for the general populations and subgroups. No similar scale has been identified and this scale might be useful not just for research but as a quick measure of the information and attitudes of potential clients. The scale would require research in clinical settings supporting its adaption to the field.

There is large potential to determine the influence of play therapy information on specific groups particularly those people who refer or choose therapy for children. Many people seek mental health information from doctors (Clarke et al., 2016; Cutilli, 2010; Rains, 2007) and as a result, physicians play a big part in determining the type of therapy children receive. It would be worthwhile to examine whether play therapy information influences doctors' perceptions of play therapy utility. Mental Health professional in training could potentially be studied. For example, researchers could investigate whether masters' students' in counseling programs perceptions of play therapy utility change over their experience and exposure to play therapy information in play therapy courses and clinical experiences. Parents', foster care providers', or guardians' perceptions of utility could also be investigated as their children receive play therapy services in school, hospital/inpatient, and clinic settings.

Public policy often determines the type of therapy and mental health interventions to which a child may have access. This is particularly true for children in marginalized groups dependent on government sponsored access to therapy. It would be important to see play therapy educational information influenced people who could make powerful, large-scale systemic change (e.g., department heads, politicians, lobbyists, and insurance and health care billing employees) perceptions of play therapy. It may be that educational approaches would need to be specifically tailored for policy makers and include economic and other types of information than is required for the general public.

This study primarily involved perceptions of play therapy. An important way the research could be advanced would be to know if play therapy information not only influenced perception but if it also influenced actual help-seeking behaviors for parents to take their children to receive play therapy or advocacy for and sharing about play therapy services for children. Expanding research from perceptions to behavior would be perhaps the most important way to advance in the future.

Conclusion

Children across the world experience the stress of developmental challenges. Some children face more extreme trauma from abuse, armed conflicts, and natural disasters (International Labour Organization [ILO], 2017; UNICEF, 2017). Play therapy is beneficial for children who have experienced a wide range of stressful and traumatic situations as well as for prevention (APT, 2019h; Ray, 2017). Despite play therapy's efficacy and developmental appropriateness for children, many people are unfamiliar with it or have limited access to services. This dissertation should be regarded as an initial exploration into public knowledge and potential for public education concerning play therapy.

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APPENDICES

Appendix A: IRB Approval Letter



To: Margaret L Hindman
BELL 4188

From: Douglas James Adams, Chair
IRB Committee

Date: 12/13/2019

Action: **Exemption Granted**

Action Date: 12/13/2019

Protocol #: 1912236436

Study Title: The Adult Publics' Perception of the Utility of Play Therapy

The above-referenced protocol has been determined to be exempt.

If you wish to make any modifications in the approved protocol that may affect the level of risk to your participants, you must seek approval prior to implementing those changes. All modifications must provide sufficient detail to assess the impact of the change.

If you have any questions or need any assistance from the IRB, please contact the IRB Coordinator at 109 MLKG Building, 5-2208, or irb@uark.edu.

cc: Kristi Leann Perryman, Investigator

Appendix B: Informend Consent

Perceptions of Play Therapy

Consent to Participate in a Research Study

Principal Researcher: Margaret Hindman, MS, LAC

Faculty Advisor: Kristi Perryman, PhD, LPC-S, RPT-S

Protocol #: 1912236436

INVITATION TO PARTICIPATE

You are invited to participate in a research study about perceptions of the usefulness of play therapy. You are being asked to participate in this study because you speak English, are 18 years of age or older, and are an Amazon Mechanical Turk (MTurk) worker with a Master, high-satisfaction status (satisfaction rating of at least 95%). If you have already taken this survey, please do not take it again.

WHAT YOU SHOULD KNOW ABOUT THE RESEARCH STUDY

Who is the Principal Researcher?

Margaret Hindman, Doctoral Candidate of Counselor Education and Supervision

University of Arkansas

100 Graduate Education Building

Fayetteville, AR 72701

(479) 575-3208

mhindman@uark.edu

Who is the Faculty Advisor?

Kristi Perryman, PhD

University of Arkansas

100 Graduate Education Building

Fayetteville, AR 72701

(479) 575-3208

klperry@uark.edu

What is the purpose of this research study?

The purpose of this study is to learn about the publics' perception of the usefulness of play therapy and to explore whether exposure to information about play therapy can change the publics' perceptions of play therapy's usefulness.

Who will participate in this study?

Adults who are at least 18 years of age and are MTurk workers with high satisfaction ratings (have a MTurk satisfaction rating of at least 95%).

What am I being asked to do?

Your participation will require the following:

Complete the survey questions.

Watch a 1:20 minute YouTube video. The link to the video is provided within the survey.

You may take this survey on the computer, a tablet, or any hand-held device. You will not be asked for your name. You will be asked to provide your unique MTurk worker identification code (ID).

What are the possible risks or discomforts?

The risk of harm will be no greater than what would normally be present in everyday computer use.

What are the possible benefits of this study?

Participants may benefit by learning more about play therapy and receiving a list of play therapy resources at the end of the survey. MTurk workers will receive payment of 90 U.S. cents upon completion of the survey and providing their MTurk ID. The benefits to the researchers include data that will allow them to analyze perceptions about the utility of play therapy.

How long will the study last?

The survey is anticipated to take about 7:30 minutes.

Will I receive compensation for my time and inconvenience if I choose to participate in this study?

MTurk workers will receive 90 U.S. cents for completing the survey and providing their MTurk worker ID and secret code. Work will be rejected and not paid for if the attention check questions are not answered correctly and/or if the participant already completed the study.

Will I have to pay for anything?

There will be no cost to you for your participation other than the time spent on the survey.

What are the options if I do not want to be in the study?

If you do not want to be in this study, you may refuse to participate. Also, you may refuse to participate at any time during the study. Your MTurk employment will not be affected in any way if you refuse to participate.

How will my confidentiality be protected?

All information will be kept confidential to the extent allowed by applicable State and Federal law and as the technologies/systems utilized will allow. You will not be asked for any personal identifying information. You will be asked selected demographic and background questions for the researchers to understand the diversity of the participants. Once the researcher confirms the MTurk workers ID code, the code will be deleted and the data de-identified. While the primary researcher may view the worker's ID, the primary researcher does not know the person's name associated with the ID. Google Forms and MTurk provide the same level of protection of personal data used for Amazon.com services such as those that protect credit card information.

Will I know the results of the study?

At the conclusion of the study, you will have the right to request feedback about the results. You may contact the faculty advisor, Dr. Kristi Perryman <klperry@uark.edu> or Principal Researcher, Margaret Hindman <mhindman@uark.edu>. You are encouraged to make a copy of this form for your files.

What do I do if I have questions about the research study?

You have the right to contact the Principal Investigator listed below for any concerns that you may have.

Margaret Hindman
Doctoral Candidate of Counselor Education and Supervision
University of Arkansas
100 Graduate Education Building
Fayetteville, AR 72701
(479) 575-3208
mhindman@uark.edu

You may also contact the University of Arkansas Research Compliance office listed below if you have questions about your rights as a participant, or to discuss any concerns about, or problems with the research.

Ro Windwalker, CIP
Institutional Review Board Coordinator
Research Compliance
University of Arkansas
109 MLKG Building
Fayetteville, AR 72701-1201
479-575-2208
irb@uark.edu

WILLINGNESS TO CONSENT:

If you are willing to participate by completing this survey, please select the “Next” button below to continue.

Perceptions about Play Therapy

*** Required**

Section 1 of 6

Perceptions of Play Therapy

Consent to Participate in a Research Study

Principal Researcher: Margaret Hindman, MS, LAC

Faculty Advisor: Kristi Perryman, PhD, LPC-S, RPT-S

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Institutional Review Board Coordinator
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University of Arkansas
109 MLKG Building
Fayetteville, AR 72701-1201
479-575-2208
irb@uark.edu

WILLINGNESS TO CONSENT:

If you are willing to participate by completing this survey, please select the “Next” button below to continue.

After Section 1 Continue to next section

Section 2 of 6

Perceptions of Play Therapy

Type your MTurk Worker ID in the space below. *

How old are you? * Mark only one oval.

- ☐ Younger than 18
- ☐ 18-24
- ☐ 25-30
- ☐ 31-40
- ☐ 41-50
- ☐ 51-60
- ☐ 61-70
- ☐ 71-80
- ☐ 81-90
- ☐ 91-100
- ☐ above 100

Which of the following sexes best describes you? Or please type how you identify. * Mark only one oval.

- ☐ Male
- ☐ Female
- ☐ Nonbionary/third gender
- ☐ Intersex
- ☐ Prefer not to disclose
- ☐ Other: _____

Would you describe yourself as being Spanish, Hispanic, or Latino origin / decent? * Mark only one oval.

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

Which of the following race or ethnicity best describes you? * Mark only one oval.

- ☐ African American / Black Asian
- ☐ Asian / Pacific Islander
- ☐ Caucasian / White Hispanic
- ☐ Marshallese
- ☐ Hispanic/Latinx
- ☐ First Nations People
- ☐ Other: _____

What is the highest level of school you have completed? If you are currently enrolled in school, please select the highest degree you have received. *

Mark only one oval.

- ☐ Less than High School Diploma
- ☐ High School Diploma or Equivalent
- ☐ Associate's Degree (e.g., AA, AGS) or Equivalent (i.e., Completion of 60 Semester Credit Hours at a College/University)
- ☐ Bachelor's Degree (e.g., BS, BS, BFA)
- ☐ Master's Degree (e.g., MA, MS, Med, MAT)
- ☐ Doctorate or Terminal Degree in Field (e.g., PhD, EdD, JD, DNP)
- ☐ Vocational / Technical School Certificate

Which of the following best describes your area of current work/study? * Mark only one oval.

- ☐ Mental Health Professions (e.g., Counselor, School Counselor, Social Work, Psychology, Psychiatry)
- ☐ Physical Health Professions and Related Programs (e.g., Nursing, Athletic Trainer, Preveterinary Studies, Nutrition)
- ☐ Humanities (NOT related to mental health)
- ☐ Agriculture and Related Sciences
- ☐ Architecture and Related Services
- ☐ Business Management, Marketing, Computer and Information Sciences, and Related Support Services
- ☐ Education
- ☐ Visual and Performing Arts (e.g., Art History, Drama, Fashion Apparel Design, Game Design, Music)
- ☐ Science, Technology, Engineering, and Mathematics (STEM)
- ☐ Other: _____

What is your combined family income (or household income) category?

- ☐ \$0-\$39,999
- ☐ \$40,000-\$79,999
- ☐ \$80,000-\$119,999
- ☐ \$120,000-\$159,999
- ☐ \$160,000 or more

How would you best describe the area you live?

- ☐ Urban
- ☐ Suburban
- ☐ Rural

Select the most applicable. Where did you learn most about mental health? * Mark only one oval.

- ☐ I do not know about mental health.
- ☐ From friend(s) or family
- ☐ From television / movie(s) or social media
- ☐ From TedTalk(s) / YouTube/ Educational Internet video(s)
- ☐ From informational website(s) From course(s) / workshop(s) or book(s)
- ☐ A mental health professional (e.g., school counselor, counselor, psychologist, psychiatrist)
- ☐ From medical doctor(s) who does NOT specialize in mental health
- ☐ Other: _____

Have you ever received mental health services? * Mark only one oval.

- ☐ Yes
- ☐ No

Have you ever received play therapy services? * Mark only one oval.

- ☐ Yes
- ☐ No

Do you know a close friend or family member who has received mental health services? * Mark only one oval.

- ☐ Yes
- ☐ No

Do you know a close friend or family member who has received play therapy services? * Mark only one oval.

- ☐ Yes
☐ No

Are you a parent? * Mark only one oval.

- ☐ Yes
☐ No

Do you currently have at least one child 12 years old or younger? * Mark only one oval.

- ☐ Yes
☐ No

Which of the following best describes your awareness of play therapy? * Mark only one oval.

- ☐ I know of what play therapy is.
☐ I have never heard of play therapy.
☐ I think I have heard of play therapy, but am unsure of what it is.

After Section 2 continue to next section

Section 3 of 6

Play therapy is a relationship between a child and a trained play therapist. The play therapist provides toys and facilitates a safe relationship for the child to express and explore who they are (feelings, thoughts, experiences, and behaviors) through play. Play is the child's natural way to communicate, grow, and develop. Toys are children's words and play is their language (Landreth, 2012, p. 11, p. 156).

Please indicate your level of agreement with each of the following statements, using the scale below:

Strongly Disagree (1), Disagree (2), Neutral (3), Agree (4), Strongly Agree (5)

<https://www.a4pt.org/page/AboutAPT>

** Mark only one oval.*

1. Play is a child's natural way to communicate.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

2. Play therapy is useful for those under 3 years old.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

3. Play therapy is not useful for children 3 to 12 years old.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

4. Play therapy helps children use empathy.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

5. Play therapy is useful for children going through change.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

6. Children mostly talk to understand their world.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

7. Play therapy helps children express feelings.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

8. Play therapy is useful for children.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

9. Play therapy helps children feel confident.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

10. Play therapy is useful to learn social skills.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

11. Children mostly use play to understand their world.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

12. Play therapy helps children respect themselves.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

13. Children's brains are not as mature as adults.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

14. Play therapy is useful to treat mental issues.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

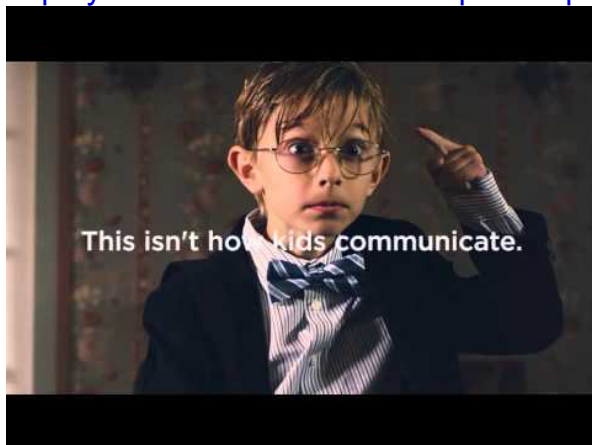
After Section 3 continue to the next section

Section 4 of 6

Watch Video

The video is 1 minute and 24 seconds.

<http://youtube.com/watch?v=reJpo-GaopM>



What drink was mentioned in the video? * Mark only one oval.

- ☐ Ice Tea
☐ Coke Float
☐ Chocolate Milk on the Rocks
☐ Lemonade on the Rocks

After section 4 continue to next section

Section 5 of 6

Please indicate your level of agreement with each of the following statements, using the scale below:

Strongly Disagree (1), Disagree (2), Neutral (3), Agree (4), Strongly Agree (5)

*** Mark only one oval.**

1. Play is a child's natural way to communicate.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

2. Play therapy is useful for those under 3 years old.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

3. Play therapy is not useful for children 3 to 12 years old.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

4. Play therapy helps children use empathy.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

5. Play therapy is useful for children going through change.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

6. Children mostly talk to understand their world.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

7. Play therapy helps children express feelings.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

8. Play therapy is useful for children.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

9. Play therapy helps children feel confident.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

10. Play therapy is useful to learn social skills.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

11. Children mostly use play to understand their world.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

12. Play therapy helps children respect themselves.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

13. Children's brains are not as mature as adults.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

14. Play therapy is useful to treat mental issues.*

Strongly Disagree

Strongly Agree

1

2

3

4

5

☐☐☐☐☐

Would you recommend play therapy services in the future? * *Mark only one oval.*

☐

Definitely will

☐

Very likely

☐

Likely

☐

Not Likely

☐

Definitely not

After section 5 Continue to next section

Section 6 of 6

Concluding Section

For Your Convenience: Additional Information About Play Therapy in Case You are Interested

This information is provided solely for your convenience. The University of Arkansas provides no endorsement or guarantee of the services provided by these facilities.

Interested in finding a play therapist? Look here:

<https://www.a4pt.org/page/ParentsCornerHomePag>

Interested in learning more about play therapy? Look here:

<https://www.a4pt.org/page/AboutAPT>

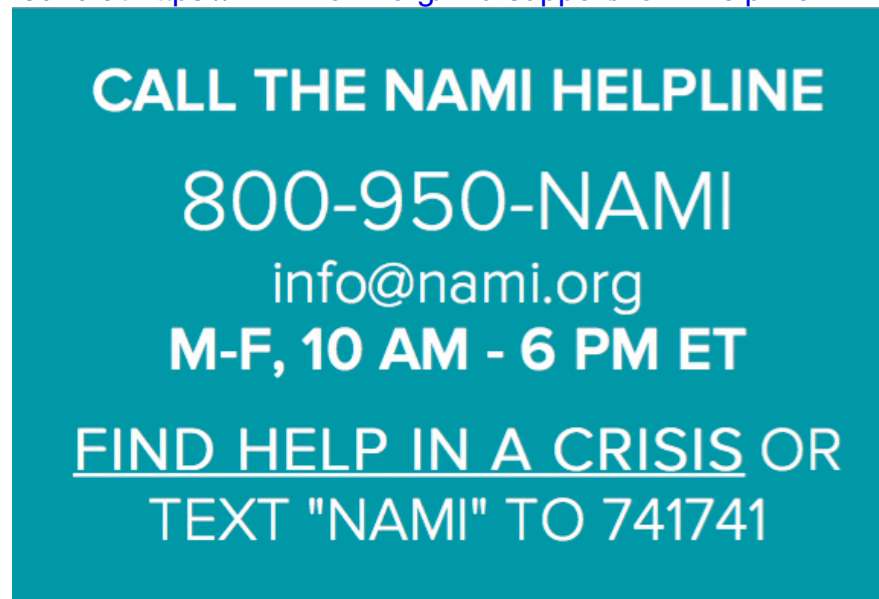
Interested in becoming a play therapist? Learn more:

<https://www.a4pt.org/page/EducationTraining>

Interested in play therapy research? Start here: <https://www.a4pt.org/page/Research>

Are you okay?

If there is an emergency, call 911. If you would like someone to talk to, use the National Alliance on Mental Illness crisis services listed below. The below NAMI information found at <https://www.nami.org/find-support/nami-helpline>



Thank you!

Thank you! We appreciate you taking the time to complete this survey! Also we appreciate your willingness to share about your ideas, aspects of your identity, and your experiences.

As your secret code, please simply type the LAST FOUR CHARACTERS of your MTurk Worker ID. *



<https://docs.google.com/forms/d/e/1FAIpQLSeAkZxLII61X4ezUPCk868WryemE8vIC->

[m32BA3wS6YWnhWIA/viewform?usp=sf_link](https://docs.google.com/forms/d/e/1FAIpQLSeAkZxLII61X4ezUPCk868WryemE8vIC-m32BA3wS6YWnhWIA/viewform?usp=sf_link)

Appendix D: Demographics in More Detail

Sample Demographics in Detail: Combined Family Income and Race

	<i>Frequency</i>	<i>Percent</i>	<i>Cumulative Frequency</i>	<i>Cumulative Percent</i>
Income				
\$0-\$39,999	119	40.07	119	40.07
\$120,000-\$159,999	16	5.39	135	45.45
\$160,000 or more	4	1.35	139	46.8
\$40,000-\$79,999	112	37.71	251	84.51
\$80,000-\$119,999	46	15.49	297	100
Race				
African American / Black	15	5.03	15	5.03
Asian / Pacific Islander	74	24.83	89	29.87
Caucasian / White	198	66.44	287	96.31
First Nations People	1	0.34	288	96.64
Hispanic/Latinx	6	2.01	294	98.66
White and Filipino	1	0.34	295	98.99
Biracial	1	0.34	296	99.33
Black and Asian	1	0.34	297	99.66
Black and White mixed	1	0.34	298	100

Note. For race, some participants typed their response and some were selected their response from a list of choices.