THE ROLE OF PLAY THERAPISTS’ CHARACTERISTICS AND SELF-EFFICACY
IN PREDICTING BARRIERS TO ENGAGING PARENTS

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The current study sought to explore play therapists’ barriers to engaging parents in their clinical work as well as understand the relationship between play therapist characteristics and their attitudes toward parents. Using a demographic questionnaire, Therapist Barriers to Engaging Parents (TBEP), and the Counseling Self-Estimate Inventory (COSE), 136 members of the Association for Play Therapy were surveyed to explore predictors to engaging with parents. Overall, play therapists reported low scores on barriers to engaging parents indicating play therapists are likely to report positive attitudes toward working with parents. Through two multiple regression analyses measuring the predictive value of self-efficacy subscales including Dealing with Difficult Clients and Counseling Process, play therapist identification as a parent, years of experience, and hours of training on parent engagement, both models demonstrated statistically significant findings with large effect sizes. This study found that play therapist self-efficacy was the strongest predictor of play therapists’ attitudes toward parents accounting for approximately 80% of the variance in the models. Play therapists’ identification as a parent as well as years of practice also predicted their barriers to engaging parents. Hours of training in parent engagement had no relationship to TBEP scores. Implications for practice include a need to provide play therapists with training experiences that involve working with parents directly rather than traditional training models, as well as attend to general counseling self-efficacy of play therapists. Implications for future research as well as limitations are discussed.
ACKNOWLEDGEMENTS

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# TABLE OF CONTENTS

ACKNOWLEDGEMENTS ......................................................................................................................... iii

LIST OF TABLES .................................................................................................................................. vi

THE ROLE OF PLAY THERAPISTS’ CHARACTERISTICS AND SELF-EFFICACY IN PREDICTING BARRIERS TO ENGAGING PARENTS ......................................................................................... 1

## Introduction ..................................................................................................................................... 1

Play Therapists’ Attitudes toward Parent Engagement ................................................................. 2

Parents as Play Therapists .................................................................................................................. 4

Play Therapist Self-Efficacy ............................................................................................................... 5

## Methods .......................................................................................................................................... 6

Participants ......................................................................................................................................... 6

Instruments ......................................................................................................................................... 7

Procedures ......................................................................................................................................... 9

Data Analysis ..................................................................................................................................... 10

## Results ........................................................................................................................................... 11

Descriptive Results of Therapists Barriers to Engaging Parents ................................................... 11

Predictive Factors of Therapist Characteristics on Therapist Barriers to Engaging Parents ......... 13

## Discussion ..................................................................................................................................... 16

Play Therapists’ Barriers to Engaging Parents ............................................................................... 17

Relationship between Play Therapist Characteristics and Barriers to Engaging Parents ........... 17

Predictors of Barriers to Engaging Parents .................................................................................... 19

The Role of Self-Efficacy .................................................................................................................. 19

Identification as a Parent ................................................................................................................... 22

Limitations ........................................................................................................................................ 23

Implications for Practice .................................................................................................................... 23

Implications for Future Research ....................................................................................................... 24

## Conclusion ..................................................................................................................................... 25

## References ...................................................................................................................................... 25
LIST OF TABLES

Page

Table 1. Linear Regression with Predictors (Dealing with Difficult Client Behaviors, Years of practice, Parent Training, and Identification as a parent) and TBEP Total Score ........................ 14

Table 2. Linear Regression with Predictors (Counseling Process, Years of practice, Parent Training, and Identification as a parent) and TBEP Total Score .................................................. 16
THE ROLE OF PLAY THERAPISTS’ CHARACTERISTICS AND SELF-EFFICACY IN PREDICTING BARRIERS TO ENGAGING PARENTS

Introduction

Play therapists often report that working with parents is the most difficult part of their work with children (Ray, 2011). However, the Association for Play Therapy (APT) outlines the necessity of parent engagement in their Best Practices framework (APT, 2022), and play therapy competencies created in 2020 (Turner et al., 2020) indicate play therapists’ obligation to engage parents in their work. Parent engagement can be confusing for play therapists as the specialization is defined via multiple educational disciplines, theoretical models, and approaches to play therapy. Furthermore, parent engagement can take the form of consultation where the child is the client of focus (Landreth, 2012; Ray, 2011) or parent-training programs that provide direct support to parents to support child outcomes (Leitão et al., 2021; Lindsey et al., 2015). Though many approaches and models of parent engagement exist (Becker & Chorpita, 2016; Jeon, 2017; Stulmaker & Jayne, 2018), there is currently no one-size fits all approach to parent involvement in play therapy. Thus, play therapists may struggle to engage parents effectively and often rely on their own experiences and expertise. Furthermore, without a manualized approach to parent engagement, research in this area presents a challenge.

Meta analyses measuring the success of parent engagement in play therapy demonstrate the benefits to child outcomes when involving parents in play therapy in humanistic approaches (Bratton et al., 2005; Lin & Bratton, 2015). Although direct parent training programs demonstrated the most substantial effect sizes, additive parent involvement in individual child-focused play therapy yielded higher effect sizes than individual therapy alone (Bratton et al., 2005). Through meta-analysis of directive parent-based interventions, Mingebach et al. (2018)
confirmed the results from the studies above and determined behavioral parent training programs were efficacious, outperformed individual treatment with children, and were stable over time.

Further research determined that parent engagement, though demonstrating less consistent effects when compared to parent-based training programs (Cardy et al., 2020; Reynolds et al., 2013; Thulin et al., 2014) provides additive effects of child counseling such as controlling for attrition (Athanasiou, 2001; Kazdin, 2006) and demonstrating improvements in parent practices (Leitão et al., 2021). Studies measuring the impact of parent engagement determined that the therapist/parent alliance appears to be paramount in predicting success in child therapy (Kazdin, 2006). However, perceptions of the relationship reported by the parent are more predictive than those relationships reported by the therapist (Giannotta et al., 2019; Kazdin, 2006; Leitão, 2021). Furthermore, Leitão (2021) found that therapists’ perception of their own satisfaction with treatment was correlated with stronger outcomes with parents. These findings demonstrate the impact of therapist self-awareness, consideration of blind spots, and internal barriers to parent engagement.

Play Therapists’ Attitudes toward Parent Engagement

Though there is research on the benefits of engaging parents in child counseling, there is mixed evidence about therapists’ perceptions of parent engagement. Play therapists often report parent engagement in play therapy as important (Haslam & Harris, 2011; Lolan et al., 2011), and that they need more training on parent involvement procedures (Kranz et al., 1998; Lolan, 2011), however, parent engagement support is not always rated as the most important consideration for training (Nalavany et al., 2005). Specific to play therapists’ attitudes towards parents, Kranz et al. (1998) surveyed 81 play therapy conference participants, and when asked the most difficult issues to navigate as play therapists, 18 of the 81 participants listed work with parents. Moreover,
when asked the most gratifying part of their jobs, the majority of participants discussed their relationship with the child while only 7 participants reported seeing family relationships improve was the most gratifying experience (Kranz et al., 1998). Haslam and Harris (2011) found that play therapists’ responses varied significantly when asked about their perceptions regarding parents’ willingness to engage in their child’s treatment.

In Lolan’s (2011) sample of 431 APT members, she found that most participants (69%) strongly agreed that engaging parents was related to the child’s therapeutic outcome, however, most of her sample reported dissatisfaction with training regarding parent engagement. Furthermore, Lolan (2011) created a measure to understand play therapists’ barriers to engaging parents. She determined that play therapists were most likely to cite financial concerns (51%), parents’ lack of education about play therapy (54%), and mandated clients (40%) as the biggest barriers to engaging parents. In the free response portion of her measure, play therapists cited concerns such as parent resistance to change, caregivers’ mental health issues, early disengagement by parent after problems are resolved, caregiver apathy, time constraints of parent, lack of follow through from parent, and caregivers’ deference to therapist as the expert. Each of these concerns appear to reside within the parent, rather than the counselor, indicating that barriers held are often seen as the parents’ problem. Moreover, of the concerns that play therapists in this study cited least were lack of rapport (27%) and multicultural competence of the play therapist (6%) which appear to indicate that play therapists often believe that lack of parent engagement may be due to the parent rather than attitudes held by the therapist. The lack of research and understanding of play therapist characteristics that impact work with parents indicates a need to explore this area more closely.
Parents as Play Therapists

Though there is a dearth of literature on play therapists as parents, Jalowiec’s (2011) dissertation study explored the phenomenological experiences of 11 child trauma therapists who also identified as parents. Of the group studied, 100% of the participants stated that they involved parents in their work when it was possible and/or necessary. However, when questioned about actual parent involvement in therapy, only 4 participants stated they involved parents in all of their cases, and the other 7 participants reported a range from 25% to 90% of their cases (Jalowiec, 2011). In studying the phenomenological experiences of this dual role, Jalowiec (2011) found that participants reported an increased understanding of development due to their own experiences with their children and an increased understanding of what their child clients needed. Furthermore, a theme that developed from this study was that child trauma therapists who identified as parents believed that parenthood enhanced their clinical work. Specific to their clinical work with parents, all 11 participants in this study reported countertransference in their work with parents. Participants reported increased empathy and compassion and less judgment toward parents as a result of their identity. Two participants reported increased anger and frustration toward the parents with which they work as a result of their own identity as a parent, however, because this study is related to children who had experienced trauma, this may not be generalizable to all play therapists who are parents (Jalowiec, 2011). The majority of participants reported feeling more confident working with parents due to increased empathy, fundamental understanding of the difficulty of parenthood, and a deeper understanding of the significance of a bond between parent and child. Moreover, Slattery and Park (2007) described how therapists’ dual role as a parent may lead to increased awareness and empathy for clients which allows for decreased judgment and blame for parents. This is beneficial in understanding
how the dual role of a parent and counselor may positively impact therapist self-efficacy.

Play Therapist Self-Efficacy

Larson and Daniels (1998) defined self-efficacy in counselors as the beliefs and judgments about their own abilities related to counseling-related activities. Their seminal research with counselors-in-training determined that counselors high in self-efficacy were more likely to perceive themselves as highly capable in counseling clients whereas counselors-in-training with lower self-efficacy struggled to perceive themselves as having adequate skills to be successful with clients (Larson & Daniels, 1998). Moreover, counselors in training with higher self-efficacy were more likely to handle difficult client situations and implement feedback they received as part of their training. In considering the difficulty play therapists perceive in engaging parents, counselor self-efficacy appears to be an important consideration with this particular client factor.

Though there are many studies of counselor self-efficacy, there is a dearth of research related to self-efficacy in play therapists specifically. Haslam and Harris (2011) found that play therapists reported feeling more confident in working with children alone than in working with children and parents together. Seymour’s (2001) dissertation study used a validated instrument to measure play therapists’ self-efficacy and found that his sample of 250 APT members had overall high scores with the mean of the sample within 2 standard deviations from the highest possible score on the measure. However, his sample did not include any play therapists with fewer than 3 years of experience, indicating samples with newer graduates may include more variability. Dynes et al. (2018) also measured play therapists’ self-efficacy using a validated instrument and found that years of practice and counselors’ age were statistically significantly correlated with this construct. Beyond the two studies mentioned (Dynes et al., 2018; Seymour,
play therapists’ internal self-concept is not a factor that is often considered in the research, though it is a large consideration for conceptual pieces (Brooks et al., 2022; Cuschieri, 2016). Connecting self-efficacy with parent engagement, researchers, clinicians, and trainers have a more holistic understanding of play therapists’ needs.

Review of the literature demonstrates inconsistencies in play therapists’ perceptions of parent engagement in play therapy. Though many believe it is important (Lolan, 2011), parent involvement strategies do not rank as high as other skills in play therapy (Nalavany et al., 2005). Practice patterns of play therapists in engaging parents have been studied (Lolan, 2011), however, there has yet to be research on play therapists’ internal barriers to engaging parents to understand possible resistance to engagement. Furthermore, there is a dearth of research on play therapist self-efficacy. Play therapists have reported they wish there were more training opportunities for engaging parents (Kranz et al., 1998), however, developing those opportunities may be difficult without first understanding play therapists’ attitudes toward parents and characteristics that may predict those attitudes.

Methods

The research questions to be investigated for the current study include the following:

1) What are the relationships among demographic characteristics and barriers to engaging parents? 2) Do years of practice as a play therapist, training on working with parents, identification as a parent, and play therapist self-efficacy predict internal barriers to working with parents?

Participants

Participants were recruited from an email listserv of professional APT members. Inclusion criteria included individuals who identified as a current professional member of APT
with at least a master’s degree and were currently practicing play therapy. The sample included 136 participants with mean age of 44.88 (SD=11.63). Participants reported a mean of 12.72 years of practice (SD=8.16) and ranged from 1 to 35 years of experience. The sample was predominantly female (88.2%), came from the Counseling discipline (56.6%), and predominantly practiced in a private practice setting (66.2%). The majority of the sample identified as parents (67.6%), held a master’s degree (86%), and reported Child Centered Play Therapy as their theoretical orientation (65.4%). Participants wrote in their own identification of race/ethnicity rather than selecting from a list with the predominant response as White, Caucasian, or some variation of these two responses (86.67%). Participants reported that a mean of 67.83% (SD=25.68) of their clients identified similarly to them in race or ethnicity. The sample reported that they completed on average 3.62 parent consultations for every 10 play therapy sessions they conduct with a child (SD=2.50). Regarding play therapy credentials, 36% of the sample held a Registered Play Therapist-Supervisor (RPT-S) credential, 31.6% reported they held a Registered Play Therapist (RPT) credential, and 31.6% reported not holding a credential through APT.

Instruments

Once participants self-selected into the study, they were asked to complete a demographic questionnaire, the 13-item Therapist Barriers to Engaging Parents (TBEP) measure (Dynes et al., 2018), and the Counseling Self-Estimate Inventory (COSE) (Larson et al., 1992).

Demographic Questionnaire

Demographic data collected included participants’ gender, self-report of race and ethnicity, years of practice, age, discipline, APT credential, frequency of parent consultations, client population, additional parent credential, licensure and state of licensure, highest degree
conferred, practice setting, training related to working with parents/caregivers, participants’ identification as parents, and theoretical orientation. Participants’ identification as a parent was collected via a yes/no format in response to whether they are a parent or caregiver of a child of any age. Training related to working with parents/caregivers was measured via self-report of continuing education credits and graduate coursework related to parent engagement. In order to measure client population, participants were asked to report the percentage of clients they work with on average that identify similarly to them in race/ethnicity.

**Therapist Barriers to Engaging Parents (TBEP)**

To measure internal barriers, participants completed the 13-question Therapist Barriers to Engaging Parents measure (Dynes et al., 2018). The TBEP measure was created specifically for child and family therapists to measure internal barriers counselors experience when engaging parents. Questions included items such as, “I am hesitant to continue involving a parent if they become defensive or angry with me”. The TBEP is scored on a 5-point Likert scale ranging from 1 (never) to 5 (almost always) with higher scores indicating more internal barriers to engaging parents. Dynes et al. reported the overall internal reliability for the TBEP with Cronbach’s alpha of .86. The TBEP was significantly negatively correlated with measures of the COSE which demonstrated convergent validity.

**Counseling Self-Estimate Inventory (COSE)**

The COSE was created to measure counselors’ perceptions of their capabilities to be successful in counseling situations (Larson et al., 1992). To examine the relationship between internal barriers related to engaging parents and play therapists’ overall sense of therapist efficacy, participants answered 37 items from the COSE measure. However, only two subscales of “Dealing with Difficult Client Behaviors” and “Counseling Process” of the COSE measure
were included in the analysis (Larson et al., 1992) due to the focus of the research questions. Following the rationale presented by Dynes et al. (2018), analysis was narrowed to these specific subscales due to the likelihood that therapists with higher confidence in their overall counseling abilities would be more likely to separate their own therapeutic skills from parents’ behavior. The COSE uses a 6-point Likert scale response from 1 to 6 with higher scores indicating stronger self-perception of overall counseling self-efficacy. Larson et al. (1992) reported the Cronbach’s alpha for reliability for Counseling Process subscale reliability was .87, and the Dealing with Difficult Client Behaviors subscale was .8. Counseling Process subscale questions include statements such as “I am uncertain as to whether I will be able to appropriately confront and challenge my client in therapy” and measures counselors’ confidence in their actions that occur over multiple responses in counseling and are driven by an overall assessment of the client (Larson et al., 1992). Dealing with Difficult Client Behaviors subscale questions include “I am uncomfortable about dealing with clients who appear unmotivated to work toward mutually determined goals” and measures the counselor’s confidence in working with unmotivated or indecisive clients (Larson et al., 1992).

Procedures

After receiving Institutional Review Board approval, I obtained a list of contact information from APT for the population studied (all 6967 professional APT members) and randomly selected a sample of 1500 play therapists using a research randomizer website, www.randomizer.org. I emailed these individuals a recruitment message that briefly summarized the research and provided a link to a Qualtrics survey. Responses were tracked, and individuals who had not yet responded received two follow up emails. A total of 150 individuals submitted responses to the survey which resulted in a 10% response rate. Using g*power to complete an a
priori analysis for multiple regression with an effect size (f2) of .15, 4-total predictors, alpha error probability of p < .05, and power (1-beta error probability) of .80, the sample size required was 85 participants.

Data Analysis

Data from the Qualtrics survey were imported into SPSS for data analysis. Of the 150 responses, 14 participants did not complete either the COSE or the TBEP, therefore, they were removed from the sample. Of the 136 participants included in the analyses, 27 participants completed the measures, but skipped one to two questions, therefore, I entered the mean of that item for the whole sample in place of the missing item. For the Counseling Process COSE subscale score (10 items with scores ranging from 10 to 60), Dealing with Difficult Client Behaviors COSE subscale score (7 items with scores ranging from 7 to 42) (Larson et al., 1992), and TBEP total score (13-items ranging from 13 to 65) (Dynes et al., 2018), the summed score was entered for each variable. To measure total hours of parent engagement training, I multiplied each graduate course reported by 67.5 (the number of hours of continuing education credit APT considers for a 3-hour graduate course) (Association for Play Therapy, n.d.) then added that number to the number each participant reported for continuing education hours for that category. For the first research question, the data set included 136 participants, however, due to lack of clarity in one response, one participant was removed prior to completing the multiple regression analysis, thus, that analysis included 135 participants.

To answer the first research question regarding the relationships among demographic characteristics and barriers to engaging parents, I reviewed descriptive statistics for the TBEP measure. Next, I completed several one-way analyses of variance (ANOVA) and two bivariate correlational analyses to determine if demographic factors (gender, APT credential, age,
discipline, ethnicity, and client population race/ethnicity) impacted the results of TBEP total scores. For both the ANOVAs and bivariate correlational analyses, \( p \) values equal to or less than .05 were considered statistically significant. Moreover, effect sizes were calculated, and partial eta squared (\( \eta^2_p \)), were used to determine the magnitude of the effect of the demographic variable on the differences in mean TBEP scores for that group. Correlational analyses were also interpreted by reviewing the \( p \) values and Pearson correlational coefficients (\( r \)).

To answer the second research question regarding predictors for parent engagement, I conducted two multiple regression analyses using TBEP scores as the outcome variable. The first multiple regression analysis used years of practice, identification as a parent, total hours of parent training, and the Difficult Client Behaviors subscale score of the COSE as predictors. The second regression analysis replaced the Difficult Client Behaviors subscale predictor with the Counseling Process subscale. Prior to running the analyses, I ensured that the data met the assumptions for normality, linearity, and homoscedasticity. In each model, I observed the Adjusted \( R^2 \) effect size to assess what percentage of the variability of a play therapist’s overall attitude toward parents can be explained using the four predictors. Next, beta weights and \( p \) values were observed for both models to identify the dominant predictors within the regression models. \( P \) values less than or equal to .05 were considered for significance. I then computed and examined the structure coefficients and squared structure coefficients for each predictor variable and used those values in conjunction with beta weights to determine if each predictor variable accounted for the variance in the predicted TBEP scores.

Results

Descriptive Results of Therapists Barriers to Engaging Parents

To understand play therapists’ barriers to engaging parents, I analyzed descriptive data
for the participants’ TBEP scores. The mean of participants’ total score was 27.64 with a
standard deviation of 5.53 (with a range of possible scores from 13 to 65). This indicates that the
majority of participants responded with never (1), rarely (2), or sometimes (3) and participants
rarely chose “often” or “almost always” when asked about a barrier to engaging parents.

Because this is the first time this instrument has been used in research, the only
benchmark with which to compare these results is the initial exploratory factor analyses (EFA)
conducted on the measure. In this study, Dynes (2016) stated “summed scores in therapist
barriers to parent engagement ranged from 16 to 50, with most therapists reporting average
barriers corresponding to the “rarely” or “sometimes” level” (p. 32). The mean of her sample of
148 therapists was 31.65 with a standard deviation of 5.77. Results of this current study
appeared to replicate her findings with the mean of my sample within one standard deviation of
hers and with a similar standard deviation value.

I conducted additional analyses to explore demographics and characteristics of the
sample. I conducted 4 one-way analyses of variance to determine if there were statistically
significant differences in the sample as related to gender, ethnicity, APT credential, and
discipline. There were no significant differences related to gender, ethnicity, or mental health
discipline. The only statistically significant difference among group means existed within the
APT credential variable. There was a statistically significant difference among TBEP scores of
participants who reported they held an RPT credential, RPT-S credential, or did not hold a
credential through APT, $F(2, 132)=3.609, p=.03$. Of the groups included in this analysis, RPTs
reported the most barriers to engaging parents ($M=28.74, SD=5.50$), followed by those with no
APT credential ($M=28.23, SD=5.92$), and RPT-Ss reported the fewest barriers to engaging
parents ($M=25.94, SD=4.71$). Though there was a statistically significant difference between
groups, the effect size of this difference is small to medium ($\eta^2_p=.05$). Using bivariate correlational analyses, I found that age and TBEP were statistically significantly negatively correlated ($r=-.25, n=135, p=.004$). This relationship demonstrates there was a negative relationship with age and barriers to engaging parents such that the older a participant reported that they were, the fewer barriers to engaging parents that they reported having. I also completed a bivariate correlational analysis between TBEP scores and the percentage of families that play therapists reported they served that identified similarly to them in race and ethnicity and found no statistically significant relationship ($r=-.051, p=.554$).

Predictive Factors of Therapist Characteristics on Therapist Barriers to Engaging Parents

*Multiple Regression Analysis with Dealing with Difficult Client Behaviors Subscale*

For the first multiple regression analysis, I conducted a preliminary analysis to ensure there were no violations of the assumptions of normality, linearity, and homoscedasticity for the first regression. In assessing the assumptions of linearity, scatterplots between each predictor and the dependent variable (TBEP scores) were assessed. All continuous variables (years of practice, Dealing with Difficult Client Behaviors subscale, and parent hours of training) yielded a linear result (as opposed to a curvilinear pattern). To assess the assumption of normality, each continuous variable was plotted via frequency plots to determine both the skewness and kurtosis of the variable. The TBEP total score, years of practice, and Dealing with Difficult Client Behavior scores were reasonably normally distributed. Parent engagement hours of training was positively skewed due to a floor effect as the lowest score possible was 0. Homoscedasticity was evaluated by assessing the scatterplot between the regression standardized predicted value and regression standardized residual values and determining if the error of prediction is reasonably similar above and below the line of “0”. In assessing the scatterplot, it was reasonable to assume
that the model met the assumption of homoscedasticity.

After evaluating the assumptions of normality, linearity, and homoscedasticity, a multiple regression analysis was conducted predicting TBEP total scores with years of experience, hours of parent engagement training, identification as a parent, and Dealing with Difficult Client Behaviors subscale of the COSE. The overall model was statistically significant with an Adjusted $R^2 = .30$, $F(4, 126)=15.006, p<.001$. This effect size given the literature (Henson, 2006) represented a meaningful effect that was worth interpreting (see Table 1).

Table 1

**Linear Regression with Predictors (Dealing with Difficult Client Behaviors, Years of practice, Parent Training, and Identification as a parent) and TBEP Total Score**

<table>
<thead>
<tr>
<th>Variables</th>
<th>$R$</th>
<th>$R^2$</th>
<th>Adj $R^2$</th>
<th>$F$</th>
<th>$p$</th>
<th>$\beta$</th>
<th>$r_s$</th>
<th>$r_s^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBEP Total Score&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.568</td>
<td>.323</td>
<td>.301</td>
<td>15.006</td>
<td>&lt;.001*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficult Client Behaviors Subscale&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.453</td>
<td>-.900</td>
<td>.809</td>
</tr>
<tr>
<td>Years of Practice&lt;sup&gt;b&lt;/sup&gt;</td>
<td>.029*</td>
<td>-.169</td>
<td>-.544</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Hours of Training&lt;sup&gt;b&lt;/sup&gt;</td>
<td>.916</td>
<td>.008</td>
<td>.004</td>
<td></td>
<td></td>
<td>&lt;.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identification as a Parent&lt;sup&gt;b&lt;/sup&gt;</td>
<td>.039*</td>
<td>.159</td>
<td>.428</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.183</td>
</tr>
</tbody>
</table>

<sup>a</sup> dependent variable.  <sup>b</sup> predictor variable.  *$p \leq .05$

The 30% effect size of this regression model had statistically significant contributions from three of the four predictors. In assessing both beta weights and squared structure coefficients (Courville & Thompson, 2001), the three biggest predictors appeared to be Dealing with Difficult Client Behaviors subscale scores, years of practice, and identification as a parent or caregiver (in that order), all of which were identified as statistically significant predictors to the
model. The Dealing with Difficult Client Behaviors subscale score accounted for 81% of the variance in predicted TBEP scores, which is more than double the variance accounted for by the next strongest predictor, years of practice which accounted for 30% of variance. Identification as a parent accounted for 18% of variance in the overall model. Due to this dichotomous variable yielding a positive correlation \((r=.243, p=.002)\) and parents being coded as 1 while nonparents are coded as 2, this would demonstrate that individuals who did not identify as parents were correlated with higher TBEP scores. Parent engagement training accounted for less than one percent of the variance accounted for, had the lowest beta weights \((\beta=.008)\), and was not statistically significant \((p = .916)\), thus it appears that hours of training in parent engagement did not predict TBEP scores in comparison with the other three variables.

**Multiple Regression Analysis with Counseling Process Subscale**

I completed a second regression analysis with the same outcome variable (TBEP total score) and four predictors, Counseling Process subscale score, years of practice, parent hours of training, and identification as a parent. Prior to conducting the regression analysis, I conducted preliminary analyses to determine there were no violations of the assumptions required for this analysis, and again, all assumptions were met. The overall model was statistically significant with a meaningful effect size, \(Adjusted R^2=.28, F(4, 126)=13.834, p<.001\). In this regression model, 83% of the variance in TBEP predicted scores could be accounted for by the Counseling Process subscale scores. This means that counselors who reported confidence in their clinical responses and assessment of the client across sessions (Larson et al., 1992) were less likely to report barriers in engaging parents in their clinical work. Similarly to the first regression model, this value was more than double the predictive value of the next strongest predictor, years of practice, which accounted for 31% of the variance in predicted scores. Identification as a parent
predicted 19% of variance accounted for in the model while parent training was a negligible predictor. In this regression, though the squared structure coefficients demonstrated that years of practice accounted for almost twice the variability in the scores as compared to identification as a parent, their beta weights are almost identical. This demonstrates that identification as a parent may have accounted for more unique variance in the model than years of experience. This is also demonstrated by reviewing the correlation between predictors as years of experience is highly correlated with Counseling Process scores whereas identification as a parent was not.

Table 2

<table>
<thead>
<tr>
<th>Variables</th>
<th>$R$</th>
<th>$R^2$</th>
<th>Adj $R^2$</th>
<th>$F$</th>
<th>$p$</th>
<th>$\beta$</th>
<th>$r_s$</th>
<th>$r_s^2$</th>
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<tr>
<td>TBEP Total Score$^a$</td>
<td>.552</td>
<td>.305</td>
<td>.283</td>
<td>13.834</td>
<td>&lt;.001*</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Counseling Process Subscale$^b$</td>
<td></td>
<td></td>
<td></td>
<td>&lt;.001*</td>
<td>-.441</td>
<td>-.909</td>
<td>.827</td>
<td></td>
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<tr>
<td>Years of Practice$^b$</td>
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<td>-.152</td>
<td>-.560</td>
<td>.313</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Parent Hours of Training$^b$</td>
<td>.715</td>
<td>.028</td>
<td>.004</td>
<td>&lt;.001</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identification as a Parent$^b$</td>
<td>.051*</td>
<td>.153</td>
<td>.440</td>
<td>.194</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

$^a$ dependent variable. $^b$ predictor variable. *$p \leq .05$

Discussion

The current study revealed that play therapists overall reported fewer barriers to engaging parents. Moreover, this study found that counseling self-efficacy scores were the strongest predictors of whether play therapists’ reported barriers to engaging parents, with play therapists who reported higher confidence in their responsiveness as a counselor (Counseling Process) and their abilities to work with unmotivated clients (Dealing with Difficult Client Behaviors)
reporting fewer barriers to engaging parents. Additionally, play therapists’ self-identification as a parent also predicted their barriers to engaging parents such that counselors who reported they had children of any age reported fewer barriers to engaging parents in counseling services with children. Years of practice was a significant predictor of number of barriers to engaging parents, whereas hours of parent engagement training did not have a relationship with barriers to engaging parents.

Play Therapists’ Barriers to Engaging Parents

In the present study, play therapists’ attitudes toward engaging parents was measured using Dynes et al.’s (2018) TBEP measure, a 13-item questionnaire with scores ranging from 13 to 65 with higher scores indicating more barriers to engaging parents. The range in the present study indicates that at least one participant rated themselves as never experiencing a barrier in any area of parent engagement while no participants identified experiencing barriers often in all areas. The skew toward reporting fewer barriers to engaging parents is unsurprising, given that several of the questions listed on the measure appeared to be negatively written indicating that social desirability may have been a factor (Heppner et al., 2016). For example, it may be difficult for play therapists to state via an online questionnaire that they “almost always” agree with the statement, “I have honestly not felt like trying anymore with some guardians, that it was hopeless.” According to the current study’s findings, play therapists reported fewer barriers to engaging parents overall demonstrating that they report fewer negative attitudes toward parents in child counseling services.

Relationship between Play Therapist Characteristics and Barriers to Engaging Parents

According to the ANOVA and correlational analyses completed with this sample, there are several demographic factors that may have impacted barriers to engaging parents. First, those
who held a Registered Play Therapist – Supervisor (RPT-S) credential reported the fewest barriers to engaging parents at a statistically significant level when compared to those who reported they had a Registered Play Therapist (RPT) credential. Interestingly, those who reported they did not hold a credential through APT resulted in mean scores almost identical to those with an RPT, again a statistically significant difference from those who held an RPT-S. This finding demonstrates that holding a credential through APT does not necessarily mean that play therapists are more likely to engage parents. However, those who have undergone the additional training to hold a supervision credential through APT have statistically significantly fewer barriers than the other respondents. Though no other studies have found a relationship between APT credential and parent engagement, this finding suggests that more experience working with children may impact therapists’ willingness to work with caregivers. However, this assumption would not explain the mean differences between those without an APT credential and those credentialed as an RPT. The unexpected result that participants with an RPT and those with no credential reported similar levels of parent engagement indicates a need for more exploration related to credentialing and training requirements.

Another reflection of the relationship between time/experience and barriers to engaging parents was indicated through the statistically significant relationship demonstrating a notable finding that older play therapists reported fewer barriers to engaging parents. Findings between age and barriers to parent engagement in the current study support Dynes’ (2016) original results of the statistically significant relationship between participant age and barriers to parent engagement scores. Gender, professional discipline, and ethnicity characteristics did not yield statistically significant relationships with parent engagement scores in the current study. Moreover, there was no statistically significant difference among different ethnicity’s mean
parent engagement scores or participants’ self-report of the average percentage of clients who identify similarly to them in race and ethnicity and parent engagement scores. However, these findings should be interpreted with caution given the limited race/ethnicity diversity of the sample.

Predictors of Barriers to Engaging Parents

Beyond the demographic factors that impact barriers to engaging parents, I sought to understand the predictive value of self-efficacy, years of experience, self-identification as a parent, and hours of training on parent engagement. Both regression models were statistically significant and had large effect sizes demonstrating that much of the variance accounted for in predicted parent engagement scores was due to these predictor variables. Most notably, the strongest predictors in both models were the subscales of counseling self-efficacy (Counseling Process and Dealing with Difficult Client Behaviors) which accounted for more than double the variance accounted for of the next strongest predictor (years of experience). Identification as a parent and years of practice also accounted for variance in predicted TBEP scores, however hours of training demonstrated little to no relationship with parent engagement scores. These results indicate that even though years of experience and identification as a parent are important factors, self-efficacy predicted most of the variability in parent engagement scores.

The Role of Self-Efficacy

Results of the first regression analysis demonstrated that play therapists who feel more confident in their ability to work with clients who “do not verbalize their thoughts during the counseling session”, “appear noncommittal and indecisive”, or “deal with crisis situations that may arise during the counseling session” (Larson et al., 1992), are less likely to report that they have barriers to working with parents. This can be understood by recognizing previous literature
on play therapists’ attitudes toward parent involvement. For example, more than 20% of the participants in Kranz et al.’s (1998) study reported that working with parents was the most difficult issue to navigate as a play therapist. Furthermore, in Haslam and Harris’s (2011) study, participants were asked about their perceptions of parents’ willingness to engage in their child’s treatment and found mixed results. Thus, it is evident that though play therapists believe engaging parents and caregivers is important (Haslam & Harris, 2011; Kranz et al., 1998; Nalavany et al., 2005; Phillips & Landreth, 1995), they may believe it is an arduous task and may have differing attitudes toward parents.

The second regression using the Counseling Process subscale score demonstrated that play therapists who reported confidence in their timing of appropriate responses, clarity of responses, understanding of clients’ nonverbal behaviors, assessment of client concerns, ability to confront and challenge in session, and ability to lead clients toward selection of concrete goals in counseling (Larson et al., 1992) are less likely to report barriers to engaging parents. Becker et al. (2018) determined that effective parent communication for successful child outcomes included assessment and goal setting. Moreover, in Lee and Ray’s (2020) q-methodological study, parents reported expecting play therapists to demonstrate expertise and help in understanding the counseling process. Thus, play therapists who feel confident in their ability to do so may be more likely to want to engage with parents and may demonstrate fewer barriers to including parents in treatment.

Though the two self-efficacy subscales appear to be strong predictors of therapists’ attitudes toward parents, caution is warranted regarding conclusions related to competence. Though play therapists who rate themselves as confident on self-efficacy also reported they had
fewer barriers to engaging parents, this does not mean that self-efficacy rating is correlated with strong client outcomes.

Historically, self-efficacy reports have been shown to be unrelated to client outcomes (Clements-Hickman & Reese, 2022; Heppner et al., 1998). Heppner et al. (1998) found that career counselors’ self-report of self-efficacy was not statistically significantly correlated with many of the client outcomes that were measured such as client report of progress toward self-selected goals. More recently, Clements-Hickman and Reese (2022) found no statistically significant relationship between counselors’ self-efficacy and client outcomes. Moreover, only a small percentage of the variability in outcome scores could be contributed to therapist characteristics measured such as self-efficacy, professional self-doubt, and ratings of humility. It appears that the relationship between counselor self-efficacy and client outcomes may be more nuanced and may require the consideration of additional factors. Future studies would benefit from researching client outcomes as related to this construct.

Moreover, the above-mentioned studies are not specific to play therapists. Seymour (2001) conducted the only other study measuring self-efficacy specific to play therapists and found that play therapists rated themselves highly on self-efficacy with little variability in scores. In the current study, the ranges on Dealing with Difficult Client Behavior and Counseling Process were variable including scores from the lower and higher ends of the spectrum. This may be due to the current sample including more novice counselors while Seymour’s (2001) study only included participants with three or more years of experience. However, there appear to be no studies that specifically explored the relationship between play therapists’ self-efficacy and outcomes indicating a gap in the literature.
Identification as a Parent

This study is the first quantitative study measuring the role of parenthood in play therapists. In this sample, almost 65% of play therapists identified as parents themselves. Results indicated a meaningful relationship such that play therapists that reported they were parents or caregivers to children of any age were statistically significantly less likely to report barriers to engaging parents. In a close examination of results, identification as a parent received as much credit as years of experience for the Counseling Process regression model and the parent predictor appeared to have more unique variance indicating its contribution to the model. Because identification as a parent was not statistically significantly correlated with either of the self-efficacy subscales and years of experience was, identification as a parent provided the most unique variance accounted for in the model.

The role of identification as a parent in relation to barriers to engaging parents can be understood as related to Jalowiec’s (2011) qualitative study that found that play therapists who identified as parents or caregivers reported confidence in their work due to increased empathy, a deeper understanding of the bond between parent and child, and a fundamental understanding of how difficult parenthood is. Slattery and Park (2007) also addressed the dual role of parent and play therapist leading to increased awareness for parents and a decrease of judgment and blame. These findings support the supposition that play therapists who are also parents see themselves as more strongly empathizing with parents thus experiencing fewer barriers to engaging them in clinical work. This relationship is important to consider in that identification as a parent was not correlated with self-efficacy, thus, play therapists who are parents may empathize more with caregivers of their clients even though they may not appear more confident than play therapists who are not parents.
Limitations

There are several limitations of the present study. First, this study utilized self-report which may be vulnerable to distortions and social desirability (Heppner et al., 2016) which may explain the smaller range of TBEP scores. Additionally, another limitation of this study included the measure of hours of parent engagement training. Because participants were asked to report the number of courses and continuing education hours completed related to parent engagement, this variable appeared skewed. Thus, results of this study related to that variable should be interpreted with caution. Lastly, this study included limited multicultural considerations. Though the demographics of the sample aligned closely with the population studied (APT professional members), both the population and sample lack diversity in race, ethnicity, and gender. Thus, though it is a strength that the sample aligned with the population, future studies may benefit from a more diverse sample of play therapists.

Implications for Practice

Involving parents in clinical practice with children not only benefits child outcomes (Bratton et al., 2005; Lin & Bratton, 2015; Mingebach et al., 2018), but also benefits many factors related to the play therapy process such as attrition (Athanasiou, 2001; Kazdin et al., 2006), stronger treatment engagement (Greef et al., 2016), and greater improvement in parenting practices (Leitão et al., 2021). Due to the strong predictive value of play therapist self-efficacy on barriers to engaging parents, play therapists benefit from experiences that increase their confidence in their work. For example, counselor training programs offering play therapy courses may consider requiring students to develop case conceptualizations that not only assess and measure progress to goals but require developing verbiage to communicate this progress to parents and caregivers. Furthermore, counselor education programs may consider implementing
supervised micro practicum experiences that involve mock parent consultations or observing seasoned play therapists in sessions that involve parents. Supervisors may consider role playing difficult client conversations with parents and caregivers to allow supervisees to develop confidence in their ability to communicate effectively and deal with difficult behaviors in parent sessions. Given the relationship between identification as a parent and decreased barriers to engaging parents, counselor educators may consider integrating a panel of parents who are play therapists in their courses to provide an opportunity for students to help develop empathy and acceptance for parents in the play therapy process. Furthermore, play therapists who are parents may consider adding to the literature by developing additional conceptual pieces or conference presentations about how their dual role helps develop more positive attitudes toward parents in their work. These efforts may provide more opportunities for students and practitioners to learn from play therapists in this dual role.

Implications for Future Research

The current study was the first to research play therapists’ attitudes toward parents using a measure with reported reliability and validity, the first to quantitatively study the dual role of parent and play therapist and was among few studies that measured self-efficacy in play therapists specifically. Thus, future studies should further substantiate the findings of this current study, preferably with a larger, more diverse sample. Though research demonstrates that increased parent involvement in play therapy services is related to stronger child outcomes (Bratton et al., 2005; Lin & Bratton, 2015; Mingebach et al., 2018), this study did not make the direct link between the two constructs. Thus, the relationship between play therapists’ parent engagement scores and client outcomes warrants further study. Lastly, this study focused on play therapists’ perceptions related to parent engagement, however, future studies could gain the
perspective of parents in relation to this treatment modality. Specifically, future research may explore the relationship between play therapists’ attitudes toward parents and parents’ ratings of satisfaction with play therapy services. Additionally, play therapists’ attitudes toward parents could also be studied throughout the therapeutic process in relation to parents’ ratings of the therapeutic relationship, parenting stress, and the parent-child relationship.

Conclusion

The current study explored play therapists’ attitudes toward caregivers using a validated measure of barriers to engaging parents, and found that play therapists have an overall positive attitude toward engaging parents in counseling. Furthermore, there is a significant relationship between play therapists’ barriers to engaging parents and their confidence in their ability to work with difficult client behaviors and manage the overall counseling process. These findings demonstrate the importance of developing counselor confidence in assessing child progress, developing goals for sessions, and confronting and challenging in session. Moreover, play therapists who identify as parents also demonstrate more positive attitudes toward parents. Though there are limitations of this study, the results demonstrate findings that can benefit the field of play therapy.

References


Becker, K. D., & Chorpita, B. F. (2016, August). Enhancing the design of engagement interventions to enhance the public health impact of mental health treatments for youth. In K. Becker (Ed.), *Extending the reach and impact of science on clinical care for youth*


APPENDIX A

EXTENDED LITERATURE REVIEW
Introduction

In studying the concepts of play therapists’ internal barriers to engaging parents and counselor self-efficacy, current and historical literature clarifies definitions of these constructs. The history of play therapy provides a rich understanding of the multiple disciplines and unique specialization that play therapists hold. Furthermore, a deep understanding of play therapists’ demographics, credentials, and therapist identity is required to recognize the multifaceted approach counselors may take to parent engagement dependent on their educational discipline, theoretical approach, and ongoing training and development. Parent engagement in play therapy is not well-defined, though it is a requirement based on play therapists’ competencies (Turner et al., 2020) and Best Practices (Association for Play Therapy, 2022). This review will consider parent engagement through various theoretical lenses, parent-training programs, and models of parent engagement throughout conceptual pieces and literature.

Play therapy research demonstrates mixed evidence for the support of parent engagement, however, considering meta-analyses and outcome research provides a clear picture of both the impact of parent engagement and the difficulty in measuring the construct. Furthermore, investigating previous research on play therapists’ attitudes toward parent engagement provides clarity in determining the methodology of this present study in order to add to the field of literature. This literature review allows for greater insight into future approaches for research, constructs that require further investigation, and clarity in research methodology. Lastly, understanding previous research on self-efficacy among therapists provides greater awareness into the predictive models of parent engagement practices. Thus, this review of literature helps to inform the current study and to demonstrate the purpose of studying play therapists’ internal barriers to engaging parents, play therapist self-efficacy, and various therapist factors.
What is Play Therapy?

Play therapy is defined 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” (Association for Play Therapy, 1997). Play therapy is delineated from a child’s everyday play as it is both a systematic and therapeutic approach with multiple theoretical models (Association for Play Therapy, 2022). As play therapy is a specialty area for mental health professionals, this operational definition served as the basis for future research on play therapy, unified efforts to promote the intervention, and allowed for further development of theories of play therapy (Seymour, 2016).

History of Play Therapy

Play therapy’s historical underpinnings can be traced back to Sigmund Freud whose observation and analysis of play behavior in a client with a specific phobia created the groundwork for interventions specifically for children (Ray, 2011). Play was first used as a tool for psychoanalysis by Hermine Hug-Hellmuth in the early 1920s (Johnson, 2016). Hug-Hellmuth observed children’s play directly and developed theoretical conclusions which she presented to the Psychoanalytic Society in 1913 (Johnson, 2016). Her work was followed by the work of Melanie Klein and Anna Freud who are credited with expanding play therapy as a method for psychoanalysis (Ray, 2011). Klein and Freud disagreed in their suppositions of children’s capacity for insight, however, both employed a non-directive approach to play therapy (Ray, 2011, Johnson, 2016). Margaret Lowenfield was the fourth pioneer of play therapy through her use of “the world technique” using miniatures and sand (Johnson, 2016). Lowenfield allowed
children to choose any item in the playroom and observed children without intrusion, interpretation, or suggestions.

The primary form of play therapy in the 1900s was psychoanalytic play therapy until more structured approaches to the intervention were utilized in the 1930s (Ray, 2011). For example, Jacob Conn utilized the “play interview” in which he supported children in self-expression with family dolls, and Joseph Solomon created active play therapy in which he took an active role in playing out the child’s problems through dolls and other props (Johnson, 2016). Additionally, David Levy is credited with the development of release therapy which allowed children to release their aggressive behaviors and feelings through selected toys (Frost, 2012). Though developed two decades later, Gove Hambridge also developed an approach involving release or catharsis of emotions. In structured play therapy, Hambridge disagreed with the use of flooding to release emotions, and rather, believed that through a strong relationship between counselor and child, repetition of stressful events allowed children to free themselves of negative emotions and move toward recovery (Frost, 2012).

In the 1940s, Carl Roger’s Person-Centered theory informed Virginia Axline’s development of nondirective play therapy, which has since been referred to as Child-Centered Play Therapy (CCPT). Axline’s 1947 text, *Play Therapy*, tailored Roger’s Person-Centered approach with adults into a more developmentally appropriate way of working with children. Her approach to working with children emphasized the non-directive nature of Rogers’ theory while providing the core conditions of empathy, unconditional positive regard, and congruence. Axline considered the importance of developing a safe environment using a playroom with which children could express themselves (Axline, 1974). Axline believed the power of the relationship between child and therapist was sufficient for healing and stated, “parents who show a
willingness to participate in their children’s therapy can be helpful, and their participation is
desired, though not essential, in CCPT” (Axline, 1974, p. 149). Thus, according to Axline, parent
involvement in the individual play therapy approach was not necessary.

Through the work of Louise Guerney and Garry Landreth, Virginia Axline’s model for
play therapy emerged into the Child-Centered Play Therapy (CCPT) approach most widely used
today (Lambert et al., 2005). Dee Ray’s seminal text (2011) worked to further manualize the
treatment, and later, Ray and colleagues created the research integrity checklist which continued
to operationalize the approach and allowed for greater opportunities in research (Ray et al.,
2017).

Throughout the remainder of the 20th century, various other theoretical approaches
adopted their own play therapy procedures. Each theory differs in its beliefs of human nature and
psychopathology, however, the operational definition created by the Association for Play
Therapy provides commonalities among approaches. Furthermore, parent engagement differs
among approaches with goals for parent involvement tailored to the tenets of the theory. Thus, a
brief description of seminal theories provides clarity on the various parent engagement strategies
play therapists may employ.

Though this section provides a simplistic explanation of each theory and does not cover
every theoretical approach to play therapy, these were highlighted due to their consideration in
play therapy literature. Ray (2011) discussed cognitive behavioral play therapy (CBPT),
Adlerian play therapy (ADPT), Child-Centered play therapy (CCPT), Jungian Analytical play
therapy, and Gestalt play therapy in her seminal text, as she reported these are the most popular
current approaches. The Association for Play Therapy (APT) mentions the aforementioned five
approaches as well as Psychoanalytic play therapy, Ecosystemic play therapy, filial, and
Theraplay as their “seminal and historically significant play therapy theories” (Association for Play Therapy, 2022). However, from this list, Psychoanalytic play therapy and Ecosystemic play therapy are the only additional approaches that focus on the child individually rather than providing a parent-based approach to childhood concerns. Moreover, psychoanalytic or psychodynamic theories are also highlighted in the seminal work of O’Connor et al. (2016) and Crenshaw and Stewart (2016), and Ecosystemic Play Therapy is discussed at length in O’Connor et al. (2016). Though Murdock (2016) stated that psychodynamic theories have significantly declined over the last 40 years, its inclusion in this section will provide rich context for the theoretical differences in play therapy approaches. This movement away from psychoanalytic theory toward CCPT was also reported in dated studies of play therapists’ perceptions (Kranz et al., 1998; Phillips & Landreth, 1995) demonstrating the trend away from psychoanalytic play therapy preceded the 2016 work. Ray (2011) confirmed the suppositions of Phillips & Landreth (1995) and Kranz et al. (1998) that play therapists’ proclivity toward certain approaches appears to be connected to individuals who provide ample trainings, education, and research for their approach.

Thus, this section will focus on the seven approaches that focus on the child as client highlighted through the Association for Play Therapy’s website, and I will discuss Theraplay, filial therapy, and other parent-based interventions in a later section regarding parent involvement in play therapy. Each approach will be detailed in its theoretical underpinnings, consideration of maladaptive functioning, and approaches to parent engagement to highlight the differences among theories.
Child Centered Play Therapy (CCPT)

Child-centered play therapists follow a non-directive approach to play therapy and consider the relationship between child and therapist as the primary healing factor (Ray & Landreth, 2019). CCPT therapists focus on creating a safe environment for the child that demonstrates unconditional positive regard, empathy, and congruence to allow the child to move toward her own innate ability to heal and move toward self-growth (Ray & Landreth, 2019). Care is taken to develop rapport and to follow the child’s lead by using therapist skills such as tracking, reflecting feeling, reflecting the larger meaning, and facilitating responsibility (Landreth & Ray, 2019). CCPT play therapists believe that maladaptive behaviors are a result of incongruence between how the child perceives herself and the messages she receives from others. Through a safe environment created in the playroom, the child will feel accepted and perceive the healing messages from the play therapist, which will lead to the child fully accepting herself (Ray, 2011). CCPT is different from other approaches in that the therapist does not rely on verbalizations or clear understanding of the incongruence, but rather, the therapist trusts the child will move herself toward self-actualization and healing (Ray, 2011).

Parents are involved in CCPT through the use of parent consultation (Ray, 2011). Though play therapists do not set behavioral goals, they do communicate with stakeholders such as parents, teachers, and other caretakers in order to partner with the child’s system (Ray & Landreth, 2019). In parent consultations, play therapists provide information regarding play themes expressed in the child’s play, provide support for parents through role playing and teaching, and communicate progress toward behavioral change achieved as a result of their own proclivity toward self-healing (Ray & Landreth, 2019). Though a manualized approach to parent consultations has yet to be developed, several authors have provided guidance for play therapists.
For example, Ray (2011) developed a developmental history questionnaire play therapists can utilize at intake. In her chapter discussing parent consultation, Ray (2011) also provides guidance on attitudes of play therapists toward parents, recommendations for communication throughout the therapeutic process, and instructions for how to provide psychoeducation for parents. Post and colleagues (2012) provided guidance for play therapists about how to establish behavioral goals within the consultation model. Schottelkorb et al. (2015) built off of Ray’s (2011) approach to parent consultations and developed a Child Centered Parent Consultation (CCPC) model that could be used for both research and practice. In their conceptual piece, Schottelkorb et al. (2015) established goals of consultation throughout the therapeutic process and outlined attitudinal conditions play therapists possess. Lastly, Stulmaker and Jayne (2018) developed a model specific to clinicians and clinical practice in which they recommend play therapists provide clear expectations, communicate progress, and promote systemic change for the child.

**Cognitive Behavioral Play Therapy (CBPT)**

Cognitive behavioral play therapy is the second most cited approach among play therapists (Lambert et al., 2005). This approach to working with children is brief, structured, directed, and problem oriented (Knell, 2016). The theoretical underpinnings of this approach conclude that children may be facing errors in logic which lead to negative emotions and behaviors (Knell, 2016). Through this approach, the CBPT therapist is often directive, provides psychoeducation, and includes behavioral techniques which can lead to positive outcomes for children (Knell, 2016). CBPT therapists focus on the child’s environment, feelings, thoughts, and perceptions to then provide strategies for more adaptive thoughts and behaviors (Drewes & Cavett, 2019). Through CBPT, play therapy sessions are often conducted in a playroom, however, sessions can take place in other venues. Directive intervention techniques include
interventions such as the use of puppets, bibliotherapy, drawing, art, or the development of coping skills (Drewes & Cavett, 2019).

CBPT focuses heavily on goal setting as the critical first step. In parent consultations, CBPT therapists discuss treatment progress, revise goals, and discuss and utilize assessment. Parents and caregivers are often involved in therapeutic interventions through techniques such as co-creating behavioral contracts, praising the child for acquiring a new skill or preventing behavioral concerns, and assessing and moving toward therapy graduation (Drewes & Cavett, 2019).

Adlerian Play Therapy (ADPT)

The third most identified theory in use in play therapy is Adlerian Play Therapy (AdPT; Lambert et al., 2005). Terry Kottman developed Adlerian play therapy using the tenets of Individual Psychology outlined by Alfred Adler (Kottman & Ashby, 2019). Adlerian play therapists utilize both directive and non-directive approaches to counseling (Kottman & Ashby, 2016). The theoretical considerations for AdPT play therapists include the idea that children hold mistaken beliefs that lead them to feel inferior, therefore, they must direct their thinking in order to help build insight and develop coping behaviors (Kottman & Ashby, 2019). Adlerian play therapists are strengths-based and believe that children have goals of misbehavior directly related to their feelings of discouragement and inadequacy (Kottman & Ashby, 2016). Through this approach, children will proceed through eight goals of therapy which include a stronger feeling of connectedness with others, development of positive strategies for belonging, learning new ways of coping with their feelings of inferiority, understanding thought patterns that lead to self-defeating beliefs and working toward positive patterns, development of coping strategies for
moments when they are stuck, gaining awareness about their lifestyle, and recognizing and using their assets (Kottman & Ashby, 2016; Kottman & Ashby, 2019).

Parents are actively involved in therapy using consultation. Adlerian play therapists communicate often with parents and other significant adults in the child’s life to teach concepts and support them in parenting tools and techniques to aid in the child’s growth (Kottman & Ashby, 2016). Through this approach, parent involvement is clearly defined (Jeon, 2017). Kottman (2011) lists play therapists’ multiple roles in engaging parents and stated that they should teach parents skills and strategies for discipline, support parents’ exploration with their personal concerns and family dynamics that may impact parenting, aid parents in understanding their child, and facilitate insight development for parents related to their relationship with their child. Furthermore, through consultation, parents are encouraged to develop insight into how their own issues may impact their ability to be fully present with their child, and parents may be referred to their own counseling (Kottman & Ashby, 2016). Of the approaches discussed, AdPT provides strong guidelines to play therapists in their involvement of stakeholders and clearly defines the role of parents in their approach (Jeon, 2017).

**Gestalt Play Therapy**

Violet Oaklander can be credited as the founder of Gestalt play therapy (Carroll & Orozco, 2019). This approach was founded on the Gestalt theory created by Fritz Perls who believed in the power of integration demonstrating purposeful and balanced behavior. Gestalt play therapists believe that children are growth oriented and self-regulating inherently and that understanding a child requires the play therapist to understand the context in which they live (Ray, 2011). The tenets of Gestalt play therapy include Organismic Regulation, a striving toward life and connection, and Dialogic Process, the symbiotic relationship between counselor and
child (Carroll & Orozco, 2019). The goal of this approach is to move toward healthy self-regulation in the child, demonstrate awareness of both internal and external processes, and to use the environment to meet one’s needs (Carroll & Orozco, 2019). Gestalt play therapists use techniques to directly introduce awareness to the child.

Parents are involved in this approach through promotion of safety and security in the relationship (Carroll & Orozco, 2019). Moreover, Gestalt play therapists involve parents in play therapy by allowing the child to understand why she was brought to therapy so that she can be involved in the process of assenting to treatment, developing goals and expectations, and selecting interventions.

**Jungian Analytical Play Therapy**

Jungian play therapists believe that the unconscious processes occurring within the child are paramount (Allan, 1997), and that healing is an internal process and does not come from an outside person or technique (Lilly & Heiko, 2019). Through this approach, children move toward “individuation” which is the process by which they acknowledge their unconscious processes and integrate them into their consciousness to move toward healing (Lilly, 2016). John Allan (1997), the credited figure for the Jungian approach, stated that the purpose of play therapy is to support the child in developing “his or her unique identity to overcome or come to terms with his or her losses or traumas while accepting and adapting to the healthy demands of family, school, and society at large” (p.105). Jungian play therapists often utilize tools such as drawings or sand play to interpret and analyze the child’s transference. Though similar to CCPT in its focus on developing a nurturing and safe environment for the child, Jungian play therapists are more directive, often asking questions, providing activities, using metaphors, creating dramas, and interpreting symbols the child may address (Lilly, 2016; Lilly & Heiko, 2019). In this approach,
Play therapists are observers and active participants of the play process and interact through tracking and affect identification.

Parents and families are heavily involved in the intake process for Jungian play therapy (Lilly & Heiko, 2019). The first phase of treatment includes examining three generations of the family system to determine parents’ unresolved issues which could be passed down and adopted by children (Lilly & Heiko, 2019). Familial development and emotional history such as trauma are assessed through meetings with the parent. Because Jungian play therapists are working through symbols and need to have multiple working hypotheses of what is occurring for the child, they should have a good working understanding of the child prior to meeting her for the first session (Lilly, 2016). In the intake, parents provide information regarding the multigenerational system, the child’s adaptive functioning, and any events or issues that may lead to the maladaptive functioning being processed through play (Lilly, 2016). However, because Jungian play therapy is an approach focused on the relationship between therapist and child, parents are involved through consultation rather than directly involved in play.

Psychoanalytic Play Therapy

Similarly to Jungian analytical play therapy, psychoanalytic play therapists are mindful of the symbols in a child’s play and believe they are manifestations of the child’s unconscious mind. Focusing less on technique, the psychoanalytic play therapist is attuned to the child’s defenses, fantasies, and anxieties through verbalizations and play behaviors (Punnett, 2016; Punnett & Green, 2019). Psychoanalytic play therapists believe that children’s maladaptive behaviors are a result of disturbances between the id, ego, and superego, and growth occurs when a child relies less on the id and the ego. The psychoanalytic play therapist relies on free association, interpretation, parallel and conjoint play, and directed play (Punnett, 2016).
Though Murdock (2016) discussed psychodynamic play, which differs from psychoanalytic play therapy in the devaluing of the libidinal influences, his text regarding the theory highlights the role of the caretaker. Murdock (2016) stated that the psychodynamic play therapist involves caregivers through consultation and provides information gleaned through the child’s play to help parents and stakeholders become more aware of the child’s emotional concerns and provides positive tools to help address problem behaviors. Murdock (2016) stated that caregiver support is often the catalyst for change rather than the actions of the play therapist in the playroom.

_Ecosystemic Play Therapy_

In 1991, Kevin O’Connor developed Ecosystemic Play Therapy, a meta-theoretical and integrative approach to play therapy (O’Connor, 2016). EPT was inspired by psychoanalytic play therapy, object relations and attachment theories, Theraplay, and reality therapy (O’Connor & Vega, 2019). EPT play therapists believe pathology in children is a result of unmet needs and a child’s dysfunctional attempt at getting “unstuck” (O’Connor, 2016). EPT therapists consider the child’s system and serve as an advocate for the child within various systems including the child’s parents and school. EPT therapists are directive in that they include many interventions that range from minimally to highly structured. EPT therapists believe the therapist-child relationship is necessary but not sufficient for change. Goals of EPT include supporting the child in meeting his needs through various contexts, developing attachment and social relationships, and a focus on developmental functioning.

Ecosystemic Play Therapy focuses heavily on the child’s ecosystem, therefore communication with parents and teachers is paramount through this theory. However, O’Connor recommends that play therapists activate systems rather than directly intervening in them.
(O’Connor & Vega, 2019). For example, if a play therapist believes a child’s needs are not being met through his school, Ecosystemic play therapists may support the parents in their endeavors to request modifications rather than directly intervening with the school themselves. Parent support through various ecosystems is a basic tenet of this approach.

Summary of Theoretical Approaches to Play Therapy

With many different theoretical approaches to play therapy, play therapists are often left without clear guidance in engaging parents in child therapy (Jeon, 2017). Though some of the approaches above clearly outline the role of parents, others outline therapeutic progress through the theory, but do not define how parents can be involved. In fact, many theories lack attention to parent involvement which demonstrates how the topic of parent engagement is often neglected in discussion of critical components of therapy that lead to successful child outcomes (Jeon, 2017). Furthermore, Kottman (2011) stated that child therapists may be less anxious in engaging parents if they were provided with clear guidance on the skill. However, with many educational disciplines and theoretical orientations making up the field of play therapy, this may be an arduous task. Therefore, reviewing the history of play therapy demonstrates the various approaches to parent engagement throughout the decades and highlights the vast differences in theoretical foundations that impact the value play therapists may place on parent engagement in their work.

Characteristics of Play Therapists

Consideration of the history of play therapy demonstrates the broad spectrum of parent engagement practices. Moreover, considering the characteristics of play therapists currently working in the field further adds to this discussion. The Association for Play Therapy warns that it is “unethical and misleading for other professionals who work with children/adolescents and
incorporate toys or play-based techniques into their work, but are not trained Play Therapists, to represent themselves as a ‘play therapist’ (Association for Play Therapy, 2022, Clarifying the Use of Play Therapy section, para. 6). Therefore, the consideration of training, educational disciplines, and credentialing of play therapists will be reviewed.

Play therapy is a multidisciplinary field and includes professionals from counseling, psychology, social work, psychiatry, family therapists, and nurse practitioners (Seymour, 2016). With many different educational disciplines making up the profession, clear guidelines defining the role of a play therapist are necessary. The Association for Play Therapy states that play therapists must be “graduate level mental health professionals who have met the required education, clinical licensure, and additional specialized training and supervision specific to Play Therapy” (Association for Play Therapy, 2022, Clarifying the Use of Play Therapy section, para. 3).

Credentialing Standards

With such diversity in the field, there appeared to be a need for a standard set of credentials. In 1993, The Association for Play Therapy created credentials for play therapists including Registered Play Therapist (RPT) and Registered Play Therapist-Supervisor (RPT-S; Seymour, 2016). Later, the association developed the School-Based Registered Play Therapist (SB-RPT) credential. These credentials were created to demonstrate high standards of training, protect client welfare, create specialization within the field, and provide greater public awareness (Seymour, 2016). However, not all play therapists hold the additional credentials (Association for Play Therapy, 2022).

To become a Registered Play Therapist (RPT) through the Association for Play Therapy, play therapists must hold a master’s degree or higher in counseling, marriage and family therapy,
psychiatry, psychology, or social work (Association for Play Therapy, 2022). Applicants must hold a current, active, and independent license to provide clinical mental health services in one of the disciplines mentioned above. Furthermore, RPTs must document at least 150 hours of play therapy instruction and a minimum of 350 supervised, direct client contact hours in play therapy. The RPT credential was created to provide more stringent requirements for mental health professionals providing play therapy (Seymour, 2016), and furthermore, APT recently changed their application process to provide even more rigorous requirements in 2020 (Turner et al., 2020). As part of these new requirements, APT created a phase model for credentialing and developed professional competence standards to create greater credibility for the field of play therapy (Turner et al., 2020).

Play Therapists without Credentials

Though a credential in play therapy is preferable for play therapists, there are barriers to training that preclude some counselors from obtaining the credential. In a dissertation study of 83 graduate play therapy trainers, Pascarella (2013) found that few programs had a play therapy requirement that met APT standards and that a main barrier to play therapy training was lack of faculty with play therapy experience and time limitations within the program. As of today, there are 155 universities across the United States that provide play therapy courses, 86 universities that provide supervised play therapy experience, and 106 universities with an RPT-Supervisor on their faculty (Association for Play Therapy, 2022). As of December 31, 2021, there are 6967 professional members of the Association for Play Therapy, with 5005 members holding an RPT, RPT-S, or SB-RPT credential (Association for Play Therapy, n.d.).
Play Therapist Demographics

When play therapists begin or renew their APT membership, they are asked to report demographic information on a voluntary basis. Play therapists can choose to report their gender, race, generation, geographical location and work setting, credential, discipline, degree, certifications, language, theoretical orientation, and populations served. As of May 2022, 76.7% of professional members identified their race/ethnicity, 75.9% identified their gender, and 87.2% identified their generation. Of those who reported race, 74.1% of professional members identified as White, 6.2% identified as Hispanic, Latino, or Spanish origin, 5.6% identified as Black or African American, 1.6% identified as Chinese, and .5% identified as American Indian or Alaskan Native. Demographics of gender for those who chose to provide information included 92.6% female, 6.1% male, and .14% identified as nonbinary. The largest percentage of professional members were born between 1979 and 1999 (42.3%), followed by 1965-1978 (35.4%), and 1946-1964 (21.3%). The smallest percentage of professional play therapists were born before 1946 (1.1%).

Professional members can also choose to report demographic data regarding their work as play therapists. As such, 99.9% reported their discipline, 31% reported a specialty area or additional certification, 35.7% reported their primarily population served, and 78.4% identified a primary work setting. The majority of APT members reported working in private practice (55.7%), followed by community agency or nonprofit settings (15.5%), and 5.6% of respondents reporting they worked in a school setting. APT professional members are primarily from a counseling background (54.4%) with others identifying as social workers (26.0%), marriage and family therapists (11.8%), and psychologists (6.4%).
Play Therapist Competencies and Best Practices

Regardless of their credentials, APT attempts to hold play therapists to high standards of practice. Among these standards are the play therapist competencies (Turner et al., 2020) and Best Practices set forth by APT. In 2020, Turner and colleagues completed a Delphi study with eleven play therapy leaders to determine specific indicators of professional competence within play therapy. Play therapists were presented with 27 final indicators under three categories of competence (Turner et al., 2020). These three categories were pre-established and included knowledge and understanding of play therapy, clinical play therapy skills, and professional engagement in play therapy. Participants came to consensus on the majority of indicators in the second round of the Delphi study with only a few remaining indicators requiring a third round for consensus. Within the category of clinical skills, experts agreed that play therapists should “demonstrate relationship and rapport building skills” in relationships with not only children, but also with caregivers and other stakeholders in play therapy (Turner et al., 2020, p. 183). Furthermore, the eleven experts in play therapy came to consensus that family and systemic theories are important for play therapists to recognize as working with the child also includes therapeutic support of the system in which they are being raised. Thus, parent and family engagement in play therapy practices are among the competency standards play therapists are obligated to meet. The experts in this study also agreed that play therapists should practice within APT’s Best Practices framework (Turner et al., 2020).

APT Best Practices

The APT Best Practices framework was established as a guideline for instruction, supervision, and the practice of play therapy (Association for Play Therapy, 2022). Though play
therapists are urged to consider both the legal and ethical codes of the state in which they practice, these guidelines provide best practices for play therapists nationally.

Section B of the Best Practices framework considers play therapists’ work with parents and families (Association for Play Therapy, 2022). The document outlines the legal and ethical implications of working with parents such as custody concerns, the importance of providing informed consent, confidentiality when working with children, and access to records. Furthermore, the document outlines the importance of involving children’s families in the play therapy process as they “have influence in the client’s psychosocial growth and development” and may aid the therapist in providing support to the child (Association for Play Therapy, 2022, p. 7). Play therapists are advised to provide transparency in treatment planning, and it is recommended that parents and caregivers are involved in the formulation of treatment plans and goals.

The Role of Parents and Caregivers in Therapy

As both the play therapy competencies and APT Best Practices state, working with parents and caregivers in play therapy is a responsibility for play therapists. However, the role of parents and caregivers in play therapy is often variable and dependent on many factors. This nuance and variability impacts play therapists who are obligated to engage parents but may struggle with understanding how.

General Consideration for Parents and Caregivers in Therapy

In a survey of 298 participants measuring the adult public’s perception of play therapy, 42% reported not knowing what play therapy was, and a little under 40% reported that they had heard of play therapy but were unsure what it was (Hindman et al., 2022). Though adults participating in this study varied in their preliminary understanding of play therapy, participants’
initial ratings indicated that they had a strong to very strong perception that play therapy was a useful therapeutic intervention (Hindman et al., 2022). This particular study is beneficial in understanding what parents may know about play therapy prior to engaging in services for their children, however, of the sample studied, only 51.3% identified as parents.

In another study specific to parents, O’Connor and Langer (2018) surveyed 196 parents of 4 to 17-year-old children about their help-seeking behaviors, familiarity with child counseling, and experiences with mental health services for children. Parents were asked their familiarity with different modalities of treatment for their children including cognitive behavioral therapy (CBT), Dialectical Behavior Therapy (DBT), psychoanalysis, interpersonal psychotherapy, mindfulness-based therapy, family therapy, and play therapy. Parents surveyed reported most familiarity with family therapy and CBT as opposed to recognizing play therapy, regardless of their prior experiences with youth services. However, parents who had sought services for their children in the past were statistically significantly more likely to report familiarity with play therapy than parents who had not sought services for their children (O’Connor & Langer, 2018). Furthermore, parents who reported they had received therapeutic services in the past were more likely to rate play therapy as a helpful modality (O’Connor & Langer, 2018). Considering the findings of Hindman et al. (2022) study in conjunction with O’Connor and Langer’s (2018) study, parents appear to endorse youth services, but may have some confusion about the role of play therapy in youth interventions. Thus, engaging parents in treatment through clarity of therapeutic interventions and expectations may be a difficult task for play therapists. With play therapists deeply entrenched in their work, they may forget the adult public’s perception does not include a strong understanding of child counseling interventions. Even with parents who have engaged in youth services, these statistics demonstrate how not engaging parents in play therapy
services may lead to further confusion. These studies demonstrate the necessity of educating parents about the utility of play therapy.

**Varied Approaches to Parental Involvement**

Play therapy appears to be a confusing concept for the adult public, parents, and caregivers. This confusion can be attributed to the multitude of approaches to play therapy. As mentioned, there is diversity in the educational background of play therapists, but there is also diversity in the approach based on the theoretical orientation of play therapists. Thus, the role of parents in play therapy varies greatly upon which theory a counselor is employing. Parents can be involved via consultation or can be more directly involved in treatment through parent-based interventions targeting child outcomes (Leitão et al., 2021; Lindsey et al., 2013). Though not comprehensive, this section serves to address the multitude of roles play therapists take toward parent engagement.

**Individual Treatment with Children and Involvement via Consultation**

As mentioned in earlier sections of the Review of Literature, play therapists come from various training backgrounds and employ multiple theoretical interventions. For play therapists who engage in therapeutic interventions directly with the child, parent consultations are often conducted. Though no one model of parent consultation exists, many scholars have created conceptual pieces to support practitioners in this endeavor.

Landreth (2012) began to outline how play therapists engage parents in their work via consultation. Landreth’s attitudes toward parent involvement began with his perception that parents should be partners in play therapy. Moreover, he stated that “any effort by the therapist to be helpful to children must begin with the consideration for the parameters of the relationship to be established with the parent” (Landreth, 2012, p. 125). Landreth recommends play therapists
gather background information about the child from parents and suggested that parents could benefit from filial therapy to help them gain skills as caregivers. Landreth (2012) outlined appropriate parent involvement as meeting with parents once a month to keep them involved in the process, help explain play therapy, provide and gain feedback, and to build rapport with caregivers.

Ray (2011) built upon Landreth’s (2012) guidelines for parent engagement by outlining best practices for play therapists. In her text, Ray (2011) recommended meeting with parents every 3 to 5 child play therapy sessions for 30 to 50 minutes and suggests that play therapists involve all major caretakers in the process. Ray (2011) stated that the first consultation serves the purpose of developing a relationship with the parent, gathering developmental history, and establishing clear expectations for the play therapy process. Subsequent parent consultations address parents’ concerns, inform parents of progress in play therapy, and provide psychoeducation of concepts that may benefit the child at home (Ray, 2011). Ray (2011) encourages play therapists to have respect for the parent’s role by providing affection and patience for the parent. However, Ray (2011) recommended play therapists balance between respect for parents and establishing themselves as an expert with a clear focus on the child as the client. In her manual, Ray (2011) states that parent consultation is not clearly outlined via a manualized approach the way that CCPT is. Thus, she suggests that prior to engaging in research with consultation, a manual is required. This may lead to confusion among practitioners and explains the impact on research designs that measure the impact of parent involvement.

Cates et al. (2006) created guidance for effective parent consultations in play therapy. Through their conceptual piece, the authors outlined goals for communication for the initial phone call with parents, through subsequent parent consultations, and finally, discussion of
termination. This guidance sought to educate play therapists on attitudes toward parents, information that must be gathered, and effective communication of progress. Post et al. (2012) further added to the literature by suggesting ways in which play therapists could collaborate with parents to establish and discuss behavioral goals. Through their conceptual piece, Post and colleagues suggest strategies for considering cultural influences related to parents’ concerns and provide case examples from which play therapists may learn.

Stulmaker and Jayne (2018) attempted to create a model for parent consultation in Child Centered Play Therapy. Through their approach, play therapists were encouraged to provide core conditions to parents, support parents in understanding their child, help the parent experience greater empathy for their child, and promote systemic change in the child’s environment. Through their approach, Stulmaker and Jayne (2018) suggested the importance of developing coursework related to parent engagement as it is often a skill play therapists strive to learn.

McGuire and McGuire (2001) authored a text about linking parents to play therapy and provided a structured approach for play therapists to follow. The authors suggested that developing a relationship with the parent is at the forefront of the play therapist’s mind as they make initial contact. Moreover, McGuire and McGuire (2001) recommended play therapists engage skills such as reflecting feelings, gathering background information, clarifying the role of parents, and defining therapy goals. Similarly to others’ guidance on parent consultations, McGuire and McGuire stressed the importance of the therapeutic relationship, empathy, and validation of parent concerns throughout their text.

Rise VanFleet’s (2000) seminal work on parent resistance suggests play therapists consider parent resistance through the lens of their own internal barriers and the therapeutic alliance between counselor and parent. VanFleet’s conceptual piece highlights the need for
investigation of a play therapist’s internal barriers to parent engagement and need for training and supervision of play therapists regarding parent consultation. VanFleet et al. (2010) later outlined engaging parents in Child-Centered Play Therapy as the authors stated parent involvement is vital to the CCPT process. In their text, VanFleet and colleagues suggested that empathy plays a role in introducing CCPT to parents due to feelings of inadequacy, defensiveness, and questions about the process. VanFleet et al. (2010) suggested play therapists first observe a family play session to understand the child client in context prior to establishing treatment goals. VanFleet and colleagues recommended play therapists meet with parents regularly, with parents struggling with establishing limits at home meeting with therapists as often as once a week. Furthermore, VanFleet and colleagues recommended that play therapists engage in teachable moments where they guide parents on how to handle behavioral issues at home and to allow children to understand and express their emotions.

Cochran et al. (2010) also addressed parent involvement in their CCPT text. They stated that the initial meeting with stakeholders lays the groundwork for a therapeutic relationship and makes CCPT more effective. Cochran et al. (2010) suggested that play therapists focus on demonstrating empathy, recognizing the problem the parent is hoping to resolve, and validate the parent concerns by conveying understanding. Moreover, Cochran et al. (2010) recommended five messages play therapists convey to parents after an initial meeting including the counselors’ care for the child, understanding of the presenting concern, trust in the counselors’ process, a belief that the play therapist views them in a positive light, and clarity about ongoing communication. In subsequent meetings, play therapists provide feedback, allow the parent to voice concerns, and introduce parenting skills. Cochran et al. (2010) recommended setting clear goals that are measurable and discussing progress with parents frequently.
Though similar in their approaches, parent consultations are not clearly outlined in the literature. Conceptual pieces provide goals for play therapists; however, barring Ray’s (2011) text outlining how often play therapists should meet with parents, direct instructions are not often provided to play therapists. Thus, each play therapist is left to individually decide how to engage parents when providing direct services to children. In direct contrast to the parent consultation method, parent-based interventions are often much more prescriptive.

**Parent-Based Interventions Targeting Child Outcomes**

For some play therapists, parent engagement involves a more direct approach through parent-based interventions. These play therapy interventions exist through multiple theoretical lenses, are directed primarily toward parents, generally structured, short-term, and can be provided via group or individual formats (Leitão, 2021). Though the list below is not comprehensive, programs included in this review were selected due to their inclusion on the National Registry of Evidence-Based Programs and Practices (NREPP) list and the Substance Abuse and Mental Health Services Administration (SAMHSA) lists and addition on the Association for Play Therapy webpage. SAMHSA is the “leading force in evaluating and promoting mental health interventions based on quality of research and readiness for dissemination” (Association for Play Therapy, 2022). Parent-based interventions on this list include filial family therapy, Child-Parent Relationship Therapy (CPRT), and Theraplay.

**Filial Family Therapy**

Bernard Guerney developed Filial therapy (FT) in 1964 as an extension of Virginia Axline’s Child-Centered Play Therapy approach (Scuka & Guerney, 2019). Guerney’s approach considered the benefit of play therapists teaching the techniques of CCPT to parents in order to complete their own play therapy sessions with their children. Through this process, parents of
children ages 3 to 12 became oriented to the principles of CCPT to better understand their children and respond more effectively to them at home (VanFleet & Tophman, 2016). The goals of FT include parents better understanding their child’s feelings, motivations, behaviors, and needs and learning how to respond with empathy and limit-setting skills. The improvement of the parent-child relationship and reduction of problem behaviors in children were also goals of this approach. Furthermore, through FT, children become more accepting, demonstrate more positive emotions, increased self-esteem and self-confidence, and appear more well-regulated (Scuka & Guerney, 2019).

With his wife, Louise Guerney, Bernard developed the group Filial Family Therapy model (Scuka & Guerney, 2019). In FT, parents meet for two hours weekly for 20 sessions in which they learn skills and provide support for other parents. Each week, parents engage in play sessions with their children which are observed by other parents in the group. The filial therapist works with the group to provide feedback and supervision. Filial groups are conducted in groups of no more than 10 parents (with their 10 children), however, due to difficulty in assembling groups, modifications have been made to the filial model for individual families. Furthermore, due to time constraints of participants, 10-12 session models have been adapted from the 20-week model (VanFleet & Topham, 2016). Individual filial therapy for families lasts on average from 17 to 20 one-hour sessions (VanFleet & Topham, 2016). Play therapists providing FT should be trained by Certified Filial Therapy instructors who provide continuing education and supervision for the model.

Filial therapy is well researched. In a meta-analysis measuring effect sizes of child outcomes discussed later in this review of literature, filial therapy demonstrates superiority to
individual play therapy treatment with children (Bratton et al., 2005). Moreover, FT has been highlighted in over 50 research studies over the past 50 years (VanFleet & Topham, 2016).

Child-Parent Relationship Therapy (CPRT)

Garry Landreth immersed himself in the filial approach and found that he resonated with the model, however, believed that with shorter treatment, he may capture parents that had difficulty committing to the time intensive requirements of the intervention (Landreth & Bratton, 2020). Thus, Landreth experimented with 15 and 12-week models before landing on a 10-session model (Landreth & Bratton, 2020). In 2006, Landreth and Bratton published their development of a 10-week, group-based, manualized approach founded on Guernsey’s work. Child Parent Relationship Training (CPRT), a filial therapy approach, centers on the relationship between the child and parent as a means to allow the child to move towards his own greater potential (Landreth & Bratton, 2006). This is based on Rogers’ original supposition through person-centered counseling that the relationship is the means by which clients move toward their innate tendency toward self-actualization (Rogers, 2007). Similarly, Landreth and Bratton posit a positive child-parent relationship allows a child to move toward his own innate ability to self-heal (2006). Landreth and Bratton (2006) outline the therapeutic goals of CPRT as including a “reduction of symptoms, development of coping strategies, and an increase in positive feelings of self-worth and confidence” (p.12).

The structure of the 10-week group model emphasizes a balance of both a didactic and processing model of therapy (Landreth & Bratton, 2006). As parents progress through the psychoeducational pieces and emotional experiences are evident, processing is necessary in order to ensure a parent is fully present and available to absorb the material. Landreth and Bratton (2006) created a group approach to this filial training with the supposition that group processing
allows safety to “break down barriers of defensiveness and isolation” (p. 19). Through the 10-week model, parents are taught a variety of skills that they are asked to utilize in order to engage in weekly play sessions with their children (Landreth & Bratton, 2006). Play sessions are recorded and supervised by the group facilitator each week to allow further understanding and generalizability of skills (Landreth & Bratton, 2006).

CPRT is also well-researched. Over 33 studies and 800 participants have demonstrated the efficacy of Child Parent Relationship Training (CPRT) with multiple populations and presenting concerns (Landreth & Bratton, 2006). Over the past two decades, research has been published outlining the effectiveness of CPRT with children who have witnessed domestic violence (Smith & Landreth, 2003), children who have been sexually abused (West, 2010), utility among incarcerated fathers (Landreth & Lobaugh, 1998), adopted children with attachment disruptions (Holt & Bratton, 2014), and parents who identify as Hispanic, low-income, and first-generation immigrants (Ceballos, 2008).

Counselors interested in this approach can obtain three levels of certification (Center for Play Therapy, n.d.). Level One Certified CPRT Associates, or parent educators, are eligible to provide the didactic content of the CPRT manual but are not certified to conduct the full protocol. Level Two certification is required to become a certified CPRT practitioner and conduct the 10-session protocol. This certification requires educational training and a supervised clinical experience component. Lastly, Level Three certification denotes an advanced CPRT practitioner and supervisor and requires all qualifications for Level Two as well as a license as a supervisor and additional supervised clinical experience (Center for Play Therapy, n.d.).
Theraplay

Theraplay was developed by Ann Jernberg with the purpose of developing secure attachments between the child and parent (Booth & Windstead, 2016) and is suitable for parents with children from infancy to adolescence. The goals of treatment include self-regulation, adequate social skills, learning, and creation of internal working attachment models (Booth & Winstead, 2016). Furthermore, the parent-based intervention was developed from Bowlby’s Attachment Theory. Theraplay can take place in both group and individual formats with the group format created by Rubin and Tregay in 1989. Theraplay therapists believe that a strong caregiver attachment where parents are responsive, sensitive, and playful with their children impacts the behavior and feelings of children. Through strong caregiver attachments, children believe they are loveable, and the world is safe, therefore they are free to believe others are loveable and competent.

Theraplay is provided by therapists trained through the Theraplay Institute with supervision from a Certified Theraplay Supervisor and can be completed in a variety of settings. Theraplay sessions are often conducted once a week beginning with a 15-to-20-minute caregiver discussion followed by a 30-45 session including interaction with the child and parent. Parents play with their child while the therapist observes in sessions one through three. In session four, only the therapist and the caregiver meet to discuss treatment goals and progress. Additionally, the therapist will review videos of play sessions and provide the parent with feedback. Sessions five through eight are similar to the first few sessions where the caregiver and child interact with the therapist observing. Session nine includes another feedback session. Theraplay often is completed in 25 sessions following this treatment protocol, however, severity of the child’s concerns will inform treatment length (Booth & Winstead, 2016).
Theraplay is well-researched in the literature, thus, it has been recognized by the California Evidence-Based Clearinghouse as demonstrating promising research evidence and by the Washington State Inventory of Evidence-Based, Research-Based, and Promising practices for Prevention and Intervention services for Children and Juveniles. Multiple peer-reviewed controlled studies have been conducted on Theraplay demonstrating its benefit as a parent-based program (Booth & Winstead, 2016).

Play Therapist Training in Parent-Based Interventions

Though play therapists may not always be credentialed as a Registered Play Therapist, several of the parent-based interventions mentioned above have their own credential and training programs. Thus, when understanding play therapists’ perspectives of parent engagement in play therapy, a clear understanding of these approaches to child counseling becomes paramount. Furthermore, with play therapists who hold these additional credentials, training of parent engagement and involvement becomes much more in depth and prescriptive than the suggestions outlined by conceptual pieces for parent consultation. Furthermore, the programs and descriptions outlined in this review provide further clarification of the nuance of training play therapists may receive regarding this construct.

Effective Models for Parent and Caregiver Engagement

As highlighted above, play therapists’ work with parents is nuanced and highly variable. Though the Association for Play Therapy has created an operational definition for play therapy and outlined best practices to working with parents, multiple theories and approaches to play therapy leave counselors with a lack of consensus to how best involve parents in treatment (Jeon, 2017). However multiple models for parent and caregiver engagement have outlined effective parent support in child counseling.
First, Jeon (2017) worked to address the need for an overarching illustration on parent engagement to support play therapists by conducting semi-structured interviews with experts in the field of play therapy who employed multiple theoretical approaches to counseling. Experts in this study included credentialed play therapists with over 7 years of experience practicing from theoretical orientations including Child-Centered Play Therapy (CCPT), Adlerian play therapy, Theraplay, Gestalt play therapy, and Jungian analytical play therapy. Through this study, Jeon (2017) developed a model for parent engagement using the Discrimination Model of supervision. Practitioners’ roles as a counselor in parent involvement included emotional support, aiding in gaining insight, and minimal counseling. The teacher role for play therapists engaging with parents included psychoeducation for parents, experiential learning, and modeling techniques.

Lastly, in Jeon’s model, play therapists should serve as a consultant by assessing the child’s problems and resources, functioning within the family, facilitating communication among family members, providing information and process sharing with parents, and discussing alternatives for interactions with the child (Jeon, 2017).

Becker and Chorpita’s (2016) REACH model outlines five domains for parent engagement that lead to effective therapeutic outcomes for children. These domains include the Relationship (the therapeutic alliance between parent and counselor), Expectancy (parents’ preconceived beliefs about counseling, their children, and their own role as parents), Attendance, Clarity (parents’ understanding of treatment modalities and their role in the process), and Homework (parent adherence to participation in the treatment or completion of assigned therapeutic homework). In a 2018 study of this model using 40 years of children’s mental health services engagement research, Becker et al. (2018) determined that many of these domains were represented among effective treatments. For example, in studying interventions that
demonstrated effective impacts on child outcomes, elements such as assessment, psychoeducation, barriers to treatment, and goal setting demonstrated the importance of the Expectancy domain in this model. In a 2022 study, Chorpita and Becker (2022) determined the structural validity of their framework across age, race, region, and caregiver language.

In a 2014 study of family engagement in 40 interventions with children, Lindsey et al. studied practice elements that are connected to study outcomes and found 22 different engagement practice elements employed throughout the interventions. Moreover, Lindsey et al. (2014) measured which of the practice elements were connected to “winning” treatments when a study had a comparison condition such as another intervention or a control group. Of those engagement tactics of therapists, Lindsey et al. (2014) found that counselors were most likely to employ assessment strategies with parents and that assessment was the engagement strategy most employed in “winning” treatments. For the purpose of this study, assessment was defined as measuring the caregivers’ needs and strengths through various methods such as observations, interviews, questionnaires, or reviewing records. Lindsey et al. (2014) describe this engagement strategy as one where the counselor can begin to build the therapeutic alliance. Lindsey et al. (2014) measured conditional probabilities of an engagement strategy being used in a “winning” strategy to determine what practice elements may be most effective. Lindsey and colleagues (2014) determined that 14 of the 22 elements had the highest conditional probabilities. These includes elements such as setting expectations, supporting parent coping, assessing barriers to treatment, acknowledging culture, modeling, problem solving, and relationship and rapport building (Lindsey et al., 2014). The authors note in the discussion that these elements are specific to the practitioner and may influence the therapeutic alliance. This study demonstrates the importance of therapist actions, behaviors, and attitudes in caregiver engagement rather than
supporting the belief that effective counseling relies solely on the child and caregivers’ isolated motivation for change.

Similarities exist among the three studies discussed. Parent engagement requires a focus on the relationship between the counselor and caregiver, setting clear expectations and communication regarding progress, and enhancing parent skills through various techniques. Ray’s (2011) literature describing successful therapeutic relationship with parents aligns with the results of the studies mentioned. Her approach to parent engagement includes respect for the parent’s role and knowledge of the child, admiration for the person of the parent, patience, a clear focus on the child as the client, and an establishment of the therapist as the expert (Ray, 2011, pp. 142-143). Though her text centers around the Child-Centered Play Therapy approach, her considerations for the therapeutic alliance between parent and counselor sets the basis for many other models of engagement.

Sanders and Burke (2014) added to the literature by discussing both the hard skills and the interpersonal and process skills necessary for effective parent consultation. Similarly to Ray (2011), Sanders and Burke (2014) discuss different phases of parent consultation and the benefit of attitudinal considerations for counselors. Sanders and Burke (2014) provide more insight into the “assessment” phase of consultation discussed in Lindsey et al. (2014). The authors state that the goal of assessment is to develop and clarify expectations for counseling, agree on intervention, and develop a plan for addressing counseling concerns. Sanders and Burke (2014) state that effective assessment also works to develop a strong therapeutic alliance between the counselor and caregiver. Furthermore, they discuss the importance of clear communication of progress towards goals the parents outlined in order to deter from dropout, demoralization, or disenchantment with the therapeutic process. Sanders and Burke’s (2014) model for parent
consultation includes counselors first addressing their own assumptions, beliefs, and behaviors, before introducing change to the parent. This process is similar to Ray’s (2011) recommendation to have respect for the person of the parent and their role as the child’s caregiver. Sanders and Burke (2014) suggest introducing multiple options for micro-skills parents can develop and regularly monitoring reactions, potential resistance, and understanding of these skills. Furthermore, Sanders and Burke (2014) suggest supporting change and preventing and managing resistance toward those micro-skills. Managing resistance includes directly confronting the parent while maintaining empathy and acceptance. Though this model was developed for a behavioral approach to parent engagement (Triple P), the authors note that it can be generalized to other parent engagement approaches. The model connects many of the skills and practice elements researched by Becker et al. (2018) and Lindsey et al. (2014) with the attitudinal conditions necessary for successful parent engagement recommended by Ray (2011). It also addresses the importance of the therapist’s attitudes, biases, beliefs, and internal processes when working with parents.

Though this section outlines the nuances of training in parent engagement, play therapists may not always be exposed to research on effective parent engagement. In fact, play therapists often report they receive more training about parent engagement in workshops or continuing education credits after their graduate programs rather than receiving the training as part of their graduate program (Lolan, 2011). Therefore, though parent engagement is considered in many conceptual pieces, play therapists may not be exposed to them unless they are seeking further guidance to improve their practice. Furthermore, parent perspectives do not always demonstrate the importance of including them in treatment. One mixed-methods research study demonstrates parent support for Ray’s (2011) model for parent engagement. Lee and Ray (2020) completed a
q-methodological study with parents to understand what parents need and expect in CCPT services. Data was collected from 19 parents who were already receiving CCPT services at a university clinic. Lee & Ray (2020) chose q-methodology as it married both qualitative and quantitative methods to understand parents’ perspectives. The q-set statements selected for this study were collected from an extensive review of literature including peer reviewed journals, the ACA code of ethics, and best practices set forth by the Association for Play Therapy. The set was revised in two phases, once by a team of doctoral level educators, and next by a team of 4 doctoral level play therapists. Parents involved in the study were then asked to sort through the 40-statement q-sort to determine what they found to be the most and least important aspects of the CCPT process. Results of the study demonstrated parents most valued the play therapist gathering information about the child, helping the parent understand the process, teaching effective response strategies, demonstrating expert knowledge about children, seeking to understand parent concerns, and receiving training and supervision in play therapy. Among the least important factors were completing therapy in as few of sessions as possible, incorporating current technology, identifying as a parent themselves, and caring about the parent or caregiver. Due to the limitations of this study, it cannot be generalized to all parents seeking play therapy as it does not include the perspectives of parents whose children prematurely ended therapy or parents who have not yet begun the counseling process with their children.

Research Outcomes Measuring Benefits of Involving Parents in Play Therapy

Meta Analyses

Many conceptual pieces discuss the importance of counselor/parent alliance as a key component of strong outcomes for children (Kottman & Ashby, 1999; Post et al., 2012; Schottelkorb et al., 2015; Stulmaker & Jayne, 2018; VanFleet, 2000). However, though these
conceptual pieces discuss the benefit of parent engagement, there is conflicting evidence of the importance of parent engagement in research measuring child outcomes.

In the 2005 meta-analysis (Bratton et al., 2005), effect size was compared between studies that included the mental health professional as the provider of treatment with children and studies that included the parent as such. Because there were few studies that included parent consultation as an adjunct to play therapy intervention, Bratton et al. reported more specifically on play therapy studies that were parent-based such as filial therapy which trains parents to become the therapeutic agent for their children. The outcomes demonstrated a larger effect size for treatments with parents as the therapeutic agent (1.15) as compared to a moderate effect size for treatments that only included the mental health professional as the therapeutic agent (0.72).

A decade later, Lin and Bratton (2015) completed a meta-analysis using 52 CCPT studies that were determined to be controlled outcome studies. In this study, the authors sought to measure the impact of CCPT, and, in doing so, they also measured the relationships between effect size and multiple factors including the child’s age, publication status, presenting concerns in treatment, and the child’s ethnicity. Within this study, Lin and Bratton (2015) also measured the impact of caregiver involvement. Caregiver involvement was broken down into three types including full parental involvement (24 studies), full teacher involvement (4 studies), and partial or no caregiver involvement (24 studies). Therapeutic interventions that included parent consultation only were bucketed into the last category, partial or no caregiver involvement. Studies that fit within the first category were only parent-based interventions that employed CPRT or filial therapy. Though all groups demonstrated positive effects, the effect sizes for full parental involvement (.59) were statistically significantly greater than the results for the group with partial parent involvement (.33).
When considering the impact of parent engagement in those two meta-analyses, Ray (2011) posited:

There is a question regarding whether parent involvement is more successful because the therapist is facilitating changes in the system by enhancing the parent/child relationship, or the parent is utilizing new skills taught by the therapist, or the parent is feeling better because of emotional support provided by the therapist and can thereby give more emotional support to the child, or other facilitative factors. Not enough research has been conducted in this area to isolate how parent involvement is helpful. More than likely, benefits are enhanced because of a combination of factors. It appears common sense that play therapy will make a bigger difference if play therapists can engage parents in the process (Ray, 2011, pp. 141-142).

Lin and Bratton (2015) and Bratton et al. (2005) measured the impact of humanistic theories when considering parent involvement, however, a study by Mingebach et al. (2018) demonstrated that parent-based approaches that were behavioral also outperformed individual treatment for children. Mingebach et al. (2018) completed a meta-analysis of meta-analyses using 26 meta-analyses studying parent-based intervention with children demonstrating externalizing symptoms. This study considered parent training programs including PCIT, Triple P, Incredible Years, Cognitive Behavioral Play Therapy, Barklay’s Parent Training Programme, PMTO, Stepping Stones, and other behavioral parenting trainings that worked specifically with parents rather than engaging a consultation model. With over 400 primary studies of parent-based interventions included, Mingebach et al. (2018) found a statistically significant result with a moderate effect size for overall child behavior and externalizing behaviors that was stable over time. A strength of this study is a limitation of many others. Often outcome studies that measure the effects of parent engagement are using parents as the sole respondent for child behaviors. In
this meta-analysis, 59 of the 411 studies used observation as a tool for measurement further demonstrating the positive impact of these parent-based interventions. Furthermore, Mingebach et al. (2018) study confirms Lin and Bratton (2015) and Bratton et al. (2005) studies demonstrating parent-training programs outperform individual treatment, and that parent involvement has a positive impact on child outcomes.

*Intervention Study Research on Parent Engagement*

The meta-analyses mentioned above focused on parent engagement as defined by parent-based interventions. When considering the nuanced approach of parent involvement in child counseling, there are additional studies that consider parent engagement beyond parent-based training models. Multiple meta-analyses studying parent participation in CBT approaches demonstrate the difficulty in measuring this construct.

For example, Reynolds et al. (2013) measured the additive impact of parental or family involvement in CBT counseling by measuring the impacts of treatment of obsessive-compulsive disorder (OCD). Using random assignment, 50 participants ages 12-17 were split into two treatment groups, one involving parents and one group receiving individual CBT treatment. After receiving 14 sessions of CBT counseling, effects were measured using the Children’s Yale-Brown Obsessive Compulsion Scale (CYBOCS). In both groups, there were large treatment effect sizes, demonstrating both treatments were effective in alleviating OCD symptoms. However, when comparing groups, there was no statistically significant difference in effect size, meaning involving parents in CBT interventions for OCD treatment did not demonstrate additive effects.

Additionally, Thulin et al. (2014) completed a meta-analysis of 16 intervention studies using CBT to treat anxiety disorders. The meta-analysis’s purpose was to examine the impact of parent
involvement in therapeutic interventions by comparing CBT treatments that were child-only with CBT interventions that involved parents. Participants in this meta-analysis ranged from 5 to 17 years old, with the mean age of 10.6. The four types of parent involvement included in the study were services that includes parents individually with the child, treatment of the parent without the child, group therapy not including the child, and group therapy with the child present. In this study, the outcome demonstrated that CBT interventions that did not include parents (child-only treatments) outperformed treatments that involved parents. Though the difference favoring child-only treatments was non-significant, this study demonstrated involving parents does not enhance treatment benefits in CBT.

Further demonstrating the difficulty in measuring additive impacts of parent engagement in CBT approaches, Cardy et al. (2020) completed a systematic review of 23 research articles to determine if involving parents in CBT therapy for adolescents with anxiety disorders was more effective than CBT approaches working with the child only. Studies were broken down into categories including involvement through separate parent sessions, joint sessions including the parent and the adolescent, and through completing a workbook while the adolescent attended sessions. Through this study, the authors found that involving parents in CBT treatment for anxiety is effective, however, they were unable to determine if the addition of parent involvement enhanced the effects because only three of the studies included a primary outcome measure and because of inconsistencies in treatment protocols.

All three of the meta-analyses mentioned focused solely on CBT interventions, and furthermore, had a much older mean age than previous meta-analyses demonstrating the superiority of parent involvement (Lin & Bratton, 2015; Mingebach et al., 2018). Furthermore, a study by Dowell and Ogles (2010) provides clarity to the assertion that CBT approaches may not
demonstrate larger effect sizes when involving parents. Dowell and Ogles (2010) studied 48 outcome studies to determine if individual child treatment or parent-child or family therapy treatments yielded stronger outcomes for children. In this study, the authors determined that there was a moderate effect of including parents in treatment. Furthermore, the authors conducted a moderator analysis and determined that Cognitive Behavioral treatments were impacted least by the addition of parent involvement (Dowell & Ogles, 2010). Furthermore, they state “these findings suggest that cognitive-behavioral child-only treatments, with smaller overall effect sizes, are closer to the effectiveness of all combined treatments (lower effect size indicates more similar effectiveness) than non-cognitive-behavioral child-only treatments (Dowell & Ogles, 2010, p. 158). The authors discuss the finding that CBT treatments were statistically significantly more likely to tack on a parenting addition to an independent child intervention than other treatment approaches that were more likely to develop unique approaches for parents.

These findings may help clarify the findings from Thulin et al. (2014) and Reynolds et al. (2013) and help the reader recognize the difficulty in researching this construct. In reading through the methods of the studies mentioned, it is apparent that there is difficulty in isolating parent consultation or parent services from child services especially in CBT approaches. Wei and Kendall (2014) discussed suppositions for why parent involvement has not yet proved efficacious in CBT treatment and discussed concerns with methodological limitations of the studies mentioned, outcome measure variations, inconsistencies in how treatment was delivered, and theoretical concerns with how these interventions were delivered. Wei and Kendall’s implications for future research included development of a clear model of parent involvement in order to provide a more targeted approach for parents. This supposition appears to be true for many parent engagement research studies and further illustrates the difficulty for researchers and
practitioners to clarify how best to engage parents. Perhaps, rather than considering the impact of parent involvement on child outcomes holistically, it may be more advantageous to consider outcomes beyond effect sizes. For example, in measuring internal barriers to engaging parents and considering self-efficacy of play therapists, success in play therapy may not only be measured via meta-analyses considering outcome measures, but rather, specific factors related to the therapeutic process must also be considered.

Specific Factors Related to Parent Engagement in Intervention Studies

Though research has yet to demonstrate consistent effect sizes in support of the effectiveness of parent consultations (Athanasiou, 2001), children are affected greatly by their families, and there is minimal evidence that play therapy can be more effective if therapists connect to the system. Moreover, parents are likely to discontinue treatment prematurely if they are not included in the process, treatment goals, and progress of their child’s therapy (Athanasiou, 2001). Therefore, treatment outcomes are worth considering in the review of literature, however, other factors such as premature discontinuation of therapy contribute to the consideration of efficacy of parent engagement.

Attrition in play therapy is one factor that counselors consider when engaging parents. In Campbell et al. (2000), the authors studied why children drop out from play therapy. The authors discuss the importance of communication with parents as they state that often times termination may appear premature when in reality, parents may believe their children have improved. Furthermore, Campbell et al. (2000) discusses the issue that parents may prematurely terminate due to lack of communication about progress, increased behavioral problems, or the perception that their beliefs as a caregiver are not met by the clinician. The authors suggest clinicians spend more time in consultation and training with parents and involving parents more directly in the
play therapy process. Campbell et al. (2000) suggest that attrition can be avoided by connecting with parents so they feel less isolated and more supported by the counselor.

Kazdin and colleagues (2006) add to the literature of successful parent engagement in relation to attrition. The authors investigated the therapeutic alliance between both child/therapist and parent/therapist to determine predictors of therapeutic success as measured by a decrease in the child’s symptoms. In this study, 31 families dropped out of treatment early. Kazdin and his colleagues determined that of the non-completers, family attrition from treatment was statistically significantly correlated with parents’ perception of low-quality parent-counselor alliance (Kazdin et al., 2006). However, when reviewing parent-therapist alliance rated by therapist, there was not a statistically significant difference.

Importance of Parent Perception of Counselor/Parent Alliance

As demonstrated by the Kazdin et al. (2006) study, the counselor/parent alliance is paramount, and furthermore, the identity of the rater matters. Giannotta et al. (2019) considered the implementation of multiple parenting programs in an intervention study including The Incredible years, COPE, Cornet, and another non-behavioral, attachment-based program. Parenting groups (N=104) were led by 76 different pairs of leaders, and parents completed a questionnaire both before and after the completion of program. Parents of 749 children ages 3-12 participated (M= 7.7, SD=2.60) and were either assigned to one of the four programs or a control group. Giannotta et al. (2019) measured parenting competence, parents’ reactions, and the child’s externalizing problems. They found that when parents perceived the group leaders as understanding of their problems as parents, they attended more often and were more likely to complete their homework. Parents’ satisfaction with the program was predicted by their perception that their leaders were supportive.
Similarly, Leitão and colleagues (2021) completed a systematic review of 24 quantitative articles measuring outcomes for children with externalizing behaviors when using a parent-based interventions. Interventions included structured and manualized parenting programs including both group and individualized treatments. Leitão and colleagues (2021) analyzed success in treatment with therapist factors including parent-therapist working alliance, fidelity to the treatment protocol, therapist actions/skills, and therapist personal variables. They found that the “the therapist does indeed matter in parent interventions directed at behavior problems” (Leitão et al., 2021, p. 94). Parent-therapist alliance was positively associated with changes in parenting practices with the greater the parents perceived the alliance, the greater the improvements in parenting practices. The parents’ perception of the alliance was also related to fewer perceived barriers when it came to participating in their child’s treatment, more acceptability in treatment, and greater self-efficacy and parenting satisfaction. Similarly to the discrepancy in rating in the Kazdin et al. (2006) study, parents in the Leitão et al. (2021) study perceived the alliance stronger than did the play therapist.

Though Leitão et al. (2021) recommended interpreting this finding with caution, they did find that the therapists’ prior work experience with children and families, higher rates of extroversion, and less agreeableness and neuroticism were also associated with strong intervention outcomes. Moreover, the therapists’ perception of their own satisfaction with treatment was also related to strong treatment outcomes demonstrating the importance of therapist self-efficacy. This demonstrates the importance of measuring therapists’ internal barriers to engaging parents as self-awareness appears to be an important factor in consideration of the therapeutic alliance.
Greef et al. (2016) demonstrated similar findings to the Leitão et al. (2021) study. Greef and colleagues (2016) completed a systematic review of 46 studies which included 37 published manuscripts and 9 unpublished dissertations. They included studies that measured the therapeutic alliance between parent and therapist, focused on children under 18, completed an intervention for children, parents, or families directly or indirectly, were clinical in nature rather than analog, alleviated psychological functioning (not preventative in nature), and had more than 10 participants. Greef et al. (2016) study considered 6280 parents total with children 0-20 years old (M=10.74, SD=3.98). Findings of this study confirm other research on this construct and demonstrate that stronger levels of therapeutic alliance between counselor and parent were significantly correlated with stronger treatment engagement and clinical outcomes. Furthermore, Greef et al. (2016) findings mirror Kazdin et al. (2006) and Leitão et al. (2021) work demonstrating the identity of the rater of therapeutic alliance matters.

The studies mentioned demonstrate the importance of the play therapists’ attitudes toward parent involvement. It is not enough for play therapists to consider parent involvement in their work and to self-report their beliefs about parent/therapist alliance. As demonstrated by the studies in this section, parents’ perception of the therapeutic alliance appears to be strongly correlated to outcomes whereas therapists may demonstrate blind spots and lack awareness of the strength of the relationship. Therefore, rather than measure practice attitudes of play therapists, play therapists’ internal attitudes toward parent engagement becomes an important measure in the current study.

*Play Therapists’ Attitudes Toward Parent Involvement*

Though research demonstrates the importance of parent engagement, therapists’ attitudes toward parent involvement demonstrate mixed findings. In a study of over 1000 play therapists
of all theoretical approaches, Phillips and Landreth (1995) studied perceptions of clinical issues and determined counselors perceived that success in play therapy was largely decided by the therapist’s relationship with the child and the involvement of parents and family. However, though female therapists were found to endorse family and parent involvement as a determining factor of success in play therapy overall, female therapists who identified as client-centered counselors were less likely to endorse family involvement (66%) than were female therapists who identified with a different theoretical orientation (84%) (Phillips & Landreth, 1995). This demonstrates the impact of theoretical orientation and training on the views of play therapists. Because Axline’s seminal text implies that working with parents is not necessarily tied to the success of play therapy, the results of this study possibly reflects the ideology of the theory and demonstrate how theory impacts practice.

In another dated study, Kranz et al. (1998) surveyed 81 participants during an APT conference to understand their perceptions of education, training, and practice. When asked the most difficult issues to navigate as play therapists, 18 of the 81 participants listed work with parents. Moreover, when asked the most gratifying part of their jobs, the majority of participants discussed their relationship with the child while only 7 participants reported seeing family relationships improve was the most gratifying experience (Kranz et al., 1998). This response demonstrates the focus on the child as the client rather than satisfaction of working with parents and caregivers. The authors noted that working with parents was a top issue discussed in this survey and believed that “working with parents is an essential element in play therapy that tends to be neglected in the play therapy literature and in play therapy training and education” (Kranz et al., 1998, p.82) suggesting the importance of creating more parent engagement training. The authors note the limitations include the small sample size and limits of generalizability.
Furthermore, this study is dated, however, influential when considering play therapist perspectives.

In a more recent study of play therapists’ perceptions of a “good” play therapist, Nalavany et al. (2005) surveyed 891 APT members to obtain qualitative responses to the question of what three qualities make a “good” or competent play therapist. After concept mapping the responses, Nalavany and colleagues found 14 statements that met the exclusion criteria (2005). Twenty-eight raters were selected from the original sample (through self-selection) to create a concept map which yielded 7 clusters of competent play therapist behaviors. These included factors such as child attunement, sensitivity to the child, foundational skills, knowledge development, skills with the family, theoretical understanding of working with children, and using a structured approach to children. Cluster 5, skills with the family, included play therapist parent engagement behaviors such as providing feedback to parents, coaching and directing parent behavior, advocating for the child, and setting clear expectations about the therapeutic process. The 28 raters were asked to rank the importance of each cluster, and through this rating system, Nalavany et al. (2005) determined that participants found Cluster 5 to be the least important skill in a “good” play therapist. Moreover, the participants believed that skills with the family and theoretical understanding of child therapy were the two clusters that were the easiest skills to develop. The challenges of this study included the fact that the 28 raters were non-random and self-selected their participation which may skew results and leads the reader to interpret the results with caution. However, the study provides rich context with which to conceptualize play therapists’ perceptions of parent engagement. Though family skills were listed among the top 7 clusters of working with children, play therapists believed it was the least important skills and easiest skill to acquire. These findings in conjunction with Kranz et al.
(1998) and Phillips and Landreth (1995) demonstrate the importance of further training for parent engagement. Though play therapists find parent engagement important, they may not view their work with parents as pivotal to their competence in working with children. Thus, parent engagement barriers may not impact overall play therapist self-efficacy.

Haslam and Harris (2011) also investigated play therapists’ perceptions of parent engagement by conducting a survey of APT members to determine their perceptions of integrating family therapy into play therapy. Though this study does not focus specifically on parents and caregivers, the results of this study addressed play therapists’ perceptions of working with stakeholders in play therapy. Of the 295 participants recruited from APT, 94% agreed that involving families in child-based interventions was important, 90.1% agreed it was effective, and 93.4% of respondents agreed that families played a factor in the development of emotional issues in children (Haslam & Harris, 2011). However, when participants were asked directly about parent participation in play therapy, play therapists were mixed about their perception of parents’ willingness to engage directly in their child’s treatment (35.9% agreed, 17.8% disagreed, and 47% responded neutral). These findings demonstrate the mixed attitudes toward parent engagement in play therapy. Moreover, when Haslam and Harris (2011) questioned play therapists’ competence in working with parents versus conducting play therapy, there was a discrepancy in responses. Play therapists felt generally competent in their play therapy skills with 90.7% reporting that they felt competent with individual play therapy services and only 72.9% of participants reporting that they felt some degree of competence in working with parents and children (Haslam & Harris, 2011). Self-efficacy in relation to parent engagement appears to yield mixed results in the research. Moreover, the understanding of the importance of parent
engagement in play therapy competence also appears to demonstrate mixed results in the literature.

Current Research on Play Therapists’ Perceptions of Parent Engagement

Though there is a dearth of research on play therapists’ perception of parent engagement, one dissertation study attempted to clarify the experiences of this population. Lolan (2011) investigated the practice patterns of play therapists when working with parents, play therapists’ perceptions of parent engagement, play therapist training related to engaging parents, and multiple issues related to play therapist demographics and parent engagement. Members of APT (N = 431) participated in the study, and demographic data aligned with the overall membership of APT. The largest percentage of her sample was CCPT therapists (56%). The author created a Caregiver Engagement Inventory (CEI) using a pilot study which included 36-items measuring barriers to engaging parents, perceptions of caregiver engagement on client outcomes, and practice patterns when working with parents. Using descriptive statistics to analyze the questions created for her CEI measure, Lolan (2011) determined that play therapists perceived their theoretical orientation impacted their caregiver engagement, on average, conducted 2 to 3 parent consultations a month, and preferred face-to-face communication with parents. Lolan (2011) also determined that the majority of the play therapists surveyed (69%) strongly agreed that engaging parents was related to the child’s therapeutic outcome with no participants choosing the “disagree” statements for this question.

In Lolan’s (2011) research study, she also asked her sample about training related to parent engagement in play therapy. Through descriptive statistics on her CEI measure, she determined that the play therapists surveyed reported neutral responses to the question “I received training specific to working with caregivers in my graduate program” and were more
likely to respond that they received training specific to caregivers through workshops and trainings after they graduated. Moreover, the results of her study determined that play therapists surveyed were not satisfied with the trainings that they received overall as the majority of participants only chose “somewhat agree” to the latter question.

Specific to this study, Lolan (2011) studied whether years of practice as a mental health professional and play therapist influenced perceptions of caregiver engagement and found a statistically significant, positive correlation between number of years in practice and perceived effectiveness of face-to-face communication with parents ($r=.16$, $p<.01$). Furthermore, participants who reported their theoretical orientation influenced their work with caregivers were more likely to perceive parent engagement to be effective. Moreover, there was a positive, statistically significant relationship between level of education and use of face-to-face parent consultations determining that the higher the level of education play therapists had, the more likely to they were to use face-to-face consultation with parents. When measuring whether training impacted parent practice patterns, Lolan (2011) determined there was not a statistically significant relationship between the number of play therapy courses taken at the graduate level and parent consultation practices. However, there was a statistically significant positive relationship between number of continuing education hours in play therapy and the use of face-to-face parent consultations ($r=.12$, $p<.01$).

Lastly, Lolan (2011) measured barriers to engaging parents through her self-created CEI measure. She determined that play therapists were most likely to cite financial concerns (51%), parents’ lack of education about play therapy (54%), and mandated clients (40%) as the biggest barriers to engaging parents. Each of these concerns appear to reside within the parent, rather than the counselor, indicating that barriers held are often seen as the parents’ problem. Of the
concerns that play therapists in this study cited least were lack of rapport (27%) and multicultural competence of the play therapist (6%). In the free response portion of the measure, many of the barriers cited in the TBEP measure were stated by play therapist participants. These barriers included parent resistance to change, caregivers’ mental health issues, early disengagement by parent after problems are resolved, caregiver apathy, time constraints of parent, lack of follow through from parent, and caregivers’ deference to therapist as the expert.

Lolan’s (2011) study was impactful in understanding previous research related to the current study. However, some challenges require interpreting the results with caution. First, as this is an unpublished dissertation, the peer review process that journal articles undergo was not implemented in this study. Second, many of the statistically significant findings had low practical significance. Lastly, Lolan (2011) created her own measure through a pilot study. Thus, without a validated measure to consider, it will be impactful to consider similar constructs through a validated measure (TBEP). Many of the free response answers play therapists cited as barriers to treatment appear in the validated TBEP measure, therefore, barriers to engaging parents may be measured through this empirical lens. Furthermore, other constructs such as play therapists’ self-efficacy and the role of play therapists who identify as parents will provide rich context to add to the research Lolan (2011) conducted.

Parents as Play Therapists

A final construct to review for this current study is play therapists’ self-identification as parents and caregivers. Badding (2019) highlighted the unique concerns professionals face as both a parent and a play therapist. Among those challenges, Badding described the difficulty in questioning whether one is “practicing what they preach” in raising their own children. Furthermore, Badding discussed challenges such as confidentiality, the concern of having high
expectations for oneself, and others expecting more from a play therapist as a parent. In this chapter, Badding (2019) highlighted the importance of balance and self-care in individuals who hold both the role of a parent and a play therapist and discusses the benefits of the dual role. Badding discussed the benefit she perceives in understanding how parents feel, however, often decides against self-disclosure as she has found it is not beneficial. In another conceptual piece entitled “Thinking Like a Parent”, Bowen (2016) discussed the importance of purposeful self-disclosure when deciding whether to share that she is also a parent. Though not specific to play therapy, Bowen discussed the additional insight she believes she holds as a mother. Though these conceptual pieces allow insight into the dual role of parent and play therapist, there is a dearth of research of how the dual role impacts play therapists and their client outcomes.

One dissertation study conducted in 2011 studied the phenomenological experiences of 11 child trauma therapists who also identified as parents (Jalowiec, 2011). Of the group studied, 100% of the participants stated that they involved parents in their work when it was possible and/or necessary. However, when questioned about actual parent involvement in therapy, only 4 participants stated they involved parents in all of their cases, and the other 7 participants reported a range from 25% to 90% of their cases (Jalowiec, 2011). In studying the phenomenological experiences of this dual role, Jalowiec (2011) determined both challenges and strengths just as Badding (2019) and Bowen (2016) addressed in their conceptual pieces. Among the strengths dual role parent and therapists reported were an increased understanding of development due to their own experiences with their children and an increased understanding of what their child clients needed. Furthermore, a theme that developed from this study was that child trauma therapists who identified as parents believed that parenthood enhanced their clinical work.
Specific to their clinical work with parents, all 11 participants in this study reported countertransference in their work with parents. Participants reported increased empathy and compassion and less judgment toward parents as a result of their identity. Two participants reported feeling anger and frustration toward the parents with which they work as a result of their own identity as a parent, however, because this study is related to children who had experienced trauma, this may not be generalizable to all play therapists who are parents (Jalowiec, 2011). Participants also reported mixed beliefs about the appropriateness of self-disclosure regarding their role as parents which is in line with the conceptual pieces regarding this concept (Badding, 2019; Bowen, 2016). Moreover, the majority of participants reported feeling more confident working with parents due to having their own children. Participants reported this confidence was due to increased empathy, fundamental understanding of the difficulty of parenthood, and a deeper understanding of the significance of a bond between parent and child.

Of the challenges expressed in Jalowiec (2011) study, all the themes presented were challenges with the therapists’ home life and parenting rather than challenges with clinical work. Additionally, conceptual pieces about the dual role of parenting and counseling also discuss challenges as related to parenting rather than challenges in their work (Marlin, 1988). In a more recent qualitative study of psychologists navigating work and family, themes that emerged included lack of support, contentment in choosing family, a need for increased advocacy, and concerns with discrimination (Wilhelmi et al., 2019). Again, through this study, challenges related to competence or effectiveness as a counselor were not found. Moreover, Slattery and Park (2007) described how therapists’ dual role as a parent may lead to increased awareness and empathy for clients which allows for decreased judgment and blame for parents. This is
beneficial in understanding how the dual role of a parent and counselor may positively impact therapist self-efficacy.

**Play Therapist Self-Efficacy**

In understanding the play therapist’s role in engaging parents, it is evident that there are both didactic considerations related to training and attitudinal components that impact the relationship between counselor and parent. Furthermore, in understanding the nuanced topic of parent engagement in play therapy, it is important to understand self-efficacy as a factor in this equation. Though self-efficacy research has considered both the client and the counselor (Pace et al., 2020), counselor self-efficacy plays a considerable role in therapeutic interventions and child outcomes, therefore, it is considered in the review of the literature.

**Therapist Self-Efficacy Research**

Larson and Daniels (1998) defined self-efficacy in counselors as the beliefs and judgments about their own abilities related to counseling-related activities. Their seminal research with counselors-in-training determined that counselors high in self-efficacy were more likely to perceive themselves as highly capable in counseling clients whereas counselors-in-training with lower self-efficacy struggled to perceive themselves as having adequate skills to be successful with clients (Larson & Daniels, 1998). Moreover, counselors in training with higher self-efficacy were more likely to handle difficult client situations and implement feedback they received as part of their training. In considering the difficulty play therapists perceive in engaging parents, counselor self-efficacy appears to be an important consideration with this particular client factor.

In 1992, Larson et al. conducted five studies to develop the Counseling Self-Estimate Inventory (COSE) based on Alfred Bandura’s self-efficacy theory. Using 213 master’s level
counseling studies across three universities over 2 years, Larson et al. (1992) further defined self-efficacy. Five factors emerged that reflected counselor’s confidence in their skills including the use of micro skills, attending to the counseling process, dealing with difficult client behaviors, being aware of one’s own values, and cultural competence (Larson et al., 1992). These five factors make up the COSE which is used throughout much of the self-efficacy research in counselor education. Through the validation study, Larson et al. (1992) determined there was a statistically significant relationship between level of training and COSE scores determining that students with more training appeared to report higher levels of self-efficacy. Years of experience and semesters of supervision were also statistically significantly related to COSE scores. Larson et al. (1992) determined that theoretical orientation was not statistically significantly correlated to the reports of self-efficacy.

Since 1992, many studies have investigated counselor self-efficacy to determine factors that predict counselor self-efficacy, its predictive impact on several factors, and its role in client outcomes further demonstrating the importance of counselor self-efficacy as a construct in the field. For example, Lannin et al. (2018) conducted a multiple regression study that determined counselor self-efficacy predicts physiological stress when counselors know that a difficult session is approaching. The results of this study demonstrated the importance of measuring self-efficacy in relationship to work with parents as many conceptual pieces refer to parent consultations as the most difficult part of play therapists’ roles (Ray, 2011).

Martin et al. (2004) determined that emotional intelligence as measured by the Emotional Judgment Inventory predicts counselor self-efficacy. Through their study of 140 counseling students and professional counselors, Martin and colleagues determined that the subscales of identifying one’s own emotions, expressing emotions adaptively, and using emotions in problem
solving predicted both students’ and professionals’ self-efficacy scores (R=.537). A second phase of this study was completed in 2008 and determined that counselors who could identify their own emotions and identify others’ emotions were correlated with counselor self-efficacy scores (Easton et al., 2008). These findings demonstrated the importance of self-awareness in counselors and understanding their own barriers when providing treatment.

In relation to self-awareness and self-efficacy, Hung (2014) measured the mediating effect of self-awareness, self-compassion, and self-efficacy. Using 466 graduate level trainees including PhD, Psy.D., and master’s degree students, Hung (2014) measured counselor self-efficacy, self-awareness, self-compassion, and training variables including their supervisory rapport and clinical experience. Supervisory rapport was measured by asking participants to consider any supervisor who had the most impact on their development as a counselor (either positive or negative) throughout their graduate school experience and then complete a Supervisory Working Alliance Inventory-Trainee (SWAI-T) with that supervisor in mind. Through a path analysis, Hung (2014) determined that students with more clinical hours (experience) reported higher self-efficacy, and perception of higher supervisory support predicted higher counselor self-efficacy. Furthermore, counselor report of self-compassion also predicted their counselor self-efficacy. In measuring self-awareness, Hung (2014) determined that this construct played a vital role when connecting clinical experience and counselor self-compassion with counselor self-efficacy. In discussing her results, the author posits that her findings support the theory that self-awareness plays an important role in development of counseling skills.

Urbani et al. (2002), Kozina et al. (2010), Barbee et al. (2011), and Meyer (2015) also measured self-efficacy with multiple factors, and each found that the amount of training received
is correlated with self-efficacy scores demonstrating that increased training leads to increased confidence in counseling skills. Furthermore, in a multiple regression study, Pechek (2018) determined that student age did not predict counseling self-efficacy, however, amount of experience measured by completed credit hours in a master’s program did. Counseling self-efficacy has also been found to be related to counselors’ self-esteem, empathy, mindfulness, and anxiety (Al-Darmaki, 2004; Barbee et al., 2003; Greason & Cashwell, 2009).

In a recent study of counselor self-efficacy conducted in China, Li et al. (2022) measured multiple facets of therapist self-efficacy including perception of Helping Skills, Session Management, and Counseling Challenges subscales of the Counselor Activity Self-Efficacy Scales (CASES). Through latent growth curve analysis, Li et al., (2022) determined that older therapist trainees were more likely to report higher levels of self-efficacy initially, however, there was no statistically significant difference based on age as trainees moved through their counseling course. Females were more likely to report lower levels of self-efficacy initially, however, reported larger increases over the course of the experiential course than their male counterparts. (Li et al., 2022). Though this may not be generalizable to U.S. clinicians, this study helps demonstrate the impact of demographic considerations when measuring self-efficacy in counselors.

Specific to the United States, Suh et al. (2018) determined that counselors-in-training demonstrated a positively correlated relationship between hours of experience and counselor self-efficacy. In this study, age and self-efficacy were also positively correlated meaning that the older a counselor is, the more she demonstrates confidence in her counseling abilities (Suh et al., 2018). Friedlander and Snyder’s (1983) research almost supports the supposition that level of training is correlated with counselor self-efficacy.
Most recently, Pace and colleagues (2021) measured counselor self-efficacy within a randomized controlled trial and illustrated the variable nature of the construct. Pace et al. (2021) measured self-efficacy ratings of 80 therapists who took part in a randomized controlled trial to determine changes that occurred throughout the study, the correlation between counselor self-efficacy and treatment fidelity, and therapist self-efficacy in relation to treatment outcomes. Pace et al. (2021) determined that throughout the 6-month training period where counselors received consultation, counselor self-efficacy statistically significantly improved. Furthermore, the authors determined that initial measures of counselor self-efficacy were correlated with client outcomes. Lastly, Pace et al. (2021) determined that treatment fidelity and therapist self-efficacy were not statistically significantly correlated.

Play Therapist Self-Efficacy

Though there are many studies of counselor self-efficacy when measuring the counseling profession as a whole, there is a dearth of research related to self-efficacy in play therapists specifically. However, conceptual pieces related to counselor self-doubt provide much needed context. For example, Cuschieri’s chapter (2016) regarding the challenges of CCPT include a three-stage model of self-doubt. In her chapter, Cuschieri outlines play therapists’ journey from preoccupation to being correct and effective, to questioning the therapeutic process and its utility with children, to the third and final stage of her model, doubting oneself in the role of a play therapist.

A recent phenomenological study of the journey of CCPT play therapists provides more qualitative context for play therapist self-efficacy (Brooks et al., 2022). This study followed play therapists through their educational coursework and early career to determine themes in the development of Child-Centered play therapists. Brooks et al. (2022) found that confidence
through experience emerged as a theme. Furthermore, in relation to Cuschieri’s (2016) chapter, participants in Brooks et al. (2022) study also discussed confidence for the CCPT process through experience as well as confidence in their own self-awareness and person as a therapist.

Though there is a dearth of literature measuring self-efficacy in play therapists, the conceptual pieces as well as the limited research on self-efficacy determines that age and years of experience become an important factor to consider when measuring this construct. Furthermore, the identity of a play therapist as a parent may provide rich discussion.

One study measuring self-efficacy of play therapists in family therapy did find that play therapists reported feeling more confident in working with children alone (96.1%) than in working with children and parents together (83.1%) (Haslam & Harris, 2011). However, further understanding of counselor self-efficacy in the research is necessary.

In a 2001 dissertation study measuring professional burnout and counselor self-efficacy in play therapists, Seymour determined that play therapists rated themselves as having a high degree of self-efficacy overall. Seymour (2001) measured play therapists’ self-efficacy using the Counselor Self-Efficacy Survey (CSES), a 20-item, Likert-scale measure of counselor competencies. The measure was developed with participants from a major counseling psychology program and many of these respondents had limited experience in the field. Seymour measured the predictive value of counselor self-efficacy on play therapist burnout. Through his findings, Seymour (2001) determined that play therapists rated themselves as having a high level of self-efficacy with the 250-person sample from APT scoring from 67-100, M= 89.09, SD=6.95 on a 100-point scale of self-efficacy. This specific sample appeared to be experienced play therapists (years of experience ranging from 3 to 34 years) with M=9.6, SD=6.47. This sample did not include new play therapists (less than 3 years), however, only 17% of this sample
reported having an RPT or RPT-S credential. Therefore, the high self-efficacy reported may be correlated with the years of experience. Furthermore, with his sample not including anyone with fewer than 3 years of experience, none of his participants were recent graduates of a counseling program. Moreover, the results of this study demonstrated a slight negative skew which limits the generalizability of this study.

Lastly, play therapist self-efficacy of counselors was measured in Dynes et al.’s (2018) validation of the Therapist Barriers to Engaging Parents (TBEP) measure. In their research, Dynes and colleagues determined that counselors’ age and years of practice were statistically significantly correlated with counselor-self efficacy. Further discussion of Dynes et al.’s measure will be included in the methods section of this proposal; however, preliminary understanding of her validation study demonstrates the importance of age and years of practice as constructs to measure when considering counseling self-efficacy.

Counselor self-efficacy is a widely researched construct, however, there is a dearth of research understanding how this construct impacts play therapists. Beyond the two studies mentioned (Dynes et al., 2018; Seymour, 2001), play therapists’ internal self-concept is not a factor that is often considered in the research, though it is a large consideration for conceptual pieces. With so many research studies measuring predictive factors of self-efficacy, factors that predict self-efficacy, and other correlational constructs for therapists as a whole, further investigation into play therapists’ competence specifically may lead to better training and clinical advancements. Furthermore, in connecting self-efficacy with parent engagement, researchers, clinicians, and trainers have a more holistic understanding of play therapists’ needs.
Conclusion

Parent engagement in play therapy is a difficult concept to both measure and practice. Because play therapists are trained through many different graduate programs and employ various theoretical approaches, parent engagement becomes a nuanced approach with varied importance to play therapists. Thus, research appears to demonstrate mixed results. Though meta-analyses demonstrate parent involvement creates better child-outcomes (Bratton et al., 2005; Lin & Bratton, 2015; Mingebach et al., 2018), these studies mostly compare parent-based training programs against individual child treatment. Measures of additive impacts of parent consultations fail to demonstrate a consistent pattern of outcomes when involving parents in treatment (Cardy et al., 2020; Reynolds et al., 2013; Thulin et al., 2014).

Review of the literature demonstrates inconsistencies in play therapists’ perceptions of parent engagement in play therapy. Though many believe it is important (Lolan, 2011), parent involvement strategies do not rank as high as other skills in play therapy (Nalavany et al., 2005). Practice patterns of play therapists in engaging parents have been studied (Lolan, 2011), however, there has yet to be research on play therapists’ internal barriers to engaging parents to understand possible resistance to engagement. Furthermore, though one study has measured play therapist self-efficacy (Seymour, 2001), there has yet to be empirical research on self-efficacy in relationship to parent engagement in play therapy. These constructs are important to understand when developing training and support for play therapists. Play therapists agree they wish there were more training opportunities for engaging parents (Kranz et al., 1998), however, developing those opportunities may be difficult without understanding play therapists’ overall self-efficacy and its impact on perspectives related to parent engagement.
APPENDIX B

DETAILED METHODOLOGY
Introduction

Studying counselor self-efficacy and parent engagement of play therapists is paramount in developing well-needed training for play therapists. A review of the research in the literature demonstrated mixed results when understanding play therapists’ perceptions of parent engagement. Play therapists as a whole rate themselves high on self-efficacy (Seymour, 2001), however, understanding nuances to the construct may help develop better training procedures for preparing future and practicing play therapists to work with parents. Furthermore, there are currently no studies measuring the impact of parenthood on play therapists.

Research Questions

In the present study, I sought to gain further understanding of play therapists’ self-efficacy and how this may impact counselors’ barriers in working with parents to help inform counselor training and supervision. Research questions include 1) What are the relationships among demographic characteristics and barriers to engaging parents? 2) Do years of practice as a play therapist, training on working with parents, identification as a parent, and counselor self-efficacy predict internal barriers to working with parents?

Operational Definitions

The research terms included in this study were defined from variables that were considered in the review of the literature.

Play Therapists

For the purpose of this study, play therapists are defined as Association for Play Therapy professional members who hold a master’s degree in one of the disciplines required to engage in play therapy including counseling, psychology, social work, psychiatry, family therapy, and nursing (Association for Play Therapy, 2022).
Internal Barriers to Engaging Parents

Dynes et al. (2018) defines internal barriers to engaging parents as “internal barriers mental health providers experience when trying to engage parents” (p. 967). This construct measures therapists’ perceptions and emotional experiences of engaging parents in treatment, proclivity toward blaming and judging parents in treatment, and therapists’ reactions and decision making in treatment toward parent behaviors. For the purposes of this study, internal barriers to engaging parents will be measured using the Therapist Barriers to Engaging Parents measure.

Working with Parents

Jeon (2017) defined parent involvement in his conceptual piece as parental participation in the overall process ranging from intake parent meetings, to family therapy, to child-parent sessions, and lastly to separate parent training sessions” (p. 6). For the purposes of this study, working with parents will be defined as play therapists’ self-report that they include parents and caregivers in play therapy sessions either through parent-based training interventions, child/parent sessions, or family sessions or complete at least one parent consultation meeting per child client on a consistent basis.

Overall Counselor Self-Efficacy

Counselor self-efficacy is defined as a counselors’ perception of her expected performance and achievement in a counseling setting (Larson et al., 1992). This construct will be measured using the two subscales of the COSE, Counseling Process and Dealing with Difficult Client Behaviors. The Counseling Process subscale measures counselor actions that occur over a series of responses, are dependent on feedback from client, and appropriateness of counselor responses based on nonverbal client feedback and accurate assessment of the client. The Dealing
with Difficult Client Behaviors subscale measures counselor competence in working with clients that may be unmotivated, indecisive, or silent (Larson et al., 1992).

**Identification as a Parent**

Jeon (2017) defines parent as an individual with primary legal responsibility for the child-rearing process and includes “biological parents, family members, relatives, or legally designated guardians” (p. 6). For the purposes of this study, play therapists will be asked to self-identify as a parent or caregiver in the demographic questionnaire with the caveat of the definition above. Moreover, I chose to include the nuance that the child may be of any age to avoid counselor confusion if they identify as parents to adult children.

**Participants**

Participants were recruited from an email listserv of professional APT members. Participants were presented with inclusion criteria in the recruitment email they received and self-selected to participate. The sample included 136 participants with a mean age of 44.88 (SD=11.63). Participants reported being between 25 and 78 years old. Participants reported a mean of 12.72 years of practice (SD=8.156) and ranged from 1 to 35 years of experience. The sample was predominantly female (88.2%), came from the Counseling discipline (56.6%), and predominantly practiced in a private practice setting (66.2%). The majority of the sample identified as parents (67.6%). Participants wrote in their own identification of race/ethnicity rather than selecting from a list. The predominant response was White, Caucasian, or some variation of these two responses with 86.67% of the sample reporting this ethnicity. Play therapists were asked on average, what percentage of the families they serve identify similarly to them in race or ethnicity. Participants reported that a mean of 67.83% of their clients identified similarly to them in race or ethnicity with a standard deviation of 25.68. The median of this
variable for the sample was 75.00 and the mode was 90. Play therapists reported that they complete on average 3.62 parent consultations for every 10 play therapy sessions they conduct with a child ($SD=2.55$). The mode for this variable was 2 and the median was 3. Full demographic information can be reviewed in Table B.1.

Table B.1

*Variables of Demographic Survey Questions (N=136)*

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<th>Item</th>
<th>Subcategory</th>
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<th>Percentage</th>
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<td></td>
<td>Male</td>
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<td>(9.6%)</td>
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<tr>
<td></td>
<td>Nonbinary</td>
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<td>(0.7%)</td>
</tr>
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<td>(0.7%)</td>
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<tr>
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<td>(0.7%)</td>
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<tr>
<td>LCSW</td>
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<td>19 (13.3%)</td>
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<td>Northeast</td>
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<td>School (Higher Education or University Setting)</td>
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<td><strong>Are you a parent or primary caretaker to a child of any age?</strong></td>
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<td>Adlerian Play Therapy</td>
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<tr>
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<td>Ecosystemic Play Therapy</td>
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*Participants indicated more than one license and region, therefore, these two demographics have more than 136 total responses.

**Instruments**

Demographic Form

Demographic data collected included participants’ gender, self-report of race and ethnicity, years of practice, age, discipline, APT credential, frequency of parent consultations completed, client population, additional parent credential, licensure and state of licensure, highest degree conferred, practice setting, training related to working with parents/caregivers, participants’ identification as parents, and theoretical orientation. For this study, years of practice and age were collected as numerical values. Participants’ identification as a parent was collected
via a yes/no format providing the participant with a clear definition with which to self-report using the operational definition above. Training related to working with parents/caregivers was measured by asking participants the number of hours of training they received related to parent engagement and play therapy both through their graduate coursework or through continuing education credits. Participants selected their practice setting and theoretical orientation through a list of options provided from the Association for Play Therapy website (Association for Play Therapy, 2022). Client populations were reported by individuals choosing the percentage of clients they work with on average that identify similarly to them in race/ethnicity. Frequency of parent consultations were collected by asking participants how many consultations they complete per every 10 play therapy sessions.

**Therapist Barriers to Engaging Parents (TBEP)**

The Therapist Barriers to Engaging Parents (TBEP) measure was created specifically for child and family therapists to measure internal barriers counselors experience when engaging parents (Dynes et al., 2018). To measure internal barriers, participants completed the 13-question TBEP measure (Dynes et al., 2018). Questions included items such as, “I am hesitant to continue involving a parent if they become defensive or angry with me” and “I find it difficult to maintain a friendly and open attitude towards some parents”. This measure was chosen due to its clear focus on the construct of parent engagement. Kazdin (2016) warns that in research, measures are often selected without adequate attention to the extent to which they measure the construct and suggests considering validity of the measure, psychometric properties, and sensitivity of the measure to changes predicted by the hypothesis. Furthermore, Roberts and Hyatt (2019) stated that measures should be chosen with the consideration of appropriateness for population and setting. When investigating play therapists’ perceptions of parent engagement, this measure
considered the play therapists’ perception and internal awareness of parent involvement rather than practice patterns measured through Lolan’s (2011) study. Dynes et al. (2018) TBEP measure is scored on a 5-point Likert scale ranging from 1 (never) to 5 (almost always) with higher scores indicating more internal barriers to effectively engaging parents.

In their validation study, Dynes and colleagues randomly selected child and family therapists across disciplines from 22 agencies across the United States. 148 child and family therapists engaged in the online survey which included the TBEP measure, the Therapist Efficacy for Engaging Parents measure, the Maslach Burnout Inventory-Human Services Survey (MBI-HSS) (Maslach et al., 1996), two subscales of the COSE including the Process and Difficult Client subscales, and the Rosenberg Self-Esteem Scale. Dynes and colleagues (2018) chose the two subscales of the COSE with the assumption that therapists “with higher confidence in their counseling abilities could be able to separate a parents’ behavior from their own therapeutic or interpersonal skills” (p. 971).

Three factors emerged as subscales including Therapist Emotional Experiences (Cronbach $\alpha$=.76), Therapist Judgments (Cronbach $\alpha$=.74), and Therapist Reactions in Treatment (Cronbach $\alpha$=.78). Therapist Emotional Experiences was responsible for 37.4% of variance accounted for, Therapist Judgments was 10% of variance accounted for, and Therapist Reactions in Treatment was approximately 8.3% of variance accounted for. Therapist Emotional Experiences were defined as perceptions and emotional reactions of therapists toward parents in treatment. Therapist Judgments encompassed therapists’ proclivity to blame parents and make negative judgments toward them, and Therapist Reactions in Treatment demonstrated the ways parents’ behavior in treatment could influence therapist behavior and decision making. However, because this instrument was only validated on one sample, the use of subscales should be
considered with caution (Heppner et al., 2016; Kazdin, 2016). Thus, though the subscales were
not included in the descriptive data.

The overall internal reliability for the TBEP was Cronbach’s alpha= .86. According to
Taber (2017), this measure of reliability would rank this instrument as “reliable”. Dynes et al.’s
measure was significantly negatively correlated with measures of the COSE which demonstrated
convergent validity (2018). Furthermore, the TBEP measure was statistically significantly
correlated with measures of therapist burnout.

Dynes et al. (2018) mentioned multiple limitations to her validation of the TBEP
including the small sample size and the fact that participants were not asked to report ethnicity.
This may lead to lack of generalization for multicultural populations and is a limitation of the
measure chosen according to Kazdin (2016). Furthermore, in personal communication with M.
Dynes (personal communication, April 4, 2022), she confirmed that no research studies have
used the measure since it was created in 2018. However, she did mention multiple individuals
reaching out to her to ask to use the measure for supervision purposes, indicating the potential
utility of this instrument.

**Counseling Self-Estimate Inventory (COSE)**

To examine the relationship between internal barriers related to engaging parents and play
therapists’ overall sense of therapist efficacy, participants also answered all 37 items from the
COSE measure. However, only the two subscales of “Dealing with Difficult Client Behaviors”
and “Counseling Process” of the COSE measure were included in the analysis (Larson et al.,
1992) due to the focus of the research questions. The COSE was created to measure “counselor’s
judgments of their capabilities to counsel successfully in counseling situations or their
expectancies for success in counseling situations” (Larson et al., 1992, p. 106). These two
subscales were chosen as they were included in the validation of the TBEP measure with the rationale that therapists with higher confidence in their overall counseling abilities would be more likely to separate their own therapeutic skills from parents’ behavior (Dynes et al., 2018). The COSE measure has 37 statements with a 6-point Likert scale response from 1 to 6 with higher scores indicating stronger self-perception of overall counseling self-efficacy. The Cronbach’s alpha for reliability for the COSE was reported to be .93, the Counseling Process subscale reliability was .87, and the Dealing with Difficult Client Behaviors subscale was .8 (Larson et al., 1992). According to Taber (2017), these alpha levels demonstrate “excellent” reliability. Counseling Process subscale questions include statements such as “I am uncertain as to whether I will be able to appropriately confront and challenge my client in therapy”. This subscale measures a counselors’ confidence in their actions that occur over multiple responses in counseling and are driven by client feedback and overall assessment of the client (Larson et al., 1992). Dealing with Difficult Client Behaviors subscale questions include “I am uncomfortable about dealing with clients who appear unmotivated to work toward mutually determined goals” and measures the counselor’s confidence in personal ability to work with unmotivated or indecisive clients (Larson et al., 1992).

In one of the five studies, Larson et al. (1992) determined test-retest reliability of the COSE. In this study of 30 participants, the total test-retest reliability for the measure was $r = .87$. For the Difficult Client Behaviors subscale, test-retest reliability was $r = .8$, and for Process $r = .74$.

The COSE has been well researched with many populations and constructs. Thus, the use of subscales appeared to be an appropriate choice (Heppner et al., 2016; Kazdin, 2016). Though it was created for counseling students, multiple studies have demonstrated its appropriateness for practicing professionals (Kozina et al., 2010; Meyer, 2015; Urbani et al., 2002); therefore, it
appeared appropriate for practicing play therapists in the current study. Furthermore, Larson et al. (1992) stated that the measure is sensitive to change across different levels of counselors which provides sensitivity for the sample in this current study which will measure perceptions of new and seasoned counselors.

Procedures

After receiving IRB approval, participants were recruited through the Association for Play Therapy (APT), a national professional society of play therapists (Association for Play Therapy, 2022). The population of this study included current professional members of the Association for Play Therapy. At the time of the study, there were 6967 professional members with over 5000 holding an RPT, RPT-S, or SB-RPT credential (Association for Play Therapy, 2022). I obtained a list of contact information for all professional APT members. Next, I randomly selected a sample of 1500 counselors using a research randomizer through a randomizer website, www.randomizer.org. These 1500 individuals were emailed a recruitment message that briefly summarized the research and provided a link to a Qualtrics survey with which participants could access the study. Responses were tracked, and individuals who had not yet responded received two follow up emails. The sample was a convenience sample of individuals who met inclusion criteria for this research project. Inclusion criteria included participants who 1) Identified as a current professional member of APT with at least a master’s degree, and 2) individuals who were currently practicing play therapy. A total of 150 individuals submitted responses to the survey, however, only 136 participants completed all three instruments. With 1500 individuals emailed, this resulted in a 10% response rate. Using g*power to complete an a priori analysis for multiple regression with an effect size (f2) of .15, 4-total
predictors, alpha error probability of $p < .05$, and power (1-beta error probability) of .80, the sample size required was 85 participants.

Participants received an informed consent outlining risks and benefits as the first page of the Qualtrics survey. Participants chose to either consent, which prompted the rest of the survey questions, or declined to consent which ended the survey. Participants were asked to complete a 20–25-minute survey which included demographic questions, the 13-item Therapists Barriers to Engaging Parents (TBEP) measure, and the 37-item Counseling Self-Estimate Inventory (COSE). Benefits of participation included entry into a raffle to win one of three $50$ Amazon gift cards. Data was collected anonymously, and participants were routed to a separate form to enter their information for consideration in the raffle. Information obtained from the instrument was recorded with a code number with participant names only accessed by the research team. Identifying information such as university or practice information was not collected. Data collected was confidential, however, due to the collection of IP addresses, survey data was not completely anonymous. All data was stored on an encrypted, password-protected external hard drive on campus in a locked cabinet in the supervising investigator’s office where it will remain for 5 years, after which, data will be destroyed.

Data Analysis

Data from the Qualtrics survey were imported into SPSS for data analysis. Of the 150 responses, 14 participants did not complete either the COSE or the TBEP, therefore, they were removed from the sample. An additional 27 participants completed the measures, however, skipped one to two questions on the two measures. For these responses, the mean for that item was entered as the response. The 37-item COSE measure had 19-items that were reverse scored indicating the need to invert values for scoring. Items under the Counseling Process subscale
score (10 items with scores ranging from 10 to 60) and Dealing with Difficult Client Behaviors subscale score (7 items with scores ranging from 7 to 42) were scored. The TBEP measure had one item that required reverse scoring. The TBEP was scored by calculating the sum of all 13 responses. In the TBEP, total scores range from 13 to 65 with higher scores indicating more barriers to working with parents (Dynes et al., 2018).

To measure hours of training, a new variable was created to measure total hours of parent engagement training. To calculate this total, I multiplied each graduate course reported by 67.5 (the number of hours of continuing education credit APT considers for a 3-hour graduate course) (Association for Play Therapy, n.d.). I then added that number to the number each participant reported for CEUs for that category. Because the survey asked participants to enter 100 if they had over 100 CEUs, I used that number as a ceiling to provide equity for responses. Three participants reported they did not remember the number of courses or CEUs for this variable. For these three participants, I left the new variable measuring hours of training in parent engagement blank. When participants included a range (i.e. 2-3 courses), I chose the higher number to provide equity in responses. For the first research question, the data set included 136 participants, however, due to lack of clarity in one response, one participant was removed prior to completing the multiple regression analysis, thus, that analysis included 135 participants.

To answer the first research question, what are the relationships among demographic characteristics and barriers to engaging parents, overall results of the TBEP were reported including mean, standard deviation, mode, and median. Moreover, I completed four one-way analyses of variance (ANOVA) to determine if several categorical demographic factors impacted the results of TBEP total scores. These variables included gender, APT credential, discipline, and ethnicity. Two correlational analyses were also completed to determine if there was a statistically
significant relationship between age and TBEP scores and client population of race/ethnicity and TBEP scores. To determine if there was a meaningful relationship between that demographic variable and TBEP scores, effect sizes and \( p \) values were observed to determine if the ANOVAs yielded statistically significant results. ANOVA analyses that yielded a \( p \) value equal to or less than .05 were considered statistically significant relationships. For those ANOVAs that were statistically significant, effect sizes were calculated by dividing the sum of squares between groups by the total sum of squares value. This value, the partial eta squared (\( \eta^2 \)), was used to determine the magnitude of the effect of the demographic variable on the differences in mean TBEP scores for that group. The strength of the effect size was compared to Cohen’s (1977) guidelines for interpreting the magnitude of the relation with .01 interpreted as small, .06 interpreted as medium, and .14 interpreted as large. Correlational analyses were also interpreted by reviewing the \( p \) values and Pearson correlational coefficients. \( P \) values equal or less than .05 were considered as statistically significant. The Pearson correlational coefficients (\( r \)) were compared to thresholds defined in Cohen (1988) with .10 defined as small, .30 defined as medium, and .50 defined as large.

Because participants were asked to write in their own race and ethnicity, I did not have categories within this variable. Thus, I created an additional coded variable to use in the ANOVA measuring the relationship between ethnicity and TBEP scores. Participants in this sample predominantly reported some variation of the words White or Caucasian for their ethnicity/race (81.3% or 122 responses). Thus, in order to compare meaningful group sizes, I created two categories for this variable, participants who reported White or Caucasian for race/ethnicity and participants who reported other identities.
To answer the second research question, do years of practice as a play therapist, training on working with parents, identification as a parent, and counseling self-efficacy predict play therapists’ internal barriers to working with parents, I conducted two multiple regression analyses. The first multiple regression analysis used the TBEP total score variable as the outcome variable and predictors included years of practice, identification as a parent, total hours of parent training, and the Difficult Client Behaviors subscale score of the COSE. The second regression analysis had the same outcome variable, however predictors included years of practice, identification as a parent, total hours of parent training, and the Counseling Process subscale score. Prior to running the analyses, I ensured that the data met the assumptions for normality and linearity. Additionally, I utilized an initial visual inspection of the analysis in order to address the assumption of homoscedasticity for both regression analyses. Once computing the regression models in SPSS, I observed the Adjusted $R^2$ effect size in order to assess what percentage of the variability of a play therapist’s overall attitude toward parents I can explain using my five predictors. I chose to interpret Adjusted $R^2$ values rather than $R^2$ outputs due to Leach and Henson’s (2007) supposition that $R^2$ values may “overestimate the importance of a result if effect sizes are not adjusted to account for the influence of sampling error” (p.9). Next, beta weights and $p$ values were observed for both models to identify the dominant predictors within the regression models. $P$ values less than or equal to .05 were considered for significance. I then computed and examined the structure coefficients and squared structure coefficients for each predictor variable to determine its contribution in each equation. Considered in conjunction with beta weights, I determined if each predictor variables accounted for the variance in the predicted TBEP scores and assessed the relationship between predictors in each model.
APPENDIX C

UNABRIDGED RESULTS
Descriptive Results of Therapist Barriers to Engaging Parents

To answer the first question, I analyzed descriptive data for the participants’ TBEP scores. TBEP scores range from 13 to 65 and are calculated by finding the sum of the 13-item questionnaire. The mean of participants’ total score was 27.64 with a standard deviation of 5.53. The sample was bimodal with 11 participants scoring both 24 and 27, and the median of TBEP scores for this sample was also 27. The range of scores for this sample ranged from 13 to 42. This means that the majority of participants responded with never (1), rarely (2), or sometimes (3) to most of the questions in this measure, and participants rarely chose “often” or “almost always” as a response when asked about a barrier to engaging parents.

Because this is the first time this instrument has been used in research, the only benchmark with which to compare these results is the initial exploratory factor analyses (EFA) conducted on the measure. In this study, Dynes (2016) stated “summed scores in therapist barriers to parent engagement ranged from 16 to 50, with most therapists reporting average barriers corresponding to the “rarely” or “sometimes” level” (p. 32). The mean of her sample of 148 therapists was 31.65 with a standard deviation of 5.77. Results of this current study appeared to replicate her findings with the mean of my sample within one standard deviation of hers and with a similar standard deviation value. Moreover, though the range of her results were wider, her sample did not include scores larger than 50. Results of the descriptive analysis of TBEP scores can be reviewed in Table C.1.
Table C.1.

*Descriptive Statistics for TBEP Total Score*

<table>
<thead>
<tr>
<th>Measure</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Mode</th>
<th>Median</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBEP Total Score</td>
<td>136</td>
<td>27.64</td>
<td>5.53</td>
<td>24.00*</td>
<td>27.00*</td>
<td>13.0</td>
<td>42.0</td>
</tr>
</tbody>
</table>

*This sample is bimodal with 11 participants scoring both 24 and 27 for the total TBEP score.

To provide more clarity for the first research question, I conducted additional analyses to understand the different demographics within the sample. I conducted 4 one-way analyses of variance to determine if there were any statistically significant differences in the sample as related to gender, ethnicity, APT credential, and discipline. Among these variables, the only statistically significant difference among group means existed within the APT credential variable. Of the five responses that participants could choose, no participants held an SB-RPT-S credential. Furthermore, only one participant held an SB-RPT credential, thus, in order to prevent skewed results within the ANOVA analysis, this participant was removed for this analysis. Of the remaining participants, there was a statistically significant difference among TBEP scores of participants who reported they held an RPT credential, RPT-S credential, or did not hold a credential through APT, $F(2, 132)=3.609, p=.03$. Of the groups included in this analysis, RPTs reported the most barriers to engaging parents ($M=28.74$, $SD=5.50$), followed by those with no APT credential ($M=28.23$, $SD=5.92$), and RPT-Ss reported the fewest barriers to engaging parents ($M=25.94$, $SD=4.71$). Though there was a statistically significant difference between groups, the effect size of this difference is small to medium ($\eta^2_p=.05$) According to the ANOVA analyses, there were no statistically significant differences in TBEP scores related to ethnicity, gender, or discipline. The results from these analyses can be reviewed in Tables C.2., C.3., C.4., and C.5.
Table C.2.

One-Way Analysis of Variance Comparing TBEP Scores Across Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>df</th>
<th>F</th>
<th>p</th>
<th>$\eta^2_p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>13</td>
<td>27.46</td>
<td>6.88</td>
<td>2,132</td>
<td>.231</td>
<td>.794</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Female</td>
<td>120</td>
<td>27.67</td>
<td>5.45</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Binary</td>
<td>2</td>
<td>25.00</td>
<td>1.41</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table C.3.

One-Way Analysis of Variance Comparing TBEP Scores Across Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity Self-Report Response</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>df</th>
<th>F</th>
<th>p</th>
<th>$\eta^2_p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>White/Caucasian</td>
<td>117</td>
<td>27.45</td>
<td>5.39</td>
<td>1,133</td>
<td>.750</td>
<td>.388</td>
<td>.01</td>
</tr>
<tr>
<td>A response other than White/Caucasian</td>
<td>18</td>
<td>28.67</td>
<td>6.52</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table C.4.

One-Way Analysis of Variance Comparing TBEP Scores Across Discipline

<table>
<thead>
<tr>
<th>Discipline</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>df</th>
<th>F</th>
<th>p</th>
<th>$\eta^2_p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling</td>
<td>77</td>
<td>28.52</td>
<td>5.81</td>
<td>6,129</td>
<td>1.05</td>
<td>.40</td>
<td>.05</td>
</tr>
<tr>
<td>Social Work</td>
<td>35</td>
<td>26.54</td>
<td>5.87</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage and Family Therapy</td>
<td>14</td>
<td>25.79</td>
<td>3.45</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychology</td>
<td>7</td>
<td>28.43</td>
<td>2.76</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Art Therapy</td>
<td>1</td>
<td>26.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human Development</td>
<td>1</td>
<td>26.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>22.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table C.5.

One-Way Analysis of Variance Comparing TBEP Scores Across APT Credential

<table>
<thead>
<tr>
<th>APT Credential</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>df</th>
<th>F</th>
<th>p</th>
<th>η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>RPT</td>
<td>43</td>
<td>28.74</td>
<td>5.50</td>
<td>2,132</td>
<td>3.61</td>
<td>.03*</td>
<td>.05</td>
</tr>
<tr>
<td>RPT-S</td>
<td>49</td>
<td>25.94</td>
<td>4.71</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I do not currently hold a credential through APT</td>
<td>43</td>
<td>28.23</td>
<td>5.92</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p<.05

Lastly, I conducted two correlational analyses to determine if there was a statistically significant relationship between age and TBEP total scores and client population and TBEP scores. As a result of the first analysis, I determined that age and TBEP were statistically significantly negatively correlated ($r=-.25$, $n=135$, $p=.004$). This relationship demonstrates there was a negative relationship with age and barriers to engaging parents such that the older a participant reported that they were, the fewer barriers to engaging parents that they reported having. In the second analysis, I completed a bivariate correlational analysis between TBEP scores and the percentage of families that play therapists reported they served that identified similarly to them in race and ethnicity. This relationship was not statistically significant and determined there was not a relationship between the percentage of clients that play therapists serve that identify similarly to them in race and ethnicity and their barriers to engaging parents in play therapy. The results of this analysis can be reviewed in the correlational matrix found in Table C.6.
Table C.6.

*Correlations between TBEP Dependent Variable and Various Predictors and Variables*

<table>
<thead>
<tr>
<th></th>
<th>TBEP Total Score</th>
<th>Difficult Client Behaviors Subscale</th>
<th>Counseling Process Subscale</th>
<th>Identification as a Parent</th>
<th>Parent Hours of Training</th>
<th>Years of Practice</th>
<th>Age</th>
<th>Client Population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TBEP Total Score</strong></td>
<td><em>r</em></td>
<td>.100</td>
<td>-.511</td>
<td>-.502</td>
<td>.243</td>
<td>.002</td>
<td>-.309</td>
<td>-.249</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td></td>
<td>135</td>
<td>135</td>
<td>135</td>
<td>134</td>
<td>132</td>
<td>134</td>
<td>135</td>
</tr>
<tr>
<td><strong>Difficult Client Behaviors Subscale</strong></td>
<td><em>r</em></td>
<td>-.511</td>
<td>1.00</td>
<td>.664</td>
<td>-.112</td>
<td>.063</td>
<td>.240</td>
<td>.245</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td></td>
<td>135</td>
<td>135</td>
<td>136</td>
<td>134</td>
<td>132</td>
<td>134</td>
<td>135</td>
</tr>
<tr>
<td><strong>Counseling Process Subscale</strong></td>
<td><em>r</em></td>
<td>-.502</td>
<td>.664</td>
<td>1.00</td>
<td>-.131</td>
<td>.108</td>
<td>.289</td>
<td>.268</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td></td>
<td>135</td>
<td>136</td>
<td>135</td>
<td>134</td>
<td>132</td>
<td>134</td>
<td>135</td>
</tr>
<tr>
<td><strong>Identification as a Parent</strong></td>
<td><em>r</em></td>
<td>.243</td>
<td>-.112</td>
<td>-.131</td>
<td>1.00</td>
<td>.150</td>
<td>-.196</td>
<td>-.200</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td></td>
<td>134</td>
<td>134</td>
<td>134</td>
<td>134</td>
<td>134</td>
<td>134</td>
<td>134</td>
</tr>
<tr>
<td><strong>Parent Training</strong></td>
<td><em>r</em></td>
<td>.002</td>
<td>.063</td>
<td>.108</td>
<td>.150</td>
<td>1.00</td>
<td>.009</td>
<td>.109</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td></td>
<td>132</td>
<td>132</td>
<td>132</td>
<td>131</td>
<td>132</td>
<td>134</td>
<td>131</td>
</tr>
<tr>
<td><strong>Years of Practice</strong></td>
<td><em>r</em></td>
<td>-.309</td>
<td>.240</td>
<td>.289</td>
<td>-.196</td>
<td>.009</td>
<td>1.00</td>
<td>.650</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td></td>
<td>134</td>
<td>134</td>
<td>134</td>
<td>133</td>
<td>134</td>
<td>134</td>
<td>135</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td><em>r</em></td>
<td>-.249</td>
<td>.245</td>
<td>.268</td>
<td>-.200</td>
<td>.109</td>
<td>.650</td>
<td>1.00</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td></td>
<td>135</td>
<td>135</td>
<td>134</td>
<td>133</td>
<td>134</td>
<td>134</td>
<td>135</td>
</tr>
<tr>
<td><strong>Client Population</strong></td>
<td><em>r</em></td>
<td>-.051</td>
<td>.093</td>
<td>.039</td>
<td>-.153</td>
<td>-.067</td>
<td>.194</td>
<td>.177</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td></td>
<td>136</td>
<td>136</td>
<td>136</td>
<td>135</td>
<td>132</td>
<td>135</td>
<td>135</td>
</tr>
</tbody>
</table>

*Sig. (2-tailed): p<.05*
Predictive Factors of Variables on Therapist Barriers to Engaging Parents

To answer the second research question, I conducted two linear multiple regressions. For the first linear regression, the outcome variable was TBEP total scores, and the four predictor variables included years of practice, hours of training in parent engagement, self-identification as a parent, and the Dealing with Difficult Client Behaviors subscale scores for the COSE. For the second regression, all variables remained the same except the Dealing with Difficult Client Behaviors subscale was replaced with the Counseling Process subscale score. The descriptive data for each of the continuous predictor variables can be reviewed in Table C.7.

Table C.7.

Descriptive Statistics for Each Continuous Predictor Variable

<table>
<thead>
<tr>
<th>Predictor Variable</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Mode</th>
<th>Median</th>
<th>Minimum</th>
<th>Maximum</th>
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</thead>
<tbody>
<tr>
<td>Dealing with Difficult Client Behaviors Subscale</td>
<td>135</td>
<td>35.17</td>
<td>4.82</td>
<td>37</td>
<td>36.00</td>
<td>19.00</td>
<td>42.00</td>
</tr>
<tr>
<td>Counseling Process Subscale</td>
<td>135</td>
<td>49.57</td>
<td>7.26</td>
<td>49*</td>
<td>60*</td>
<td>49.00</td>
<td>60.00</td>
</tr>
<tr>
<td>Hours of Parent Engagement Training</td>
<td>132</td>
<td>100.94</td>
<td>218.</td>
<td>0*</td>
<td>30.00</td>
<td>0.00</td>
<td>2090.00</td>
</tr>
<tr>
<td>Years of Practice</td>
<td>134</td>
<td>12.76</td>
<td>8.17</td>
<td>4</td>
<td>11.00</td>
<td>1.00</td>
<td>35.00</td>
</tr>
</tbody>
</table>

*This sample is bimodal.

Multiple Regression Analysis with Dealing with Difficult Client Behaviors

I conducted a preliminary analysis to ensure there were no violations of the assumptions of normality, linearity, and homoscedasticity for the first regression using Dealing with Difficult Client Behaviors, years of practice, parent hours of training, and identification as a parent as the predictor variables. In assessing the assumptions of linearity, scatterplots between each predictor...
and the dependent variable (TBEP scores) were assessed. Three of the four predictor variables in each regression were continuous variables with only parent identification as a dichotomous variable. All continuous variables (years of practice, Dealing with Difficult Client Behaviors subscale, and parent hours of training) yielded a linear result (as opposed to a curvilinear pattern). To assess the assumption of normality, each continuous variable was plotted via frequency plots to determine both the skewness and kurtosis of the variable. The TBEP total score, years of practice, and Dealing with Difficult Client Behavior scores were reasonably normally distributed. Parent engagement hours of training was positively skewed due to a floor effect as the lowest score possible was 0 meaning that respondents could not choose a lower rating. Homoscedasticity was evaluated by assessing the scatterplot between the regression standardized predicted value and regression standardized residual values and determining if the error of prediction is reasonably similar above and below the line of “0”. In assessing the scatterplot for this regression analysis, it was reasonable to assume that this model met the assumption of homoscedasticity as defined by the fact that “the variability in scores for one continuous variable is roughly the same at all values of another continuous variable” (Tabachnick & Fidell, 1996, p. 80). The scatter plot for the first regression can be reviewed in Figure C.1.
Figure C.1.

*Scatterplot: Dependent Variable TBEP Scores and Predictors Include Dealing with Difficult Client Behaviors COSE Subscale, years of practice, parent hours of training, and identification as a parent*

Note: This figure is a scatterplot of the regression standardized predicted and residual values which demonstrates the assumption of homoscedasticity has been met as the pattern demonstrates values are roughly similar above and below the 0 axis.

After evaluating the assumptions of normality, linearity, and homoscedasticity, a multiple regression analysis was conducted predicting TBEP total scores with years of experience, hours of parent engagement training, identification as a parent, and Dealing with Difficult Client Behaviors subscale of the COSE. The overall model was statistically significant with an *Adjusted* $R^2 = .30$, $F(4, 126)=15.006, p<.001$. This effect size given the literature (Henson, 2006) represented a meaningful effect that was worth interpreting.

In analyzing the correlations between the four predictor variables and the outcome variable (Therapist Barriers to Engaging Parents), there were three statistically significant
relationships. First, years of practice and the TBEP total score had a statistically significant negative relationship ($r=-.309$, $p<.001$) demonstrating that the more experienced a play therapist reported to be, the fewer barriers they reported to having when engaging parents. Next, the continuous variable of Dealing with Difficult Client Behaviors subscale score was also statistically significantly negatively correlated with TBEP total scores ($r=-.511$, $p<.001$). This indicates play therapists that reported higher self-efficacy in their ability to work with unmotivated clients (Larson et al., 1992) reported fewer barriers to engaging parents. Lastly, there was a statistically significant correlation between participants’ self-identification as a parent and TBEP total scores. Due to this dichotomous variable yielding a positive correlation ($r=.243$, $p=.002$) and parents being coded as 1 while nonparents are coded as 2, this would indicate that individuals who did not identify as parents were correlated with higher TBEP scores. Put plainly, this means that for this sample, non-parents reported more barriers to engaging parents. The results of the correlational analyses can be reviewed in the correlational matrix in Table C.6.

The 30% effect size of this regression model had statistically significant contributions from three of the four predictors. In assessing both beta weights and squared structure coefficients (Courville & Thompson, 2001), the three biggest predictors appear to be Dealing with Difficult Client Behaviors subscale scores, years of practice, and identification as a parent or caregiver (in that order), all of which were identified as statistically significant predictors to the model. The Dealing with Difficult Client Behaviors subscale score accounted for 81% of the variance in predicted TBEP scores, which is more than double the variance accounted for by the next strongest predictor, years of practice which accounted for 30% of variance. Both beta weights and squared structure coefficients demonstrate this finding. Identification as a parent
accounted for 18% of variance in the overall model. Parent engagement training accounted for less than one percent of the variance accounted for, had the lowest beta weights ($\beta = .008$), and was not statistically significant ($p = .916$). In conjunction with its low correlation value with TBEP scores ($r = .002, p = .493$), it appears that hours of training in parent engagement did not predict TBEP scores though all of the other three variables did. The results of this regression can be reviewed in Table C.8.

Table C.8.

Linear Regression with Predictors (Dealing with Difficult Client Behaviors, Years of practice, Parent Training, and Identification as a parent) and TBEP Total Score

<table>
<thead>
<tr>
<th>Variables</th>
<th>R</th>
<th>$R^2$</th>
<th>Adjusted $R^2$</th>
<th>$F$</th>
<th>p</th>
<th>$\beta$</th>
<th>$r_s$</th>
<th>$r_s^2$</th>
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</thead>
<tbody>
<tr>
<td>TBEP Total Score$^a$</td>
<td>.568</td>
<td>.323</td>
<td>.301</td>
<td>15.006</td>
<td>&lt;.001*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficult Client Behaviors Subscale$^b$</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Years of Practice$^b$</td>
<td>.029*</td>
<td>-.169</td>
<td>-.544</td>
<td>.300</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Hours of Training$^b$</td>
<td>.916</td>
<td>.008</td>
<td>.004</td>
<td>&lt;.001</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Identification as a Parent$^b$</td>
<td>.039*</td>
<td>.159</td>
<td>.428</td>
<td>.183</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

$^a$ dependent variable.  $^b$ predictor variable.

*p ≤ .05

Multiple Regression Analysis with Counseling Process Subscale

I completed a second regression analysis with the same outcome variable (TBEP total score) and four predictors, Counseling Process subscale score, years of practice, parent hours of training, and identification as a parent. Prior to conducting the regression analysis, I conducted preliminary analysis to determine there were no violations of the assumptions required for this
analysis. I assessed the scatterplots between each predictor variable. Again, three of the four predictors were continuous and yielded a linear result in the scatterplot. I assessed the assumption of normality via frequency plots and determined that each variable was reasonably normally distributed except for the Hours of Parent Engagement Training variable which was positively skewed due to the floor effect. Homoscedasticity was evaluated by assessing the scatterplot between the regression standardized predicted value and regression standardized residual values. The scatterplot demonstrated that the variance of the residuals around the predicted TBEP total scores was roughly the same for all of the predicted scores (Pallant, 2020). The scatter plots for the second regression can be reviewed in Figure C.2.

Figure C.2.

*Scatterplot: Dependent Variable TBEP Scores and Predictors Include Counseling Process COSE Subscale, years of practice, parent hours of training, and identification as a parent*

Note: Similarly to Figure 1, this scatterplot of standardized predicted values and residuals for the second multiple regression analysis demonstrate a similar pattern, meaning that the assumption for homoscedasticity has been met.
Once I assured all assumptions were met, I conducted the second multiple regression analysis with the four predictors. Similar to the first model, three variables had statistically significant correlations with the TBEP total score. These variables included years of practice ($r = -.309, p < .001$), identification as a parent ($r = .243, p \leq .05$), and the Counseling Process subscale scores ($r = -.502, p < .001$). The direction of the relationship was the same in this model demonstrating that when play therapists reported higher confidence in their Counseling Process subscale scores, they were less likely to report barriers to engaging parents.

The results of the overall model were similar to the first regression and can be reviewed in Table C.9. The overall model was statistically significant with an overall meaningful effect size, $Adjusted R^2 = .28, F(4, 126) = 13.834, p < .001$. In this regression model, 83% of the variance in TBEP predicted scores could be accounted for by the Counseling Process subscale scores. This means that counselors who reported confidence in their clinical responses and assessment of the client across sessions (Larson et al., 1992) were less likely to report barriers in engaging parents in their clinical work. Similarly to the first regression model, this value was more than double the predictive value of the next strongest predictor, years of practice, which accounted for 31% of the variance in predicted scores. Identification as a parent predicted 19% of variance accounted for in the model while parent training was a negligible predictor. In this regression, though the squared structure coefficients demonstrate that years of practice accounts for almost twice the variability in the scores as compared to identification as a parent, their Beta weights are almost identical. This demonstrates that identification as a parent may account for more unique variance in the model than years of experience. This is also demonstrated by reviewing the correlation between predictors as years of experience is highly correlated with Counseling Process scores whereas identification as a parent is not.
In comparing correlations with the dependent variable, the Dealing with Difficult Client Behaviors subscale was slightly more correlated with TBEP scores than the Counseling Process subscale scores, however, both demonstrated the strongest predictive value in their respective models. Both models also demonstrated that whether a participant identified as a parent and their years of practice also predicted the frequency of barriers of engaging parents in their clinical work. Lastly, both models demonstrated that self-report of parent engagement training did not predict patterns of engaging parents in practice.

Table C.9.

*Linear Regression with Predictors (Counseling Process, Years of practice, Parent Training, and Identification as a parent) and TBEP Total Score*

<table>
<thead>
<tr>
<th>Variables</th>
<th>$R$</th>
<th>$R^2$</th>
<th>Adjusted $R^2$</th>
<th>$F$</th>
<th>$p$</th>
<th>$\beta$</th>
<th>$r_s$</th>
<th>$r_s^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBEP Total Score&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.552</td>
<td>.305</td>
<td>.283</td>
<td>13.834</td>
<td>&lt;.001*</td>
<td>-.441</td>
<td>-.909</td>
<td>.827</td>
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<tr>
<td>Counseling Process Subscale&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&lt;.001*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years of Practice&lt;sup&gt;b&lt;/sup&gt;</td>
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<td>-.560</td>
<td>.313</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Parent Hours of Training&lt;sup&gt;b&lt;/sup&gt;</td>
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<td>.028</td>
<td>.004</td>
<td>&lt;.001</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Identification as a Parent&lt;sup&gt;b&lt;/sup&gt;</td>
<td>.051*</td>
<td>.153</td>
<td>.440</td>
<td>.194</td>
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</table>

<sup>a</sup> dependent variable.  <sup>b</sup> predictor variable.  
*<sup>p</sup>≤.05
APPENDIX D

EXTENDED DISCUSSION
Introduction

In the present study, I sought to gain further understanding about play therapists’ attitudes toward engaging parents in counseling services by measuring the number of barriers to engaging parents. Moreover, after understanding the overall attitudes of play therapists toward parents, I sought to further understand variables that may predict barriers to engaging parents in play therapy services. With a sample of 136 play therapists who identify as members of the Association for Play Therapy and were currently providing play therapy services, I sought to explore the relationship between therapists’ self-efficacy, years of experience, self-identification as a parent, and hours of training in parent engagement with the propensity to experience barriers to engaging parents. Specifically, I used self-report of identification as a parent, two subscales of the Counseling Self-Estimate Inventory (the Counseling Process subscale and Dealing with Difficult Client Behaviors subscale), self-report of hours of parent engagement training, and self-report of years of experience as a counselor as predictor variables in multiple regression analyses determining the predictors of Therapist Barriers to Engaging Parents (TBEP) scores. To date, this study is the first one to use a validated instrument to measure play therapists’ attitudes toward parent engagement. Furthermore, this study is one of very few that has studied self-efficacy in play therapists specifically. Lastly, the current study is the first to quantitatively measure the impact of play therapists’ identification as a parent on their attitudes toward clinical practices.

The current study revealed that play therapists in this sample reported fewer barriers to engaging parents overall (with the range of scores falling on the lower end of possible scores for the measure). Moreover, through two multiple regression analyses, this study revealed that counseling self-efficacy scores were the strongest predictors of whether play therapists’ reported
barriers to engaging parents, with play therapists who reported higher confidence in their responsiveness as a counselor (Counseling Process) and their abilities to work with unmotivated clients (Dealing with Difficult Client Behaviors) reporting fewer barriers to engaging parents. Moreover, this study revealed that play therapists’ self-identification as a parent also predicted their barriers to engaging parents such that counselors who reported they had children of any age reported fewer barriers to engaging parents in counseling services with children. Lastly, years of practice was a significant predictor of number of barriers to engaging parents, whereas hours of parent engagement training did not have a relationship with barriers to engaging parents.

The following section presents a discussion of the study and important conclusions drawn from the results presented in the previous section. Specifically, I will discuss play therapists’ barriers to engaging parents responses as measured by the TBEP instrument as well as how different characteristics of the sample correlated with these barriers. I will also provide an in-depth discussion of the results of the two multiple regression analyses I conducted measuring the predictive value of parent training hours, self-efficacy with the counseling process, self-efficacy in dealing with difficult client behaviors, self-identification as a parent, and years of experience as counselor on barriers to parent engagement scores. I will also discuss limitations of the current study, implications for practice, and implications for future research.

Play Therapists’ Barriers to Engaging Parents

Several meta-analyses have demonstrated the positive impact of parent involvement on child client outcomes (Bratton et al., 2005; Lin & Bratton, 2015; Mingebach et al., 2018), thus, studying this phenomenon benefits children and their families. Beyond effect sizes in child outcomes, several studies have demonstrated the additive impact of parent and caregiver involvement in practice. For example, Athanasiou (2001) determined that premature attrition in
counseling may be related to parents not being involved in their children’s treatment. Campbell et al. (2000) suggested that this phenomenon can be avoided if therapists connect with parents to help them feel less isolated and more supported. Furthermore, Kazdin et al. (2006) investigated attrition in their study and found that there was a statistically significant relationship between attrition and parents’ perception of low-quality parent-counselor alliance. Thus, involving parents in counseling not only benefits child outcomes but is related to avoiding attrition in child treatment. Moreover, several studies determined a statistically significant relationship between parents’ perceptions of the therapeutic alliance between parent and counselor and several therapeutic factors including greater improvements in parenting practices (Leitão et al., 2021), stronger treatment engagement and clinical outcomes (Greef et al., 2016), and parent satisfaction with counseling treatment (Giannotta et al., 2019). Thus, therapists’ attitudes towards parents impacts child counseling outcomes in more ways than one.

In the present study, play therapists’ attitudes toward engaging parents was measured using Dynes et al.’s (2018) TBEP measure, a 13-item questionnaire with scores ranging from 13 to 65 with higher scores indicating more barriers to engaging parents. Of the 136 participants, the mean score for the TBEP measure was 27.64 ($SD=5.53$) with a range of 13 to 42. The range in the present study indicates that at least one participant rated themselves as never experiencing a barrier in any area of parent engagement while no participants identified experiencing barriers often in all areas. The reported mean and median scores indicate that most participants in the current study marked “rarely” for most responses in the questionnaire. When compared to Dynes (2016) exploratory factor analysis validation of the TBEP measure, the current study appears to replicate her findings. However, her sample of 148 therapists had a wider range of scores with some participants scoring 50 (indicating they reported more barriers to engaging
The mean of TBEP scores for the current study was within one standard deviation of Dynes et al. results indicating similar findings on overall barriers to parent engagement. The skew toward reporting fewer barriers to engaging parents is unsurprising, given that several of the questions listed on the measure appeared to be negatively written indicating that social desirability may have been a factor (Heppner et al., 2016). For example, it may be difficult for play therapists to state via an online questionnaire that they “almost always” agree with the statement, “I have honestly not felt like trying anymore with some guardians, that it was hopeless.” According to the current study’s findings, play therapists reported fewer barriers to engaging parents overall demonstrating that they report fewer negative attitudes toward parents in child counseling services.

**Relationships Between Participant Characteristics and Barriers to Engaging Parents**

According to the ANOVA and correlational analyses completed with this sample, there are several demographic factors that may impact barriers to engaging parents. First, credentials held by a participant was statistically significantly related with parent engagement scores. In this sample, those who held a Registered Play Therapist – Supervisor (RPT-S) credential reported the fewest barriers to engaging parents at a statistically significant level when compared to those who reported they had a Registered Play Therapist (RPT) credential. Interestingly, those who reported they did not hold a credential through APT resulted in mean scores almost identical to those with an RPT, again a statistically significant difference from those who held an RPT-S. This finding demonstrates that holding a credential through APT does not necessarily mean that play therapists are more likely to engage parents. However, those who have undergone the additional training to hold a supervision credential through APT have statistically significantly fewer barriers than the other respondents. RPT-S credentials require 3 years of experience as an
RPT, an additional 3000 direct hours of client contact after full licensure, 500 of which must be
direct play therapy experience with children, and 30 hours of clinical supervision instruction with
6 of those hours specific to play therapy (Association for Play Therapy, n.d.). Though no other
studies have found a relationship between APT credential and parent engagement, this finding
suggests that more experience working with children may impact therapists’ willingness to work
with caregivers. However, this assumption would not explain the mean differences between
those without an APT credential and those credentialed as an RPT. The unexpected result that
participants with an RPT and those with no credential reported similar levels of parent
engagement indicates a need for more exploration related to credentialing and training
requirements.

Another reflection of the relationship between time/experience and barriers to engaging
parents was indicated through the statistically significant correlation between participant age and
parent engagement scores. The medium effect size of this result demonstrated a notable finding
that older play therapists reported fewer barriers to engaging parents. Findings between age and
barriers to parent engagement in the current study support Dynes’ (2016) original results of the
statistically significant relationship between participant age and barriers to parent engagement
scores.

Gender, professional discipline, and ethnicity characteristics did not yield statistically
significant relationships with parent engagement scores in the current study. These findings
confirm Dynes’ (2016) results in that she found no relationship between gender and TBEP
scores. Ethnicity and professional discipline information was not gathered from participants of
Dyne’s study, therefore, future studies would benefit from administering the TBEP and
validating the current results.
Race/Ethnicity Characteristics and Barriers to Parent Engagement

In the current study, participants were asked to identify their own race/ethnicity and to report the percentage of clients with whom they work that identify as a similar or different race/ethnicity. Among the analyses conducted on parent engagement scores, I measured the role of ethnicity of counselor and reported ethnicity of client populations. Due to underrepresentation of participants of color, participants were categorized into two groups: those who identified as persons of color and those that identified as White. There was no statistically significant difference among mean parent engagement scores between the two groups. Moreover, there was no significant correlation between participants’ self-report of the average percentage of clients who identify similarly to them in race and ethnicity and parent engagement scores. Thus, according to these two variables used to measure race and ethnicity of my participants and of the clients with which they work, there appeared to be no relationship between ethnicity/race and parent engagement scores. However, these findings should be interpreted with caution given the sample. In this particular sample, the majority of participants reported they were White in the free response question (87%) and the mean percentage of clients served who identify similarly to the play therapist was approximately 68%, the median was 75%, and the mode for this variable was 90% suggesting that most participants reported they worked with populations who identified similarly to them in race and ethnicity. Because the overall sample was majority White, this may suggest that the majority of both therapists and clients captured in this data identify as White.

Predictors of Barriers to Engaging Parents

Beyond the demographic factors that impact barriers to engaging parents, I sought to understand the predictive value of several factors on this construct. Specifically, I explored the role of self-efficacy in play therapists’ barriers to engaging parents as well as years of
experience, self-identification as a parent, and hours of training on parent engagement. As a result of the two regression analyses I conducted, both models were statistically significant and had large effect sizes demonstrating that much of the variance accounted for in predicted parent engagement scores was due to these predictor variables. Most notably, the strongest predictors in both models were the subscales of counseling self-efficacy (Counseling Process and Dealing with Difficult Client Behaviors), identification as a parent, and years of practice, with hours of training demonstrating little to no relationship with parent engagement scores.

The Role of Counseling Self Efficacy

In both regression analyses, the biggest predictors in the model according to both beta weights and squared structure coefficients were the Counseling Self-Estimate Inventory (COSE) subscale scores, Dealing with Difficult Client Behaviors scores and Counseling Process scores. Results related to Dealing with Difficult Client Behaviors subscale demonstrated that the more confident play therapists felt in their ability to deal with unmotivated clients, the fewer barriers they reported in working with parents. The Counseling Process subscale score also demonstrated a large effect size on parent engagement scores, demonstrating that participants who felt confident in their ability to respond to clients across sessions while assessing client progress reported fewer barriers to engaging parents. These results are similar to Dynes et al. (2018) which found a significant correlation between barriers to parent engagement and Dealing with Difficult Client Behaviors and Counseling Process.

In both regression models, the self-efficacy subscale scores accounted for the most variance explained in predicted parent engagement scores. In fact, the squared structure coefficients in both models demonstrated that Dealing with Difficult Client Behaviors subscale scores and Counseling Process subscale scores accounted for more than double the variance accounted for
of the next strongest predictor (years of experience). These results indicate that even though years of experience and identification as a parent are important factors, self-efficacy predicted most of the variability in parent engagement scores. Put plainly, this means that self-efficacy is a much stronger predictor of play therapists’ attitudes toward parents than how long they have been in practice, whether they are a parent themselves, or how many hours of training they have received in parent engagement.

These findings can be interpreted through the lens of each subscale of self-efficacy. First, the results of the regression with Dealing with Difficult Client Behaviors subscale suggests that play therapists who feel more confident in their ability to work with clients who “do not verbalize their thoughts during the counseling session”, “appear noncommittal and indecisive”, or “deal with crisis situations that may arise during the counseling session” (Larson et al., 1992), are less likely to report that they have barriers to working with parents. This can be understood by recognizing previous literature on play therapists’ attitudes toward parent involvement. For example, more than 20% of the participants in Kranz et al.’s (1998) study reported that working with parents was the most difficult issue to navigate as a play therapist. Furthermore, in Haslam and Harris’s (2011) study, participants were asked about their perceptions of parents’ willingness to engage in their child’s treatment and found mixed results with 36% agreeing, 17% disagreeing, and 47% responding in a neutral manner. Thus, it is evident that though play therapists believe engaging parents and caregivers is important (Haslam & Harris, 2011; Kranz et al., 1998; Nalavany et al., 2005; Phillips & Landreth, 1998), they may believe it is an arduous task and may have differing attitudes toward parents. Results from the current study indicate that counselors who believe they are skilled in dealing with difficult clients are more likely to want to engage parents.
The strength of the Counseling Process subscale can also be connected to the literature on parent involvement. In this study, play therapists who reported confidence in their timing of appropriate responses, clarity of responses, understanding of clients’ nonverbal behaviors, assessment of client concerns, ability to confront and challenge in session, and ability to lead clients toward selection of concrete goals in counseling (Larson et al., 1992) are less likely to report barriers to engaging parents. Becker et al. (2018) determined that effective parent communication for successful child outcomes included assessment and goal setting. Moreover, in Lee and Ray’s (2020) q-methodological study, parents reported expecting play therapists to demonstrate expertise and help in understanding the counseling process. Thus, play therapists who feel confident in their ability to do so may be more likely to want to engage with parents and may demonstrate fewer barriers to including parents in treatment.

Though the two self-efficacy subscales appear to be strong predictors of therapists’ attitudes toward parents, caution is warranted regarding conclusions related to competence. Though play therapists who rate themselves as confident on self-efficacy also reported they had fewer barriers to engaging parents, this does not mean that self-efficacy rating is correlated with strong client outcomes. Although McCarthy (2012) found a significant correlation between Dealing with Difficult Client Behaviors and client outcomes related to rehabilitation counseling goals such as placement and client satisfaction, there is strong evidence that self-efficacy reports are unrelated to client outcomes.

Specific to psychotherapy, Heppner et al. (1998) found that career counselors’ self-report of self-efficacy was not statistically significantly correlated with many of the client outcomes that were measured such as client report of progress toward self-selected goals. Moreover, there was a statistically significant negative relationship between counselor self-efficacy and client report.
of control. This finding indicated that when counselors in Heppner et al. reported higher self-efficacy in their counseling skills, their clients reported they perceived less of an internal locus of control. However, the authors found a correlation between counselors’ self-report of confidence in their ability to develop a therapeutic relationship with their clients and their clients’ level of motivation. More recently, Clements-Hickman and Reese (2022) found no statistically significant relationship between counselors’ self-efficacy and client outcomes as measured by a 4-item outcome rating scale (ORS). Moreover, only a small percentage of the variability in ORS scores could be contributed to therapist characteristics measured in Clements-Hickman and Reese’s study (self-efficacy, professional self-doubt, and ratings of humility), and when considered together, none of the three variables demonstrated a statistically significant relationship with client outcomes. It appears that the relationship between counselor self-efficacy and client outcomes may be more nuanced and may require the consideration of additional factors. Future studies would benefit from researching client outcomes as related to this construct.

Moreover, the above-mentioned studies are not specific to play therapists. Seymour (2001) conducted the only other study measuring self-efficacy specific to play therapists and found that play therapists rated themselves highly on self-efficacy with little variability in scores. In the current study, the ranges on Dealing with Difficult Client Behavior and Counseling Process were variable including scores from the lower and higher ends of the spectrum. This may be due to the current sample including more novice counselors while Seymour’s (2001) study only included participants with three or more years of experience. However, there appear to be no studies that specifically explored the relationship between play therapists’ self-efficacy and outcomes indicating a gap in the literature.
Identification as a Parent

This study is the first quantitative study measuring the role of parenthood in the practice of play therapists. In this sample, almost 65% of play therapists identified as parents themselves. Results indicated a meaningful relationship between play therapists’ identification as a parent and research outcomes. Play therapists that reported they were parents or caregivers to children of any age were statistically significantly less likely to report barriers to engaging parents. In a close examination of results, identification as a parent received as much credit as years of experience for the Counseling Process regression model and the parent predictor appeared to have more unique variance indicating its contribution to the model. Because identification as a parent was not statistically significantly correlated with either of the self-efficacy subscales and years of experience was, identification as a parent provided the most unique variance accounted for in the model.

The role of identification as a parent in relation to barriers to engaging parents can be understood as related to Jalowiec’s (2011) qualitative study that found that play therapists who identified as parents or caregivers reported confidence in their work due to increased empathy, a deeper understanding of the bond between parent and child, and a fundamental understanding of how difficult parenthood is. Slattery and Park (2007) also addressed the dual role of parent and play therapist leading to increased awareness for parents and a decrease of judgment and blame. These findings support the supposition that play therapists who are also parents see themselves as more strongly empathizing with parents thus experiencing fewer barriers to engaging them in clinical work.

Within the context of previous research, the self-efficacy and willingness to engage with parents reported by play therapists who identify as parents may not be aligned with client
expectations. In Lee and Ray’s (2020) study of parent perceptions of play therapy, they found that parents reported that a play therapist being a parent themselves was among the least important factors of the child counseling process. This demonstrates that though play therapists who did not identify as parents in this current study reported more barriers to engaging parents than those play therapists who do have children, parents of child clients may not believe this identity impacts the counseling process. However, Lee and Ray conducted their study with a limited number of parents who had reported satisfaction with their current play therapists. Findings of the current study combined with Jalowiec’s (2011) qualitative findings that play therapists who identified as parents reported increased confidence due to their dual roles juxtaposed against Lee and Ray’s findings indicate a need for more exploration related to preferences and satisfaction of parents in the play therapy process.

*Years of Practice*

Years of practice was also a statistically significant predictor of parent engagement scores such that those with more years of practice reported fewer barriers to engaging parents. However, as mentioned above, this variable was also statistically significantly correlated to the two self-efficacy scores. This relationship between years of practice and counselor self-efficacy is well documented in the literature (Larson et al., 1992; Suh et al., 2018). Though years of practice was correlated with counselor self-efficacy, beta weights in the regression models demonstrated that years of practice had unique variance accounted for in the model demonstrating its role in predicting parent engagement scores. These results are similar to Dynes (2016) study of the parent engagement measure; however, in that study, she found a weaker relationship between years of practice and parent engagement scores. The relationship between years of experience and barriers to engaging parents can be understood in conjunction with
Lolan’s (2011) study that found a statistically significant relationship between play therapists’ years of experience and their perception that face-to-face communication with parents was effective. Thus, through more experience, play therapists may find that involving parents is beneficial in practice and may be more open to engaging caregivers in their work.

**Hours of Training in Parent Engagement**

In reviewing both regression analyses and correlations, hours of training demonstrated no statistically significant relationship to parent engagement scores. Thus, the hours of parent engagement training play therapists reported was not related to their self-report of barriers to engaging parents. This supports Dynes (2016) findings that confirmed there was no statistically significant relationship between training and supervision in parent engagement. Though literature demonstrates that play therapists are often unsatisfied with the training they receive about parent engagement (Kranz et al., 1998; Lolan, 2011), it also appears that this training may not prove to be beneficial in changing play therapists’ attitudes toward parents. The findings of this study related to parent engagement training should be interpreted with caution due to limitations of this measure. In this study, participants were asked to self-report the number of courses they completed related to parent engagement and the number of continuing education credits they received on this topic. These two variables were added to create total hours of parent training, resulting in a skewed variable and increased variability in participant responses. Future studies measuring this construct would benefit from asking play therapists to list coursework and CEUs or providing a more uniform way to respond to this question.

**Limitations of the Study**

There are several limitations of the present study. First, due to the fact that there have not been replication studies conducted with the TBEP measure since its original EFA study (Dynes
et al., 2018), there may be concerns about the measure’s utility (Heppner et al., 2016; Kazdin, 2016). Furthermore, the TBEP questions appear negatively biased presenting a concern for social desirability (Heppner et al., 2016) as participants in this study may have struggled to admit that they had internal barriers to engaging parents especially given the impersonal nature of the online survey. Moreover, this study utilized self-report which may be vulnerable to distortions and may explain the smaller range of TBEP scores (with most participants reporting “never” or “rarely” for most questions). Furthermore, participants may have had skewed self-awareness or perceptions of their barriers to engaging parents (Heppner et al., 2016). Unfortunately, due to the nature of self-report, these limitations could not be avoided.

Additionally, another limitation of this study included the measure of hours of parent engagement training. Because participants were asked to report the number of courses and continuing education hours completed related to parent engagement, this variable appeared skewed with hours ranging from 0 to 2090, and the standard deviation of the variable (SD=218.78) was larger than the mean of scores (100.94). Thus, results of this study related to that variable should be interpreted with caution. Future studies may benefit from assessing this variable through different means that avoid self-report such as selecting training or coursework via a drop-down menu.

Lastly, this study included limited multicultural considerations. Though the demographics of the sample aligned closely with the population studied (APT professional members), both the population and sample lack diversity in race, ethnicity, and gender. Thus, though it is a strength that the sample aligned with the population, future studies may benefit from a more diverse sample of play therapists. Though the results of the present study can be generalized to professional members of APT, they may not be generalized among diverse
practitioners. Future research may benefit from considering a more diverse sample of play therapists as well as those who report more diversity in the clients they serve.

Implications for Practice

Involving parents in clinical practice with children not only benefits child outcomes (Bratton et al., 2005; Lin & Bratton, 2015; Mingebach et al., 2018), but also benefits many factors related to the play therapy process such as attrition (Athanasiou, 2001; Kazdin et al., 2006), stronger treatment engagement (Greef et al., 2016), and greater improvement in parenting practices (Leitão et al., 2021). Thus, play therapists’ attitudes toward parent engagement are related to effective clinical practice with children. Though play therapists demonstrate fewer barriers to engaging parents in clinical practice overall, the findings of this study demonstrated support for several factors that could impact play therapists’ perceptions of involving parents in their work.

Due to the strong predictive value of play therapist self-efficacy on barriers to engaging parents, play therapists benefit from experiences that increase their confidence in their work. Specifically, play therapists benefit from developing confidence in skills related to working with unmotivated clients and in developing their self-efficacy related to the counseling process as a whole. This can include experiences that build self-assurance in their ability to assess child progress, develop progress goals, and challenge and confront in session. For example, counselor training programs offering play therapy courses may consider requiring students to develop case conceptualizations that not only assess and measure progress to goals but require developing verbiage to communicate this progress to parents and caregivers. Furthermore, counselor education programs may consider implementing supervised micro practicum experiences that involve mock parent consultations or observing seasoned play therapists in sessions that involve
parents. Supervisors may consider role playing difficult client conversations with parents and caregivers to allow supervisees to develop confidence in their ability to communicate effectively and deal with difficult behaviors in parent sessions. Supervisors may also consider helping supervisees prepare for upcoming parent meetings by practicing sharing client progress, processing fears about upcoming difficult conversations, and assessing supervisee confidence as related to parent meetings. Not only are these skills beneficial for the child counseling process, this study demonstrates that play therapists who feel confident in these specific skills are less likely to have barriers to involving parents in play therapy. Moreover, though hours of parent engagement training was not related to barriers to engaging parents, it appears that not all training may be equal. Thus, training focused on developing confidence may be more beneficial than skills training in relation to parent engagement.

Lastly, given the relationship between identification as a parent and decreased barriers to engaging parents, future training for play therapists may consider how to amplify the voices of parents in this dual role. For example, counselor educators may consider integrating a panel of parents who are play therapists in their courses to provide an opportunity for students to help develop empathy and acceptance for parents in the play therapy process. Furthermore, play therapists who are parents may consider adding to the literature by developing additional conceptual pieces or conference presentations about how their dual role helps develop more positive attitudes toward parents in their work. These efforts may provide more opportunities for students and practitioners to learn from play therapists in this dual role.

Implications for Future Research

The current study was the first to research play therapists’ attitudes toward parents using a measure with reported reliability and validity, the first to quantitatively study the dual role of
parent and play therapist and was among few studies that measured self-efficacy in play therapists specifically. Thus, future studies should further substantiate the findings of this current study, preferably with a larger, more diverse sample. Moreover, as this study was the first to utilize the TBEP measure following its EFA study (Dynes et al., 2018), future research could benefit by further validating this instrument.

This study focused on attitudes of play therapists as related to parent engagement rather than focusing on client outcomes. Though research demonstrates that increased parent involvement in play therapy services is related to stronger child outcomes (Bratton et al., 2005; Lin & Bratton, 2015; Mingebach et al., 2018), this study did not make the direct link between the two constructs. Thus, the relationship between play therapists’ parent engagement scores and client outcomes warrants further study. Future research would also benefit from clarifying the relationship between play therapists’ self-efficacy scores and client outcomes given much of the research on the construct demonstrates mixed results.

Due to the multicultural limitations of the current study, future research benefits from inclusion of more diverse populations as well as play therapists who work with more heterogenous clients. Because the current study only considered two subscales of the COSE, future research could explore the relationship between play therapists’ confidence in their cultural competence and constructs such as therapist barriers to engaging parents, diversity in their caseload, and diversity of play therapists.

Lastly, this study focused on play therapists’ perceptions related to parent engagement, however, future studies could gain the perspective of parents in relation to this treatment modality. Specifically, future research may explore the relationship between play therapists’ attitudes toward parents and parents’ ratings of satisfaction with play therapy services.
Additionally, play therapists’ attitudes toward parents could also be studied throughout the therapeutic process in relation to parents’ ratings of the therapeutic relationship, parenting stress, and the parent-child relationship.

Conclusion

The current study explored play therapists’ attitudes toward caregivers using a validated measure of barriers to engaging parents. Furthermore, this study explored the relationship between years of experience, hours of training in parent engagement, self-identification as a parent, and counselors’ self-efficacy ratings. Though there are limitations of this study including multicultural considerations, social desirability, and a skewed variable measuring hours of training, the results of this study demonstrate findings that can benefit the field of play therapy.

The current study demonstrated that play therapists demonstrate an overall positive attitude toward engaging parents in counseling, however, there is some variance in their perceptions. For example, there is a significant relationship between play therapists’ barriers to engaging parents and their confidence in their ability to work with difficult client behaviors and manage the overall counseling process. These findings demonstrate the importance of developing counselor confidence in assessing child progress, developing goals for sessions, and confronting and challenging in session. Confidence in these skills may lead to more positive attitudes toward involving parents in play therapy. Moreover, play therapists who identify as parents also demonstrate more positive attitudes toward parents. This relationship is important to consider in that identification as a parent was not correlated with self-efficacy, thus, play therapists who are parents may empathize more with caregivers of their clients even though they may not appear more confident than play therapists who are not parents.
Though play therapists often report dissatisfaction with parent engagement training (Lolan, 2011), this study helps to clarify what type of training may be beneficial for clinicians. Clinicians may benefit from training focused on providing experiences that increase their confidence in the counseling process and in dealing with unmotivated clients who may not verbalize their concerns. Furthermore, parents who are play therapists may benefit the field in developing trainings related to building empathy for the parents’ role in their child’s life. This study serves to highlight the need for continued research exploring the dual role of parent and play therapist, barriers to engaging parents, and play therapist self-efficacy especially with more diverse and robust samples.
Informed Consent Notice

**TITLE OF RESEARCH STUDY:** The Role of Parent Engagement in Therapist Perceptions of Self-Efficacy for Play Therapists

**RESEARCH TEAM:**

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This project is being completed as part of a dissertation under the supervision of:

Dee C. Ray, Ph.D., LPC-S, NCC, RPT-S
Certified CCPT-S; Certified CPRT-S
Email: dee.ray@unt.edu
Phone: 940-565-3864

You are being asked to participate in a research study. Taking part in this study is voluntary. The investigators will explain the study to you and will answer any questions you might have. It is your choice whether or not you take part in this study. If you agree to participate and then choose to withdraw from the study, that is your right, and your decision will not be held against you.

You are being asked to take part in a research study to better understand play therapists’ barriers to engaging parents in their work with children and how parent engagement may impact play therapists’ overall counseling competence.

Your participation in this research study involves completion of a 25-minute survey. More details will be provided in the next section.

You will be provided a questionnaire which will include demographic questions about you, questions about your barriers to engaging parents in your therapeutic work with children, and questions related to how you feel about your own counseling skills overall.

You might want to participate in this study if you want to share your views about involving parents in your work and how play therapists feel about their own clinical skills. However, you might not want to participate in this study if you do not have the time to complete the survey.

You may choose to participate in this research study if you:

1) Identify as a current professional member of APT with at least a master’s degree,
2) Are currently licensed as a mental health professional (with full or provisional licensure, and
3) Are currently practicing play therapy.

The reasonable foreseeable risks or discomforts to you if you choose to take part is discomfort or emotionality in responding to questions about working with parents. There is also a potential loss of confidentiality similar to a person’s everyday use of the internet. Possible benefits of completing this study include the opportunity further education and research about parent engagement in the field of play therapy. You may receive compensation for participation as participants will have an opportunity to enter into a raffle to win one of 3 $50 Amazon gift cards.

DETAILED INFORMATION ABOUT THIS RESEARCH STUDY: The following is more detailed information about this study, in addition to the information listed above.

PURPOSE OF THE STUDY: The purpose of this study is to understand play therapists’ perceptions of working with parents in their work with children. This includes better understanding barriers that may keep play therapists from including parents in their treatment. Moreover, this study seeks to understand if there is a connection between play therapists’ perceptions of working with parents and their overall confidence in their counseling skills.

TIME COMMITMENT: Participation in this study is expected to last approximately 25 minutes which includes one-time completion of the online survey.

STUDY PROCEDURES:

1. You will self-identify if you meet the criteria to participate in this study. As a reminder, that criteria includes: a. Identify as a current professional member of APT with at least a master’s degree, b) Are currently licensed as a mental health professional (with full or provisional licensure, and c) Are currently practicing play therapy.

2. You will then read the informed consent and decide whether to participate in the study. If you consent, you will select that option at the bottom of this page which will navigate you to the study. If you decline to consent and choose that option, the survey will end.

3. You will answer demographic information about yourself, your practice as a therapist, licensure, etc.

4. You will then answer questions regarding your work with parents as a play therapist.

5. Lastly, you will complete questions about how you feel about yourself as a play therapist overall.

6. Some questions may be difficult to answer or you may not feel comfortable. In that case, you may choose to skip questions. Moreover, because you consented at the beginning of the survey does not mean you cannot choose to discontinue the survey at any time.
7. Once you complete the survey, you will be provided a link to a second form which you can fill out (with identifying information such as name and email). This form will allow you to enter into the drawing for one of 3 $50 Amazon gift cards.

8. All research will be conducted online through a survey.

**POSSIBLE BENEFITS:**
The benefits of participation may include the opportunity to share your experience as a play therapist. Specifically, you may be able to provide information that may impact training, supervision, and teaching of play therapy and parent engagement.

**POSSIBLE RISKS/DISCOMFORTS:**
The possible risks or discomforts of this study may include discomfort in answering some questions related to your work with parents and children. Moreover, a risk may include discomfort in rating your confidence in your play therapy skills. Participation in this online survey involves risks to confidentiality similar to a person’s everyday use of the internet and that there is always a risk of breach of confidentiality.

Remember that you have the right to withdraw any study procedures at any time without penalty, and may do so by informing the research team.

Participating in research may involve a loss of privacy and the potential for a breach in confidentiality. Study data will be physically and electronically secured by the research team. As with any use of electronic means to store data, there is a risk of breach of data security.

If you experience excessive discomfort when completing the research activity, you may choose to stop participating at any time without penalty. The researchers will try to prevent any problem that could happen, but the study may involve risks to the participant, which are currently unforeseeable. UNT does not provide medical services, or financial assistance for emotional distress or injuries that might happen from participating in this research. If you need to discuss your discomfort further, please contact a mental health provider, or you may contact the researcher who will refer you to appropriate services including the National Suicide Prevention Hotline at 1-800-273-8255 (988).

**COMPENSATION:**
After completion of the survey, participants will be provided a link which will navigate them to a separate form. This form will allow participants to enter personal information (name and email address) to be entered into a raffle to win one of 3 $50 Amazon gift cards. Participants are not required to enter.

Internal Revenue Service (IRS) considers all payments made to research subjects to be taxable income. Your personal information, including your name, address, and social security number may be acquired from you and provided to UNT System Tax Office for the purpose of payment. If you are an employee, we will be collecting your employee ID. If your total payments for the year exceed $600.00, UNT will report this information to the IRS as income and you will receive
a Form 1099 at the end of the year. If you receive less than $600.00 total payments in a year, you are personally responsible for reporting the payments to the IRS.

There are no alternative activities offered for this study.

CONFIDENTIALITY: Efforts will be made by the research team to keep your personal information private, including research study, and disclosure will be limited to people who have a need to review this information. All paper and electronic data collected from this study will be stored in a secure location on the UNT campus and/or a secure UNT server for at least three (3) years past the end of this research. All information will be kept confidential in a locked cabinet in the office of the principal investigator, Dr. Dee Ray, at the University of North Texas, Welch building. Only the research team will have access to the cabinet. Information obtained from the instruments and demographic information form will be recorded with a code number according to the alphabetical order of their names. The personally identifiable data will be maintained for 5 years following the end of the study. The data will be destroyed after the period of 5 years.

Participation in this online survey involves the potential for the loss of confidentiality similar to a person’s everyday use of the internet.

The results of this study may be published and/or presented without naming you as a participant. The data collected about you for this study may be used for future research studies that are not described in this consent form. If that occurs, an IRB would first evaluate the use of any information that is identifiable to you, and confidentiality protection would be maintained.

While absolute confidentiality cannot be guaranteed, the research team will make every effort to protect the confidentiality of your records, as described here and to the extent permitted by law. In addition to the research team, the following entities may have access to your records, but only on a need-to-know basis: the U.S. Department of Health and Human Services, the FDA (federal regulating agencies), the reviewing IRB, and sponsors of the study.

This research uses a third party software called Qualtrics and is subject to the privacy policies of this software noted here: https://www.qualtrics.com/privacy-statement/

CONTACT INFORMATION FOR QUESTIONS ABOUT THE STUDY: If you have any questions about the study you may contact Dr. Dee Ray at dee.ray@unt.edu or Ahou Vaziri Line at ahouvaziri@my.unt.edu. Any questions you have regarding your rights as a research subject, or complaints about the research may be directed to the Office of Research Integrity and Compliance at 940-565-4643, or by email at untirb@unt.edu.
Demographic Questionnaire

Please provide the following personal information:

1. What is your gender?
   a. Male
   b. Female
   c. Nonbinary
   d. Write in:__________

2. What is your age?

3. What is your ethnicity/race?
   a. ______________

4. How many years have you been practicing since receiving your mental health degree?
   (For example, if you graduated in 2018, you would enter 4). ______

5. Please select your discipline:
   a. Counseling
   b. Social Work
   c. Marriage and Family Therapy
   d. Psychology
   e. Art Therapy
   f. Child Life Specialist
   g. Nursing
   h. Human Development
i. Psychiatry

j. Other (please specify):_____

6. What is your license to provide clinical mental health services (e.g. LPC, Licensed Psychological-Associate, LMFT-Associate).

7. In what state(s) is your active license?

8. Do you currently hold an RPT, RPT-S, SB-RPT, or SB-RPT-S credential through APT?
   a. RPT
   b. RPT-S
   c. SB-RPT
   d. SB-RPT-S
   e. I do not currently hold a credential through APT.

9. What is your highest mental health degree conferred?
   a. Master’s degree
   b. Doctoral degree

10. What is your primary practice setting?
    a. Private practice
    b. School (k-12)
    c. School (higher education or university setting)
    d. Agency/Non-profit
    e. Psychiatric hospital
    f. Medical hospital
    g. Other (please specify) _______
11. On average, what percentage of children or families do you serve that identify similarly to you in race/ethnicity? ____________

12. What is the average number of parent consultations you facilitate for every 10 play therapy sessions that you conduct with a child?

13. Approximately how many graduate courses have you completed specifically related to play therapy?

14. Approximately how many graduate courses have you completed specifically related to parent counseling/parent consultation?

15. Approximately how many continuing education hours have you completed specifically related to play therapy? (If over 100, please respond with 100).

16. Approximately how many continuing education hours have you completed specifically related to parent counseling/parent consultation? (If over 100, please respond with 100).

17. Do you hold an additional credential or certification related to parent intervention? For example, CPRT, PCIT, The Incredible Years, etc. If so, list the credential.
   a. Yes. I currently hold _______ credential(s).
   b. No

18. Do you identify as a parent or primary caretaker (of a child of any age)?
   a. Yes
   b. No

19. What is your theoretical approach to play therapy?
   a. Adlerian Play Therapy
   b. Attachment Theory and Theraplay
   c. Child-Centered Play Therapy
d. Cognitive Behavioral Play Therapy

e. Ecosystemic Play Therapy

f. Gestalt Play Therapy

g. Jungian Analytical Play Therapy

h. Psychoanalytic Play Therapy

i. Other: Please specify________
Dear APT Member,

I hope this email finds you well. I am emailing today in hopes that you may be interested in participating in our study on parent engagement in play therapy. Your email was identified because you are a professional member of The Association for Play Therapy. The purpose of this dissertation study is to better understand play therapists’ barriers to engaging parents and how parent engagement may impact overall counseling self-efficacy.

The University of North Texas Department of Counseling is seeking participants for this research study who are at least 18 years old to participate in a research study titled, “The Role of Parent Engagement in Therapist Perceptions of Self-Efficacy for Play Therapists.” We are seeking participants that:

1. Identify as a current professional member of APT with at least a master’s degree,
2. Are currently licensed as a mental health professional (with full or provisional licensure), and
3. Are currently practicing play therapy

Participation in this study takes approximately 25 minutes of your time and includes the completion of an online survey including demographic questions, questions related to barriers engaging parents, and questions related to overall counseling self-efficacy.

To access the survey, please follow this link: [redacted]

It is important to remember that participation is voluntary. You may receive compensation for participation. For more information about this study, please contact the research team by phone at 940-565-3864 or email at Dee.Ray@unt.edu

Thank you,

Name: Ahou Vaziri Line, M.S., LPC, RPT, CSC, NCC, Certified CCPT-S
Principal Investigator Name: Dee C. Ray, Ph.D., LPC-S, NCC, RPT-S
Certified CCPT-S; Certified CPRT-S
Email: dee.ray@unt.edu
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Association for Play Therapy. (2022, April 13). *Clarifying the use of play therapy*. [https://www.a4pt.org/page/ClarifyingUseofPT](https://www.a4pt.org/page/ClarifyingUseofPT)


Becker, K. D., & Chorpita, B. F. (2016, August). Enhancing the design of engagement interventions to enhance the public health impact of mental health treatments for youth. In K. Becker (Ed.), *Extending the reach and impact of science on clinical care for youth and families: Looking for new models for the old challenges [Symposiu*m]*. 23rd NIMH Conference on mental health services research: Harnessing science to strengthen the public health impact.


156


