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Social Workers' Role in the Delivery of Play Therapy to Children

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Social Workers' Role in the Delivery of Play Therapy to Children

Submitted by: Sara B. Weil
May 2012

MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

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Abstract

The purpose of this project was to explore the role that social workers play in the delivery of play therapy services to children. This study used a quantitative design to survey 51 licensed social workers on their use of and perceptions of the effectiveness of play therapy. Data were collected through an online survey and analyzed to determine how frequently social workers use play therapy, what level of training they have in play therapy techniques, how effective social workers feel play therapy is with children and what factors are believed to contribute to its effectiveness. Findings revealed that the majority of social workers do not use play therapy with their clients, but do feel it is an effective form of intervention. Additionally, findings showed that social workers had minimal exposure to play therapy in graduate school or through continuing education; yet a majority of respondents indicated that they felt basic training in play therapy interventions should be a part of all social workers' undergraduate/graduate education. This highlights the necessity of further research on the role social workers play in the delivery of play therapy services and the need for schools of social work to better prepare students to practice play therapy in the field.

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Introduction

Mental health is essential to children's overall growth and well-being; yet too often the focus on a healthy start for children is limited to their physical health, leaving an increasing number of children to suffer needlessly because their emotional, behavioral, and developmental needs are not being met (Department of Health and Human Services, 2000). The Centers for Disease Control and Prevention (2010) estimates that at least one in ten children in the United States suffers from a mental illness severe enough to cause some level of impairment in functioning and development; yet only 20% of these children are believed to receive mental health services in any given year (Department of Health and Human Services). The level of unmet needs for services is believed to be as high now as it was 20 years ago, prompting the Department of Health and Human Services to declare that the burden of suffering experienced by children with mental health needs and their families has created a health crisis in the United States.

This crisis has led to a growing demand for empirically-proven interventions to assist children suffering from mental illness; with six decades of empirical backing, play therapy has the opportunity to emerge as a therapy of choice for these children (Department of Health and Human Services, 2000; Guerney, 2000). Landreth (2002) defines play therapy as "a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child (or person of any age) to fully express and explore self (feelings, thoughts, experiences and behaviors) through play, the child's natural medium of communication, for optimal growth and development" (p. 16).

One of the most powerful things about play therapy is that it is a *play* method; few of the outcomes achieved in play therapy could happen in traditional talk therapy regardless of how adept the therapist was because children who are too young to talk out problems would have no equivalent form of accessing them (Guernsey, 2001). Nash and Schaeffer (2010) argue that because of children's natural desire to play, play therapy offers the best method for therapists to establish a positive therapeutic bond and help children to communicate at their developmental level. Children are often unable to draw comfort from the words of others and learn to cope with the real world by exploring life's difficulties through play (Glazer, 2010; Landreth, 2002). Unlike adult's work, which is goal-oriented, play is intrinsically complete; children view their play as a meaningful and significant activity, for through play they can express themselves and enter areas that they may have difficulty expressing verbally (Landreth).

Landreth (2002) and Bratton et al. (2005) assert that the founding of Association for Play Therapy (APT) in 1982 was a major development in the growth of play therapy and its establishment as a specialized treatment genre within the field of mental health. The APT has assisted in the development of university-based training programs and a considerable growth in publishing efforts by leaders in the play therapy field (Bratton, Ray, Rhine & Jones). Growing interest in the field is evidenced by the over 2,200 publications describing its use, most of which were published since 1970 and by the rapid increase in membership of the APT which increased from 450 in 1988 to over 4,400 in 2002 (Bratton, Ray, Rhine & Jones; Landreth).

Despite play therapy's growing popularity with clinicians, play therapy has not garnered widespread acceptance from the scientific community and has often been

criticized for a lack of sound empirical evidence supporting its use (Bratton, Ray, Rhine & Jones, 2005). Current studies are attempting to fill this gap, but much work remains to be done in order for play therapy to be universally accepted as a useful and successful addition to the field of children's mental health. This study will provide an overview of the historical development of play therapy, a discussion of prominent types of play therapy and a review of studies conducted to date on the effectiveness of play therapy. In an effort to contribute to the body of play therapy research, this study will examine the research question: what are social workers perceptions of play therapy? Additionally, this study will examine:

- How frequently do social workers use play therapy in their practice?
- What is social workers level of training in play therapy techniques?
- How effective do social workers believe that play therapy is as an intervention with children?
- What factors do social workers believe contribute to the effectiveness of play therapy?

History of Play Therapy

Like many modern forms of therapeutic intervention, play therapy traces its roots to Sigmund Freud's psychoanalytic theory. According to Freud, the personality develops from biologically based, instinctual urges that seek to be gratified and conflicts occur when these urges are not fulfilled (Lee, 2009). Freud believed that while the personality continues to grow and adapt, the traumas that occur during the first six years of life create regressions, fixations and exaggerated defenses that lead to symptoms warranting psychoanalytic treatment (Lee). Freud argued that the personality develops in predictable

phases and that the failure to successfully negotiate the phases would lead to developmental deviance and pathology (Lee). Psychoanalysis then strives to restructure the personality as a whole by reconstructing repressed memories, fantasies, wishes and experiences and resolving the conflicts of unfulfilled developmental phases (Lee).

The first published case describing the use of therapeutic play with children appeared in Sigmund Freud's 1909 case of "Little Hans", a five year old with a phobia (McCalla, 1994). Working from a psychoanalytic lens, Freud advised the boy's father about more positive ways to interact with the child based on the father's notes about his play (Landreth, 2002). Aside from its therapeutic use of play, the case of "Little Hans" was also a landmark in children's therapy because it was the first record of a case where a child's problems were attributed to emotional causes; psychological disturbances were not previously believed to be present in children (Landreth). Although Freud's clinical focus was mostly on adults, his emphasis on early life experiences and his informal analysis of his own children laid the groundwork for the next logical step in therapeutic work, the treatment of children (Bromfield, 2003).

Literature Review

Play therapy is a broad field of practice with a long history of development. This study will outline the importance of play to children's development, connecting children's need to play with the success of including play activities in the therapeutic realm. An overview of 3 keys form of play therapy will then be presented including: psychoanalytic, child-centered and filial play therapy. Finally a summary of previous research measuring the effectiveness of play therapy and the populations most benefiting from its use will be discussed as well as a recommendations for future areas of research.

Importance of Play

Since the beginning of time, children in all areas of the world and of all cultures have played (McCalla, 1994). Children's play is spontaneous, enjoyable and voluntary (Landreth, 2002). Children do not need to be taught how to play or forced to play; they enjoy the simple process of play and are seldom concerned with its end product (Landreth). Children need a significant amount of play time in their early years to help them 1) learn about their world 2) master challenges 3) improve physical development 4) think creatively and 5) learn to interact with others in a positive manner (Nash & Schaefer, 2010). Play also fulfills many of children's practical needs including: discharging energy, acting aggressively in socially acceptable ways, and relieving frustrations (Landreth). Play is such a vital activity that Landreth asserts in his seminal book on developing relationships with children through play therapy, that play is the single fundamental activity of childhood and is essential to children's healthy development.

From a therapeutic perspective, play is important because it gives children the opportunity to practice the skills and experiences of everyday life and "draw on inner strengths that can become incorporated into their personalities" (Landreth, 2002, p.11). Therapists utilize play interventions because, in play the total child is present, with the child's physical, mental and emotional self all engaged in creative expression and, often, social interaction (Landreth). Prior to age 11, children do not have the capacity to engage in the abstract reasoning that dominates adult thought processes; instead children view the world through concrete realities (McCalla, 1994). Developmentally, children are often unable to articulate their feelings verbally because they lack the cognitive and

verbal skills to express what they feel in words (Landreth; Porter, Hernandez-Reif, Jessee, 2009). By engaging in play, children are able to bridge the gap between their concrete world and the abstract world of adults and explore the world on their own terms (Landreth; McCalla; Porter, Hernandez-Reif & Jessee). Therefore, children utilize toys to say what they cannot, to do things they might otherwise be uncomfortable doing and to safely express feelings and attitudes that might otherwise be too overwhelming (Landreth).

A wide range of toys can be utilized in play therapy, but what is most important is that the toys communicate to the child that a wide range of behaviors are acceptable in play sessions; toys should allow children to play out a wide range of behaviors and support the stages of playing out aggressive, regressive, independence and mastery issues (Guerney, 2001). Axline (1969) asserted that through using toys, a child can order his or her world; during play with toys children experience a range of feelings including love, anger, sadness, fear and joy and utilize independent thought to release their feelings. Toys for younger children should include dolls, baby bottles and stuffed animals while toys for older children should include board games, building materials, office equipment, science materials and a large bo-bo doll (punching bag) (Guerney, 2001). Toys for all ages can include cards, art materials, clay, puppets, dress-up clothes, tables and chairs and games that allow for competition (Guerney, 2001). Landreth (2002) argued that it is not just the selection of the toy that is important, but the child's use of the toy and verbalizations as he or she plays that will truly convey a message to the therapist.

Types of Play Therapy

Psychoanalytic play therapy. Even before the developmental importance of play was established, psychoanalysts realized that children were unable to verbally describe their thoughts as adults did and that they weren't interested in exploring or discussing their pasts through the typical psychoanalytic approach (Landreth, 2002). During the early 1900's, therapists struggled to connect with children through the psychoanalytic lens and many were forced to resort to indirect therapy with children by collecting observations of them (Landreth). All this changed with the foundational work on child therapy as we know it today, generally attributed to the work of two women: Melanie Klein in Berlin, Germany and Sigmund Freud's daughter, Anna Freud in Vienna, Austria (Bromfield, 2003).

Based on the belief that play is the means through which children express themselves most freely, both women adapted Sigmund Freud's psychoanalytic method for work with children by incorporating play into their sessions (Landreth, 2002; McCalla, 1994). By uncovering clients' past experiences, both women attempted to help children work through their difficulties by gaining insight into their behaviors (McCalla). Freud and Klein differed, however, in how they incorporated play into their work; Freud employed play as a means to enhance the therapeutic relationship and increase communication with child clients while Klein viewed play as the equivalent of verbalized free association in adult therapy (McCalla).

Klein began using play as a means of analyzing children under the age of 6 in 1919, utilizing play therapy as a direct means of accessing children's unconscious thoughts (Landreth, 2002). Klein assumed that children's play was motivated by their

unconscious desires just as the free association of adults was; she used play to motivate children to express their fantasies and anxieties, relying heavily on interpretation of unconscious meanings in the children's play (Landreth). Symbolic meaning was found in all play, especially sexual meaning. Klein also emphasized the child-therapist relationship as a manifestation of the child's earlier experiences with primary caregivers, particularly their mother; re-experiencing these struggles with the therapist was believed to allow the child to conquer anxieties, emotions and fears (Landreth).

Despite the groundbreaking achievements of Klein's work, it is Anna Freud's approach that went on to dominate the field of what became known as psychoanalytic play therapy (PPT) in the United States and was disseminated by her students and colleagues around the globe (McCalla, 1994). Anna Freud utilized play primarily as a way to encourage child clients to like her and form a therapeutic alliance with her (Landreth, 2002). She believed that play was a practical and productive means of establishing a positive emotional relationship between the child and therapist and thereby, gaining access to the child's inner life (Landreth). Freud aimed to help children consciously understand why they thought, felt and behaved as they did through verbalizing daydreams and fantasies and encouraged these insights as an opportunity for personal change within clients (Bromfield, 2003; Lee, 2009). While play opened the door to the therapeutic relationship, it was Freud's goal that the alliance between therapist and client would strengthen to the point where play was gradually replaced by verbal interactions that would uncover the real root of client's struggles (Landreth; McCalla).

The overarching goal of PPT treatment in its current form is to return children to the path of normal development, in keeping with the child's chronological and mental age

(Lee, 2009). While this may seem similar to the goal of many child therapists, Lee argues in her historical review of PPT that while psychoanalytic play therapists attempt many of the same goals as other child therapists, they are more ambitious in their attempt to change not just a behavior or symptom, but the child's entire way of dealing with life and sense of self. The therapist works to create an atmosphere of safety, acceptance, respect and honesty that demonstrates a "genuine positive regard" (Bromfield, 2003, p. 5) for the child, while enforcing limits so that the child does not hurt him or herself, the therapist or the playroom.

Play is used to facilitate children's verbal communication, allowing the child to approach their conflicts from a psychologically safe distance (McCalla, 1994; Bromfield, 2003). Play is generally nondirective with the child leading activities and the therapist offering commentaries and asking questions (Lee, 2009). Children are encouraged to speak honestly and accept their role in perpetuating their problems before deciding what changes, if any they wish to make in themselves (Bromfield). Change in the child is measured by the proportion of talking to playing as well as the quantity and quality of verbal communication (Lee).

The vast works of Melanie Klein and particularly, Anna Freud were revolutionary in changing attitudes about children and their problems and set the stage for future developments in the area of therapeutic interventions with children (Landreth, 2002). More than any other person, Anna Freud is credited with expanding the scope of psychoanalysis to include children; her contributions had lasting effects on the study of personality development in children and on the positive development of PPT for use with pathological conditions in children (Lee, 2009). While Anna Freud initially saw child

analysis as an extension of adult psychoanalysis, her over four decades of research on PPT helped solidify the restoration of children to the path of normal development as the essence of therapeutic work with children (Lee).

Child-centered play therapy. Developed in 1947 by Virginia Axline, child-centered play therapy (CCPT) is still a popular method of play therapy and has changed very little since inception (Guerney, 2001). A student of Carl Rogers, Axline (1969) adapted his method of non-directive, client-centered therapy for use with children and adolescents. Axline's (1969) work with children is considered by many the most significant development in the field of play therapy; her work and writings on the subject popularized play therapy as an effective intervention with children and was instrumental in broadening play therapy's acceptance (Bratton, Ray, Rhine, Jones, 2005). Axline (1969) based her approach to CCPT on Rogers' belief that all individuals, including children, have the innate ability to strive towards growth and maturity if provided nurturing conditions; Rogers maintained that interferences in life block this innate ability and that it is a therapist's job to provide the necessary support to return clients to a path of positive growth (Guerney, 2001).

Fundamental to this approach is the belief that the child, not the therapist, should always be directing the play session; Axline (1969) believed that all clients, even children, can map out their own best route to healing if given the opportunity to talk and play according to their own needs. In her quintessential text on CCPT, Axline (1969) outlined Eight Basic Principles of Play Therapy which remain the guiding force for this method of intervention. The principles are as follows: 1) the therapist must develop a warm, friendly relationship with the child where a good rapport is established as quickly

as possible 2) the therapist accepts the child exactly as he or she is 3) the therapist establishes a feeling of permissiveness so the child feels free to express his or her feelings completely 4) the therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to him or her in way that enables the child to gather insight into their behavior 5) the therapist maintains a deep respect for the child's ability to solve his or her own problems if given an opportunity to do so; responsibility to make choices and institute change rests with the child 6) the therapist does not attempt to direct the child's actions or conversation in any manner; the child leads the way, the therapist follows 7) the therapist does not attempt to hurry therapy along; it is recognized as a gradual process by the therapist 8) the therapist establishes only those limits necessary to anchor therapy in the world of reality and to make the child aware of his or her responsibility in the relationship (Axline, 1969, p. 73).

While psychoanalytic play therapists view play as a means of improving the therapeutic relationship, child-centered play therapists view play as the essence of the therapeutic process and the means through which children release feelings and anxieties and communicate with their therapist (Landreth, 2002; McCalla, 1994). Child-centered play therapists do not focus on getting children to verbalize their thoughts and feelings, but instead provide developmentally appropriate opportunities through play for children to explore issues they may have difficulty putting into words (Porter, Hernandez-Reif, and Jessee, 2009). Children's problems are seen as a reflection of their attitudes about themselves and play is viewed as an opportunity for children to match their external behavior with their ideal inner self and gain more emotional maturity (Guerney, 2001;

McCalla). In play, the child removes his or her own barriers to positive growth (McCalla).

The role of the child is so integral to CCPT that Sweeney and Landreth (2003) argue that a play therapist is not really a role at all and is based on a process of being with a child rather than a method of application. The child-centered play therapist focuses on the present, moving at the child's pace and trusting in the child's ability to make his or her own decisions (Cochran, 2010). Yet, the therapist is not a passive observer; in order to facilitate the child's self-growth and self-exploration, the therapist actively reflects back what he or she is observing in the child's play through a nonjudgmental attitude and verbal and non-verbal statements (McCalla, 1994). The therapist is also a willing participant in the child's play whenever invited and acts only as directed by the child (Axline, 1969). The therapist believes that when a child's feelings are identified and expressed, the child can then accept the feelings and deal with them in their own way (Landreth, 2002). Positive change occurs as the child begins to accept him or herself as wholeheartedly as the therapist does (Guernsey, 2001). Child-centered play therapy is effective in reducing symptoms of maladjustment because it allows children to experience the freedom of their play and develop self-discipline and determination as a result of their own efforts; through play negative symptoms are replaced with an evolving independence, self-acceptance and acceptance of others (McCalla).

Filial play therapy. Filial Therapy (FT) was developed in the 1960's by Bernard and Louise Guernsey in response to the growing demand for mental health services and the relative unavailability of trained professionals to meet this demand (Rennie & Landreth, 2000; Guernsey, 2000; Guernsey, 2003). The imbalance in supply and demand

of psychological services in these years meant that for the first time, paraprofessionals and nonprofessionals were providing services once reserved to the realm of doctoral professionals; this helped open the door to the idea that parents could also play a role as change agents in their children's lives (Guerney, 2003). When children were involved in psychotherapy, their problems were nearly always blamed on pathology in their parents, particularly in the mother (Guerney, 2000; Guerney, 2003). The concept of family therapy was new and untested at this time and it was generally viewed as unwise to see family members together in a therapeutic setting (Guerney, 2000).

The assumed negative influence of parents on their children's mental health made many parents at the time wary of mental health professionals and reluctant to subject themselves or their children to the scrutiny of psychotherapy (Guerney, 2000). The Guerneys hoped to combat this reluctance in parents by joining with them as partners in their children's positive development; they recognized that a lack of parental support often led to a premature termination of mental health services for children and believed that a focus on parents as primary agents of change would encourage positive growth within entire family systems (Rennie & Landreth, 2000; VanFleet, Ryan & Smith, 2005).

While most forms of play therapy focus on strengthening the relationship between the therapist and child, filial therapy (FT) focuses on the relationship between parent and child by highlighting their naturally existing attachment bond to bring about positive change (Rennie & Landreth, 2000). The Guerneys applied this approach based on the assumption that parents have much more emotional significance to their children than a therapist and that changes achieved through the parent acting as therapist would be exponentially more meaningful to the child (Glazer, 2010). The Guerney's were

proponents of Axline's (Axline, 1969) child-centered play therapy approach (CCPT) and knew that this method was found to be even more effective with the inclusion of parents in the therapeutic process (Guerney, 2003). The basic approach to FT includes: training parents to implement basic CCPT skills, parent-child play sessions and therapist supervision of the process (Rennie & Landreth).

Filial therapy typically takes place in a support group format, lasting 10-20 two-hour sessions, depending on the clients' presenting problems and the parents' ability to fully participate in FT (Guerney, 2000). While there is nothing particular about the group format which has been shown to ensure the success of FT, the group format is advantageous because it creates a more supportive atmosphere in which parents can learn FT skills and helps to normalize experiences (Guerney, 2000). Goals for families participating in FT include: 1) reducing problem behaviors in children 2) improving and restoring parent-child relationships 3) improving parenting skills such as understanding, acceptance, empathy and attunement 4) increasing children's sense of adjustment, competence and self-worth 5) allowing children to solve many of their own problems and 6) putting a priority on special parent-child times (Guerney, 2003; VanFleet, Ryan & Smith, 2005).

In beginning FT sessions, only the parents are present; filial therapists discuss the importance of play to children developmentally, explain the process and appropriateness of FT and assist in setting goals for parents and children (Glazer, 2010). Parents often watch tapes of other families engaging in play therapy and can ask questions to gain a better understanding of the process; parents then observe the therapist conducting play sessions and role play with other parents or the therapist to develop their own play

therapy skills (Glazer). Parents learn to convey acceptance and encouragement of their children and to master the skill of effective limit setting (Glazer; Rennie & Landreth, 2000). As parents become more comfortable with their skills, they begin to direct increasingly larger portions of play sessions and children are included in the therapeutic process (Glazer).

Therapists continue to observe and encourage parents' efforts and then debrief with parents after each session is completed (Glazer, 2010). These debriefing sessions are considered an essential component of the FT process, allowing parents to vent their frustrations in a safe environment and to process their feelings about their family, children and personal life (Guerney, 2000). Filial therapists also use this time to help parents understand their child's play and the parent's reaction to it (Glazer). Over time, play sessions are slowly transitioned to the home and the therapist helps parents integrate the skills and attitudes learned in play therapy to the larger home environment (VanFleet, Ryan & Smith, 2005). The therapist and parent meet with decreasing frequency to discuss concerns, progress towards therapeutic goals, and a generalization of skills to the home environment; termination occurs when therapeutic goals are met and parents are judged competent in play therapy skills (VanFleet, Ryan & Smith).

Summary. Although the various types of play therapy differ in their goals and in the role performed by the play therapist, they all agree that play is a natural form of expression in children that allows them to communicate in ways that are developmentally appropriate (Guerney, 2001). In their extensive report on the professional characteristics of play therapists, Phillips and Landreth (1995) revealed that the majority of play therapists utilize multiple theoretical orientations in their work. Additionally in this

study, CCPT was identified as the primary lens used by play therapists employing a singular theoretical orientation, while others reported the use of a psychoanalytic, cognitive-behavioral, family or directive approach (Phillips and Landreth, 1995). These results caused Phillips and Landreth (1995) to argue that the focus on psychoanalytic theories has decreased over time as the client-centered approach increased in usage.

This claim is supported by Lambert et al's (2005) more recent survey of play therapists which indicated that play therapists overwhelmingly rate CCPT as their primary theoretical orientation despite knowledge of multiple forms of intervention. Therefore, while there are many forms of play therapy being practiced today, research indicates that CCPT is currently the dominant form of play intervention; these studies suggest that Axline's (1969) conceptualization of the child as the source of his or her own positive growth still rings true with play therapists today (Phillips & Landreth, 1995; Lambert, Ray, LeBlanc, Baggerly, Mullen, White, & Kaplan, 2005).

Effectiveness Research

Nash and Schaeffer (2010) describe that the empirically-supported intervention movement originated in the medical field where scientists and practitioners began looking for treatments that had research supporting their effectiveness. The demand for evidence-based practice is currently so great that scientifically proving the effectiveness of any therapeutic intervention is essential to its widespread acceptance as a viable form of treatment (Ray, Bratton, Rhine, Jones, 2005). Parents, school officials, insurance companies and members of the legal system are now insisting on more research to validate the use of play therapy as an effective and cost-efficient means of working with children (Ray, Bratton, Rhine, Jones). Recent studies have attempted to assess and

summarize historical research in the field and gather new data in order to 1) fill the gaps in existing research 2) establish the effectiveness of play therapy and 3) institute more widely accepted best practices within the field.

In the first of these recent efforts, Phillips and Landreth (1998) led an extensive survey examining important practices, issues and perceptions of play therapy with children; survey participants were solicited from two annual play therapy conferences, the Association for Play Therapy membership and the American Psychological Association membership, resulting in 1,166 survey respondents. The survey assessed age and gender distribution of children in play therapy, criteria used for selecting play therapy for children, disorders amenable to play therapy, play therapists' estimates of the method's effectiveness and factors that most determine success in play therapy.

Practitioners rated those factors most likely to contribute to a child's success in play therapy as 1) the relationship between the child and the therapist and 2) the involvement of parents/families in treatment; the factors rated as least likely to contribute to a child's success were 1) socioeconomic status of the child's family 2) child's verbal ability 3) intelligence 4) awareness of problem and 5) frequency of PT sessions (Phillips & Landreth, 1998). Respondents estimated that a majority of children, 80%, ended treatment being at least "mostly successful".

Although practitioners listed a variety of client's needs they felt could benefit from play therapy, they reported the highest levels of agreement in the success of play therapy in treating 1) physical and sexual abuse 2) depression/withdrawal 3) acting-out/impulse control and 4) school adjustment/academic difficulties (Phillips & Landreth, 1998). Results of Phillips and Landreth's (1998) survey also indicated that the age and

the type of disorder in clients were the most significant factors in influencing treatment decisions. Overall findings of this study revealed a substantial level of agreement amongst the diverse group of play therapists surveyed; Phillips and Landreth (1998) argued that the similarities amongst responses of those surveyed suggest the emergence of a unified body of professional knowledge about play therapy.

Shortly after Phillips and Landreth's (1998) survey results were published, Bratton and Ray (2000) completed a comprehensive literature review summarizing 82 play therapy studies published from 1942-2000. Bratton and Ray's work emphasized the effectiveness of play therapy with specific presenting issues and populations, revealing the highest levels of effectiveness in the areas of self-concept, behavioral change, cognitive ability, social skills and anxiety (Bratton & Ray). A comparison of data across the 82 studies demonstrated that participants ranged in age from 3 to 17 and partook in an average of 12 play sessions; a majority of studies also reported use of a non-directive theoretical framework along the lines of Axline's (1969) CCPT approach (Bratton & Ray). Although this extensive literature review did reveal some important characteristics of play interventions, Bratton and Ray argue that when considering the six decades of play therapy research they examined, 82 studies is rather sparse evidence of its effectiveness.

Building off their comprehensive 2000 literature review, Ray et al. (2001) completed a meta-analysis of 94 previous studies that focused on the efficacy of play therapy, FT and combined play therapy and FT. Researchers utilized meta-analysis to overcome the limitation of small sample sizes that exists in most psychotherapy research by combining the results from several individual studies to produce an overall or average treatment

effect (Bratton, Ray, Rhine, Jones, 2005; Porter, Hernandez-Reif & Jessee, 2009).

Results from this study were stronger than those of previous meta-analytic child psychotherapy studies and revealed that play therapy is an effective method of psychotherapy with children across age, gender, with multiple theoretical schools of thought and in various clinical settings (Ray, Bratton, Rhine & Jones, 2001). Ray et al.'s study indicated that play therapy was significantly more effective than no intervention, with filial therapy in particular shown to have the greatest effect on clients.

This study demonstrated several significant findings including: 1) a larger effect size for non-directive play therapy approaches over those that were not client-centered 2) equal levels of effectiveness for individual and group play interventions 3) effectiveness of play therapy in less than ideal circumstances such as a limited number of sessions or lack of parental involvement and across a wide range of presenting problems in clients (Ray, Bratton, Rhine & Jones, 2001). Two factors shown to consistently increase play therapy's effectiveness were parent involvement and duration of sessions (Ray, Bratton, Rhine & Jones). Effectiveness increased with the number of sessions, peaking between 35-45 sessions, however, a large effect size was noted in children who participated in fewer sessions as well (Ray, Bratton, Rhine & Jones). Results of Ray et al.'s meta-analysis also suggested that while both parents and professionals can effectively deliver play therapy interventions, parents may achieve better outcomes than professionals.

Bratton et al.'s (2005) research expanded on the work of Ray et al. (2001) by conducting a meta-analytic review of 93 studies published between 1953 and 2000 to assess the overall effectiveness of play therapy and determine factors that might impact its efficacy. Similar to the work of Ray et al. (2001), this study revealed 1) a significant

advantage of play interventions over no intervention 2) similar levels of effectiveness for group and individual play interventions and across age and gender 3) effectiveness of play therapy regardless of therapeutic approach, with non-directive methods such as CCPT slightly more effective and 4) larger treatment effects obtained by parents conducting FT than by professionals conducting play therapy (Bratton, Ray, Rhine & Jones, 2005).

Also similar was Bratton et al.'s (2005) report of peak treatment effects obtained between 35-40 sessions, with play therapy also found to be effective with fewer than 14 sessions. Bratton et al. explained this phenomenon by stating that while negative symptoms may be controlled in just a few sessions, "therapy for significant issues takes significant time" (p.386); the researchers speculated that positive treatment effects increase with the length of treatment. Bratton et al. also established the effectiveness of play therapy across treatment settings; a majority of play interventions were conducted in school or outpatient settings, but children in residential treatment showed the most benefit from play therapy and participated in the highest amount of play sessions (Bratton, Ray, Rhine & Jones). Overall results suggested that play therapy has a large effect on children's behavior, social adjustment and personality (Bratton, Ray, Rhine & Jones). Phillips (2010) described that the results of Ray et al. (2001) and Bratton et al.'s recent meta-analyses caused great excitement in the field of play therapy and have been widely cited as support for play therapy's effectiveness; these studies organized of decades of widespread research and offered a comprehensive examination of the entire field of work.

Several studies have also examined the effectiveness of the various theoretical models of play therapy treatment. Psychoanalytic play therapy (PPT) in particular has suffered from a lack of empirical research supporting its claims; studies to date have been sparse and exist mainly in the form of case study, the in-depth analysis of a single child's treatment (Bromfield, 2003). Despite its many benefits, critics of psychoanalysis argue that it is Eurocentric, misogynistic and lacking in relevance for culturally diverse populations; many believe that this approach is dated and does not reflect the current worldview (Lee, 2009). Bromfield suggested that PPT was lacking in research because 1) the methods of PPT cannot easily be standardized for empirical study 2) many of the goals and activities of PPT are not easy to define or assess quantitatively and 3) the idea that PPT is as much an art as a science, with identical interventions often resulting in different effects on different children.

Conversely, a wealth of evidence has proven filial therapy (FT) as an extremely versatile intervention that can be adapted to meet the needs of many families in many settings while still maintaining its effectiveness (Glazer, 2010; Guerney, 2003; VanFleet, Ryan & Smith, 2005). VanFleet, Ryan and Smith's summary of FT research confirmed the effectiveness of FT with individual families, single parents and in an abbreviated 10-week model; this research also suggested that the positive effects of FT can last for several years after treatment is completed. Glazer's research on FT with grieving preschool children and Rennie and Landreth's (2000) research on the effects of FT on parent and child behaviors, established that parents who participate in FT exhibit a statistically significant increase in self-esteem, empathy and acceptance of their children and a decrease in parental stress. These two studies also showed that children who

participate in FT display a decrease in behavioral problems, an increase in overall functioning and a positive change in play behavior and self-concept (Glazer; Rennie & Landreth). Guerney (2003) speculated that as resources for health and human services continue to shrink, FT may increasingly establish its success as a promising intervention for impacting both parents and children in one singular intervention.

Populations

Guerney (2001) asserts that children with nearly every type of presenting problem have benefited from play therapy; the only children considered unlikely to respond positively to this approach are those with severe autism or active schizophrenia, but therapists are encouraged to consider these children for treatment on a case by case basis as well. Schaefer (2010) argues that one of the groups that benefits most from play therapy is young children who are preparing for upcoming stressful experiences; play aids children in combating anticipatory anxiety, helping children to play out an expected sequence of events and model effective ways to handle stressful situations. Preparatory pretend play is beneficial across a range of presenting problems in 1) making the strange familiar 2) allowing children to practice coping skills 3) allowing therapists to listen to children's concerns and 4) correcting any misperceptions the child may have about upcoming stressful situations (Schaefer).

Schaefer (2010) contends that if the healing powers of play are applied to mild or moderate problems, these problems are less likely to escalate into serious disorders. Anxiety problems are the most common psychological disorder of childhood and a wide variety of evidence-based play interventions have, consequently, developed to respond to children's anxieties and fears (Schaefer). Empirically supported play interventions have

also been identified for use with aggressive preschoolers in groups and individually (Schaefer). Researchers have approached this population by utilizing 1) cooperative games that depend on all players assisting one another to succeed at a common goal and 2) sociodramatic play training, which involves clients taking roles and acting out scenarios in imaginative fantasy play (Schaefer). Results show that children participating in this form of play therapy display increased cooperative peer interactions, decreased aggressiveness and a strengthening of emerging social skills such as: empathy, role taking, self-control and sharing (Schaefer).

Phillips (2010) contends that, when compared with other areas of play therapy research, a reasonably solid evidence base exists in support of play therapy interventions with children facing medical procedures. In fact, Schaefer (2010) argues that play preparation is now the evidence-based intervention of choice for children facing medical procedures. Typical research in this area measures children's anxiety and fear before and after medical procedures to determine if play interventions helped children feel more at ease (Phillips). Because chronic illness and disabilities in children can produce considerable stress and trigger intense fears, children who are hospitalized have a strong need to play and feel joy; in these children, play can be antidote to their distress (Schaefer).

One category of play children engage in, fantasy play with medical toys, equipment and procedures, has proven more effective than traditional methods of preparing children for medical procedures such as verbal, written or film techniques (Schaefer, 2010). Fantasy play can be used as a coping resource to help children temporarily escape their illnesses and reduce their anxiety levels (Schaefer). Existing

research recommends that play preparation for medical procedures should take place with very young children, ages 3-5, the day before the medical procedure and 5 to 7 days prior to the procedure with children aged 6-12 (Schaefer). Video game play is also being increasingly used in health care settings to distract children by providing an enjoyable and familiar activity (Schaefer).

The basic objective of psychoanalytic play therapy has been applied successfully to a number of areas of child development including: helping children to suffer less and overcome trauma, adjust to life events, cope with illness and comply with treatment, master phobias, increase school functioning, and come to terms with learning or physical disabilities (Bromfield). In Bromfield's descriptive review of PPT, she stated that PPT has been found to be effective with most any child, but is especially beneficial with children suffering from anxiety, depression, borderline or psychotic functioning, and those children who are faced with coming to terms with limitations such as chronic illnesses or learning disabilities. Psychoanalytic play therapy has shown to be effective in lessening self-hatred and problematic narcissistic behaviors in children as well (Bromfield).

Studies have also established the effectiveness of filial therapy with a wide range of populations; FT was initially intended for use with children with behavioral and emotional difficulties aged four through ten and has since proven effective with a variety of children aged three to 12 (Glazer, 2010; Guerney, 2000; VanFleet, Ryan & Smith, 2005). Rennie and Landreth's (2000) review of past FT studies revealed that FT is effective with foster parents, single parents, incarcerated mothers and fathers, parents of different cultural backgrounds, parents of mentally challenged or chronically ill children,

parents of children with conduct problems or learning disabilities and non-offending parents of sexually abused children.

Glazer's (2010) case study of a four-year old and her family grieving the loss of a child, helped establish the utility of FT with another population, grieving preschoolers. Glazer stressed therapeutic value of symbolic play in allowing children to rework and master traumatic events; she also justified her use of FT through its proven effectiveness in strengthening the parent-child bond and facilitating a family's healing process as they cope with events together.

Guernsey (2000) contends that any parent, other than those who are perpetrators of sexual abuse, is assumed to be a successful candidate for FT until proven otherwise. Filial therapists operate from a framework that assumes that even seriously impaired parents can become better parents if given the training, tools and support to do so and, consequently, few parents have ever been excluded from participation in treatment (Guernsey, 2003; VanFleet, Ryan & Smith, 2005). Despite the array of research on FT, Rennie and Landreth (2000) contend that it remains a developing field with the broader context of play therapy and requires additional research on its effects on a broader range of children's problems including: self-esteem, anxiety and behavioral adjustment, developmental delays, attachment difficulties, and witnesses to domestic violence and other traumatic acts.

McCalla (1994) speculated that child-centered play therapy in particular is effective with such a wide variety of populations because it engages the child where he or she is at a particular moment and allows the child to go wherever they need to go; therefore, varied approaches do not need to be used with various clients because one

method fits all. Despite this universal appeal, researchers have tried to establish the effectiveness of CCPT with very specific client populations. Guerney (2001) highlighted the use of CCPT in group therapy, stating that that while effective, CCPT groups must be smaller than traditional psychotherapy groups because the therapist must be able to respond to each child and the group as a whole, making multiple feelings and behaviors the focus of the group.

In an exploratory study on the effects of long-term CCPT in the school setting, Muro et al. (2006) analyzed 23 elementary-aged children identified by their teachers as exhibiting behavioral and emotional difficulties. Students participated in 32 sessions of CCPT over the course of the school year and measurements were gathered on children's negative behaviors in the classroom and on teacher-reported teacher-child relationship stress (Muro, Ray, Schottelkorb, Smith, & Blanco). The study revealed statistically significant improvement over the duration of treatment, with teachers reporting a significant decrease in students' acting out behaviors and in teacher-child relationship stress (Muro, Ray, Schottelkorb, Smith, & Blanco).

Research on the effectiveness of CCPT with a concentrated client population expanded with Kot, Landreth & Giordano's (1998) study of intensive CCPT with child witnesses of domestic violence. Kot, Landreth & Giordano argued that due to the unstable and transient nature of families experiencing domestic violence, children's stay in domestic violence shelters would likely be their only opportunity to receive treatment; therefore, they hypothesized that an intensive play therapy experience would meet the needs of this unique population more effectively than traditional once-a-week play therapy sessions.

Children who participated in this study lived at one of three domestic violence shelters in a large metropolitan area during the time of the study and received 12, 45 minute play sessions over a period of 12 days to three weeks (Kot, Landreth & Giordano, 1998). Results of the study supported the use of intensive play therapy with child witnesses of domestic violence, revealing 1) a significant increase in children's self-concept 2) a significant decrease in total behavior problems 3) a significant increase in play behavior of physical proximity to the therapist and 4) a significant increase in play behavior of nurturing and creative play themes (Kot, Landreth & Giordano).

Areas in Need of Further Research

In his review of existing play therapy research, Phillips (2010) argues that a body of credible scientific evidence supporting the efficacy of play therapy does not exist. Phillips (2010) contends that while randomized, clinical trials are one of the best strategies for approximating direct causality between research variables and allowing for statistically significant data analysis, few of these studies exist in the field of play therapy research. Additionally, in their meta-analysis of existing play therapy research, Ray et al. (2001) concluded that much of the current research on play therapy consists of small sample sizes that limit the generalizability of the research; these researchers suggest overcoming this deficiency through the establishment of a common play therapy research protocol. Ray et al. argue that a common research protocol would allow play therapists in varied settings to use similar instruments and procedures to measure their work and thereby 1) increase the ability to duplicate studies 2) increase the ease in comparison of studies 3) strengthen meta-analytic reviews of play therapy research and 4) encourage play therapists who are unfamiliar with research to conduct their own small studies.

Rennie and Landreth (2000) similarly encouraged researchers to collaborate in designing and implementing their studies to allow for the sharing of data over long periods of time.

Several prominent studies have also commented on the need for play therapy research that addresses the relationship between the length of play therapy interventions and their outcomes; these researchers contend that systematically controlling the length of play therapy interventions and measuring differences in client outcomes would help establish decisive recommendations about optimal treatment length for varied client populations (Bratton & Ray, 2000; Muro, Ray, Schottelkorb, Smith, & Blanco, 2006; Phillips, 2010; Ray, Bratton, Rhine & Jones, 2001). Other researchers suggest a need for follow-up studies that examine the immediate and long-term effects of play therapy on clients and their families to determine if play therapy has lasting positive effects (Bratton & Ray, 2000; Ray, Bratton, Rhine & Jones, 2001).

Readers of play therapy research may also be surprised to find how little research exists examining some of the core elements of play therapy such as the client-therapist relationship, training of therapists and the type of play that clients engage in. In Phillips (2010) examination of existing play therapy research, he noted that while most studies look at play as a means to a therapeutic end and measure changes in children's behavior as a result of engaging in play, few studies describe the actual play that occurs. Phillips (2010) asserts that if play is critical to treatment, researchers should measure it and link it systematically to treatment outcomes describing how play can reveal a child's difficulties as well as signs of their well-being. Child-centered play therapy literature also promotes the relationship between the client and therapist as vital to the success of play therapy, but rarely describes what exactly the therapist is doing to build this relationship; future

research would benefit from a discussion of expected links between therapist and client behaviors and an examination of whether or not relationship characteristics can be successfully articulated and measured (Phillips, 2010).

To truly establish the effectiveness of play therapy over other forms of therapeutic intervention, several studies recommend research that directly compares play therapy to other child psychotherapeutic techniques (Bratton & Ray, 2000; Ray, Bratton, Rhine & Jones, 2001). Rather than comparing play therapy to more traditional cognitive or behavioral approaches, most existing research compares play therapy to a control group that receives no therapeutic intervention; therefore researchers are currently unable to declare that play therapy is the most effective form of treatment because this evidence simply does not exist (Bratton & Ray, 2000; Ray, Bratton, Rhine & Jones, 2001). Future play therapy research is needed not just to prove its effectiveness and add to the existing body of literature, but primarily to ensure that mental health providers have the information necessary to obtain the optimal form of treatment for their clients and successfully meet their treatment goals (Lambert, Ray, LeBlanc, Baggerly, Mullen, White, & Kaplan, 2005).

Research on social workers' role in the delivery of play therapy services is nearly non-existent. While Phillips and Landreth (1995 & 1998) and Lambert et al. (2005) briefly mentioned social workers as a category of respondents in discussing the results of their studies, no previous research has specifically focused on the use of play therapy amongst social workers. Phillips and Landreth (1995 & 1998) reported that 18% of female respondents identified social work as their primary professional identity, while 22% identified as psychologists and 44% as counselor/therapist; only 8% of male

respondents identified as social workers, while 58% identified as psychologists and 26% identified as counselor/therapist. Additionally, Lambert et al. reported that 20% of overall survey participants listed social work as their primary professional identity.

While these studies do give an estimate of social workers representation in the broader field of play therapy, they give no indication of the educational background of these practitioners, how often they engage in play therapy, how successful they feel play therapy is as an intervention or how their provision of play therapy is similar or different to that of colleagues from different educational backgrounds, such as psychology. Play therapists would benefit from research describing the unique attributes that professionals from varied educational backgrounds bring to this field; the perspective of social workers in particular would be extremely valuable as play therapy is historically a psychological intervention and no research to date describes how social workers began using these techniques or what lens they offer to their clients. Social workers would also benefit from an examination of their role in play therapy to encourage more social workers to utilize these techniques and to highlight the contributions of social workers in a field dominated by psychologists.

Conclusion

In summary, research on play therapy must continue. Although play therapy is a widely used and historically well-known intervention, it receives barely a mention in evidence-based professional journals outside the play therapy field (Phillips, 2010). In his review of existing play therapy research, Phillips (2010) argued that this lack of widespread acceptance is due to the fact that play therapy is “characterized by a disparate array of studies that often do not build incrementally or conceptually on previous work”

(p.16). Identifying effective treatments for children with emotional and behavioral disorders is a growing concern in the United States (Bratton, Ray, Rhine, & Jones, 2005). Child therapists are ethically bound to provide their clients with evidence-based treatments that respond to the unique needs of children and their families in order to diminish unnecessary suffering and prevent the development of more serious impairment across the lifespan (Bratton, Ray, Rhine, & Jones, 2005). The lack of consensus about best practices and standard research measures has caused the effectiveness of play therapy as therapeutic intervention to be questioned and criticized and more work must be done to solidify the importance of play therapy (Bratton, Ray, Rhine, & Jones, 2005).

Conceptual Framework

Two major theories contributed to the development of this study, the strengths-based perspective and Erikson's psychosocial lifespan development theory; the National Association of Social Workers values also contributed to the lens of this study. These lenses were chosen due to their correlation to the core tenets of play therapy. The focus in lifespan development theory on the progression of human growth through a series of age appropriate tasks complements the value play therapists place on play as the most developmentally appropriate task for children. Additionally, the strengths-based perspective aligns with Axline's (1969) Eight Basic Principles of Play Therapy; both emphasize a respect for the client's innate ability to draw on resources within themselves to solve problems to the best of their abilities.

Lifespan Development Theory

Erikson's lifespan development theory is based on the idea that people's personalities continue to develop over the course of their lives based on their successes in

negotiating eight life stages (Hutchison, 2008). Erikson argued that human development is based on the interaction of biological, psychological and social factors, with each stage of life building on the successes of earlier stages; the progression to the next life phase was believed to involve a change in roles and statuses and the assumption of new tasks (Hutchison). Children participating in play therapy would typically fall into Erikson's stage three, ranging from ages three thru five, or stage 4, ranging from ages six thru twelve.

Erikson explained that children in stage three are focused on a struggle of initiative versus guilt; children of this age are beginning to understand society's expectations that they engage in more individual activities, but children often struggle with guilt at separating from their caretakers and developing their own sense of initiative (Forte, 2007). In stage four, children move on to a struggle of industry versus inferiority as they waver between a sense of pride in their growing competencies and a sense of inferiority about their struggles (Forte). In line with Erikson's developmental stages, Nash and Schaeffer (2010) contend that a major developmental task for children in the preschool years is to understand, identify and regulate one's emotions. Play is the primary means through which children achieve this task, learning to regulate the frequency and intensity of their emotions, gauging reactions from peers and adults and learning to communicate in a socially appropriate manner (Nash and Schaeffer).

Muro et al. (2006) build on this developmental framework by describing play therapy as a developmentally appropriate therapeutic process used to meet the social and emotional needs of children. Children's play gives us a view into their emotional world, allowing them to communicate emotionally significant experiences, express inner

thoughts and cope with their frustrations in a natural and self-healing way (Landreth, 2002). Forte (2007) described that Erikson viewed social workers as experienced mountain climbers who recommend the equipment, support systems and techniques appropriate for each stage of development; according to Erikson, the social worker helps the client to solve problems and resume progress. Play can help therapists uncover 1) what a child has experienced 2) reactions to and feelings about what was experienced 3) what the child wishes, wants or needs and 4) the child's perception of him or herself (Landreth). Because play is a familiar and nonthreatening activity for children, it can be utilized to aid children in mastering traumatic experiences and developing coping skills in a safe environment (Landreth).

Strengths-based perspective

The advent of the strengths-based perspective represented an overall shift in the focus of social work from pathology to strengths and from a focus on the past to a future orientation; using the strengths-based perspective, social workers emphasize the resiliency, resourcefulness and connectedness in every client rather than concentrating on identifying clients' risk factors (Miley, O'Melia & DuBois, 2009). The strengths-based perspective is utilized by social workers to highlight the resources available within their clients and their environmental context to promote positive growth; this theory is based on the belief that clients' strengths are resources in working for positive change and a beginning point from which to create hope about the future (Hutchison, 2008; Miley, O'Melia & DuBois).

Social workers who operate from this perspective believe that all clients have natural abilities within themselves from which they can draw on during difficult times to

reframe their stresses and work towards the development of their potential (Miley, O'Melia & DuBois, 2009). Through this lens, social workers help clients to meet challenges to the best of their abilities, highlighting how clients have coped with adversity in the past and building off these successes to make changes in the present (Hutchison, 2008; Miley, O'Melia & DuBois). Through the strengths-based perspective social workers maintain that clients know their situations best and, when given options, can determine the best solutions for themselves; social workers support clients in mastering their difficulties and gaining competencies rather than aiming to correct clients' deficits (Miley, O'Melia & DuBois).

This belief in client's inherent abilities echoes Axline's (1969) assertion that children possess an innate power to heal themselves when given the ideal therapeutic conditions; this idea was the basis for Axline's child-centered theory and supports the overall framework of this study. Axline (1969) believed that within play therapy, the child is the most important person; the child is accepted completely as an individual and is in control of determining where the therapeutic process will go. Landreth (2002) stated that play gives children a sense of control that is often lacking in their lives and allows them the security to express themselves more freely than they might otherwise. Additionally, Landreth argued that a major function of children's play is helping children change what is unmanageable in reality into manageable play situations. In play therapy, as in the strengths-based perspective, social workers recognize the unique potential of each individual and tap into latent resources to discover clients' strengths (Miley, O'Melia & DuBois, 2009).

Axline (1969) argued that the freeing environment of the play room helps to lower psychological resistance to change in clients, because in play therapy children are not criticized or told what to do; through play the child shares his or her world with the therapist (McCalla, 1994). Similarly, social workers who operate from a strengths-based perspective believe that a focus on pathology conceals clients' strengths; instead of looking at the past to discover what went wrong, strengths-based social workers help clients shift their focus from what was to what can be (Miley, O'Melia & DuBois, 2009). Through the strengths-based perspective, past struggles are not ignored, but are hoped to fade in light of clients' current successes (Miley, O'Melia & DuBois). Play therapists also use a future orientation to guide their work, believing that clients do not necessarily need to resolve past difficulties in order to succeed in the present (Landreth, 2002).

Method

Research Design

This study employed a descriptive research design and a quantitative method of data collection to answer the research question: what are social workers' perceptions of play therapy? This study also examined: how frequently social workers use play therapy in their practice, what social workers' level of training is in play therapy techniques, how effective social workers believe that play therapy is as an intervention with children and what factors social workers believe contribute to the success of play therapy.

Additionally, this study tested the following hypotheses:

- There is an association between primary practice setting and provision of play therapy services.

-There is a relationship between exposure to play therapy training and perceived effectiveness of play therapy.

-There is a difference between social workers who practice play therapy and those who do not in their perceived effectiveness of play therapy.

In her study of elementary school counselors' beliefs about the use of play therapy, Ebrahim (2008) employed a quantitative approach in order to ensure an adequate representation of her research population. Phillips and Landreth (1995 & 1998) also utilized a quantitative approach in their extensive study of play therapists in order to reach the widest range of participants possible and strengthen the value of their research findings. Lambert et al (2005) also justified their use of quantitative methods as the best means through which to widely expand the existing research base on play therapists.

This study utilized a survey to generate numerical data and identify relationships between variables, such as professional certification and level of knowledge about play therapy. A quantitative approach was chosen in order to reach a wide participant base and to enable an in-depth comparison of participants' responses through statistical analysis. Survey outcomes are directly related to social work practice and provide a snapshot of social workers knowledge about play therapy and their part in the delivery of play therapy interventions to children; social workers were surveyed directly about their experiences with play therapy. This section includes an overview of sampling procedures, protection of human subjects, data collection instruments, data collection process and a data analysis plan.

Sample

This study was carried out in the state of Minnesota. Participants in this study included members of the Minnesota Board of Social Work and members of the Minnesota Chapter of the Association for Play Therapy (MAPT). Access to participants was obtained through the Minnesota Board of Social Work, which provided contact information for a random sample of 300 licensed social workers (see Appendix D). Additionally, contact information for 12 social workers licensed in play therapy was obtained through the MAPT's online listing of play therapists at www.mnapt.net. Participants from the Minnesota Board of Social Work and MAPT were included due to convenience in obtaining their contact information and their ability to effectively respond to questions about personal experiences with play therapy. A large sampling of social workers was contacted in an effort to obtain a sufficient return rate.

Protection of human participants. All parts of this study were reviewed and approved by the University of St. Thomas Institutional Review Board in order to safeguard all human participants. Additionally, a committee of three master's level social workers, including one play therapist, reviewed this research and the Measure of Social Workers' Perceptions of Play Therapy (MSWPPT) survey before it was distributed to participants. Participants were recruited directly through a mass email to all those contacts provided by the Minnesota Board of Social Work and MAPT; email addresses were obtained through access to public data listing association members. A cover letter (see Appendix A) was sent electronically inviting participation in this survey and providing an overview of the purpose of the study; this letter also included a statement of

consent (see Appendix B), a description of how participants were chosen for this study and an explanation that participation in the study was completely voluntary.

Data were collected anonymously through Qualtrics, an online research software for collecting and analyzing data. Although participants were initially identifiable through their contact information, once the surveys were completed, results were anonymous; Qualtrics did not permit the researcher to link participants to their responses and did not allow the researcher to determine which participants had responded to the study. Additionally, the MSWPPT survey did not include any questions that could reveal the identity of participants. Names of participants were not included in the final results of this study.

Informed consent. A consent form (see Appendix B) was created in accordance with the requirements of the University of St. Thomas Institutional Review Board and attached to the initial invitation to participate in this study. The consent form explained confidentiality and the voluntary nature of the study and described that participants in this study would remain anonymous. The storage and analysis of data was described to participants along with an explanation that there was no known risk or benefit to inclusion in this study. Participants were informed that their completion of the MSWPT survey would represent their consent to participate in this study. Contact information for the researcher, faculty advisor and an institutional review board member were provided to participants to address any questions or concerns with the study.

Data Collection Instrument

No previous studies have specifically examined social workers perceptions of play therapy and, therefore, no appropriate survey was available for use in this study. A

survey, Measure of Social Workers' Perceptions of Play Therapy (MSWPPT) was created for this study based on related research by Ebrahim (2008), Lambert et al (2005) and Phillips and Landreth (1995 & 1998). The survey was made up of 19 questions and focused on four main areas, including demographic information, professional information, use of play therapy and perceived effectiveness of play therapy (see Appendix C for a full list of survey questions); the survey took approximately 10 minutes to complete.

The survey included questions about demographic information including race, gender, and age of participants. Questions about professional information included: level of education, professional certification, workplace setting and exposure to professional play therapy training. Additional questions measured the frequency with which social workers utilize play therapy methods, reasons for not using play therapy and factors believed to contribute to the effectiveness of the delivery of play therapy services. The survey also included six Likert scale questions measuring participants' beliefs about the effectiveness of play therapy with children and the connections between play therapy and professional social work practice.

Data Collection Process

The MSWPPT survey was distributed to 312 participants via mass email; data were collected through a self-administered survey completed online. Data collection was completed through the use of Qualtrics Survey Software and results were compiled through Qualtrics in order to streamline data analysis. This method was chosen due to cost-effectiveness and the ease of use for respondents. An initial email inviting

participation in the survey was sent to participants in February, with a reminder email sent one week later to encourage participation. Data collection ended on March 7, 2012.

Data Analysis

Responses to the MSWPPT survey were assembled in a Qualtrics database and then migrated to an Excel spreadsheet to enable statistical analysis with Minitab 15 data software. Minitab 15 was chosen because it allows for data to be easily managed through the development of spreadsheets and graphs illustrating its calculations of survey data. Data analysis included both descriptive and inferential statistics. Data analysis examined survey questions related to the effectiveness of play therapy, respondents' knowledge of play therapy and factors contributing to the success of play therapy; analysis also included a comparison of responses between social workers who say they practice play therapy and those who do not.

Descriptive statistics. Descriptive analysis was used to analyze demographic information gathered from this survey, including responses to Questions 1-3 (see Appendix C) and Questions 4-15 regarding professional information. A frequency distribution of results was provided for questions that employ nominal level measurements including Questions 1, 3, 4, 6-9, 12 and 13. Responses to Likert scale items in Question 16 were displayed through measures of dispersion. Ratio level measurements, including responses to Questions 2, 5, 10, 11-13, 17-19 were described through measures of central tendency and illustrated through tables and figures.

Inferential statistics. This study also examined several inferential statistics. A chi-square test was used to test hypothesis 1, "There is an association between primary practice setting and provision of play therapy services". The independent variable,

primary practice setting was measured through responses to Question 8, while the dependent variable, provision of play therapy services, was measured through responses to Question 14, “Do you practice play therapy with your clients?” A correlation test was run to test hypothesis 2, “There is a relationship between exposure to play therapy training and perceived effectiveness of play therapy”. The independent variable, play therapy training was operationalized through responses to Question 11-13, regarding coursework, supervision and continuing education in play therapy while the dependent variable, perceived effectiveness of play therapy, was operationalized through responses to Likert scale measures in question 16.

Lastly, a t-test was run to test hypothesis 3, “There is a difference between social workers who practice play therapy and those who do not in their perceived effectiveness of play therapy”. The independent variable, provision of play therapy services was measured through responses to Question 14 which asks respondents whether or not they use play therapy with their clients; the dependent variable, perceived effectiveness of play therapy, was operationalized through responses to Likert scale measures in question 16.

Findings

A survey, Measure of Social Workers Perceptions of Play Therapy (MSWPPT) was created for this study; the MSWPPT consisted of 19 questions focused on demographic and professional information as well as participants’ use of and beliefs about the effectiveness of play therapy. The online survey was sent to 312 licensed social workers from the state of Minnesota and 51 participants completed the survey for a response rate of approximately 16%.

Descriptive Statistics

Demographic information. Data analysis showed that a large majority of participants were Caucasian females; a frequency distribution revealed that 90% (n=46) of respondents were female and 92% (n=47) of respondents identified as Caucasian. Age of participants was analyzed through an additional frequency distribution which showed that the largest group of participants, 41% (n=21) were between the ages of 31-40 while an additional 25% (n=13) of participants were aged 21-30.

Table 1. Ethnicity of respondents

Ethnicity of respondents		
Ethnicity	# of responses	% of responses
African American	2	4%
Asian American	0	0%
Caucasian	47	92%
Hispanic	1	2%
Native American	0	0%
Pacific Islander	0	0%
Bi-racial	0	0%
Other	1	2%
Total	51	100%

*Note: Responses for “other” included: Bi-cultural (Mexican/European).\

Table 2. Age of respondents

Age of respondents		
Age	# of respondents	% of respondents
21-30 years	13	25
31-40 years	21	41
41-50 years	11	22
51-60 years	6	12
60 + years	0	0
Total	51	100

Professional information. Descriptive statistics assessing the highest level of education of participants showed that a majority of respondents 59% (n=30) held a master's degree, while 39% (n=20) held a bachelor's degree and 2% (n=1) held a doctorate degree. A second descriptive statistic measured for levels of professional certification; of the 50 respondents to this question, the largest group, 40% (n=20), were LSW's (Licensed Social Workers) and an additional 32% (n=16) were LICSW's (Licensed Independent Clinical Social Workers).

Table 3. Respondents' highest level of education

Respondents' level of education		
Level of education	# of respondents	% of respondents
Bachelor's Degree	20	39
Master's Degree	30	59
Doctorate	1	2
Total	51	100%

Table 4. Respondents' level of professional licensure

Respondents' level of licensure		
Licensure	# of respondents	% of respondents
LSW	20	40
LGSW	11	22
LISW	1	2
LICSW	16	32
Other	2	4
Total	50	100%

*Note: Responses for "other" included: LADC (Licensed Alcohol & Drug Counselor.)

Descriptive statistics were also used to gather information regarding respondent's primary area of social work expertise. Results showed that 27% (n=13) of respondents identified "mental health" as their primary area of expertise, 16% (n=8) identified

“children/adolescents” and another 16% (n=8) reported an “other” area of expertise including: welfare-family services, children and trauma, adult protective services, hospice, developmental disabilities and employment services. Data revealed that participants also work in a wide variety of practice settings, with 21% (n=10) working at a mental health center/community agency, 19% (n=9) in state/local government, 15% (n=7) in private practice, 15% (n=7) in schools and 23% (n=11) in “other” settings.

Table 5. Respondents’ primary area of social work expertise

Respondents' Area of Social Work Expertise		
Area of social work	# of responses	% of responses
Mental Health	14	27%
Children/Adolescents	8	16%
Other	8	16%
Gerontology	6	12%
School Social Work	4	8%
Child Welfare	3	6%
Health Care	3	6%
Private Practice	2	4%
Administration/Supervision	1	2%
Play Therapy	1	2%
Substance Abuse	1	2%
Criminal Justice	0	0%
Families	0	0%
Total	51	100%

*Note: Responses for “other” included: children and trauma, adult protective services, hospice, developmental disabilities and employment services.

Table 6. Primary practice setting

Respondents' primary practice setting		
Practice setting	# of responses	% of responses
Mental Health/Community Agency	11	22%
Other	11	22%
State/Local Government	9	18%
School	8	16%
Private Practice	7	14%
Day Treatment Center	2	4%
Hospital	1	2%
Residential Treatment Center	1	2%
Total	50	100%

*Note: Responses for “other” included: HUD housing, adult foster care, currently not practicing, home health, hospital and nursing home, residential services, skilled nursing facilities and private homes, workforce center and assisted living.

Inferential Statistics

A chi-square test was run to test hypothesis 1, “There is an association between primary practice setting and provision of play therapy services.” The independent variable, primary practice setting, was measured through responses to Question 8, which asked for respondents work setting. The dependent variable, provision of play therapy services, was measured through responses to Question 12 which asked respondents whether or not they use play therapy with their clients. However, because of the limited sample size of this study a valid chi-square test was not able to be run; the small number of responses in each data cell meant that there was an inadequate amount of information to formulate a p-value. Future studies would benefit from a greater sample size in order to properly test this hypothesis.

A correlation test was run to test hypothesis 2, “There is a relationship between exposure to play therapy training and perceived effectiveness of play therapy.” The independent variable, exposure to play therapy training, was operationalized by

combining responses to questions 11-13, with higher values reflecting a higher level of exposure to play therapy training. The dependent variable, perceived effectiveness of play therapy, was operationalized by combining responses to Likert scale questions 2-6 in question 16; higher values reflected a higher level of perceived effectiveness of play therapy. Results indicated a p-value of 0.023, showing a weak positive correlation between the variables; because the p-value was less than .05, results indicate that there is a statistically significant relationship between the variables. Therefore the null hypothesis, “There is no relationship between exposure to play therapy training and perceived effectiveness of play therapy” was rejected.

Lastly, a t-test was run to test hypothesis 3, “There is a difference between social workers who practice play therapy and those who do not in their perceived effectiveness of play therapy”. The independent variable, provision of play therapy services, was operationalized through responses to question 14 which asked respondents whether or not they use play therapy with their clients. The dependent variable, perceived effectiveness of play therapy, was again operationalized by combining responses to Likert scale questions 2-6 in question 16. Results indicated a p-value of 0.001; because this value is below .05 a statistically significant difference between social workers who practice play therapy and those who do not is indicated. Therefore, the null hypothesis, “There is no difference between social workers who practice play therapy and those who do not in their perceived effectiveness of play therapy” was rejected.

Additional Information

In order to determine how many of the survey respondents work with children, this study measured the percentage of hours spent working with children in a typical

week. Results revealed that while 43% (n=22) of participants do not work with children at all, the remaining 57% do spend at least some of their time working with children and would, therefore, have the opportunity to utilize play therapy. Findings indicated that 31% (n=16) of respondents use play therapy with their clients and 55% (n=28) have referred clients to play therapy services. The primary reason given for not using play therapy was that the respondent did not work with children; 74% (n=26) of those who said they do not use play therapy indicated that this was the primary reason. An additional 26% (n=9) of participants stated that they did not feel adequately trained in play therapy and, perhaps most interestingly, none of the respondents indicated that they do not use play therapy because they do not feel it is effective. Data also revealed that 78% (n=38) of respondents stated that their primary practice setting encouraged the use of evidence-based practice.

Table 7. Percentage of hours spent working with children

% of Hours Spent Working with Children		
% of Hours	# of Responses	% of Responses
0%	22	43
1-25%	6	12
26-50%	3	6
51-75%	9	18
76-100%	11	21
Total	51	100%

Figure 1. Respondents' use of play therapy with clients

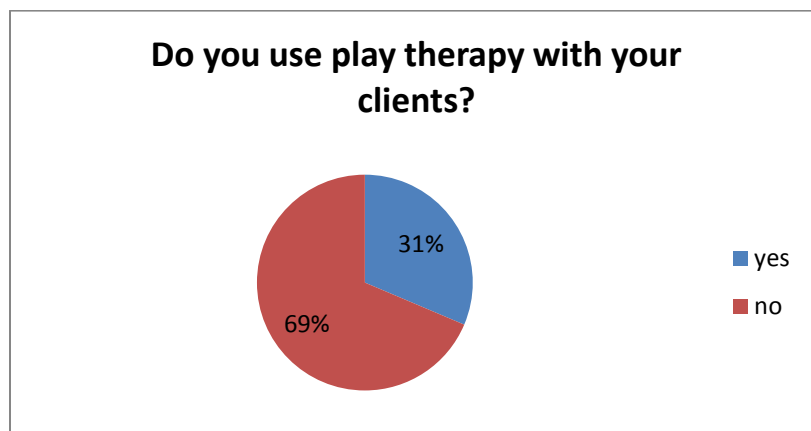


Figure 2. Respondents' referrals of clients to play therapy

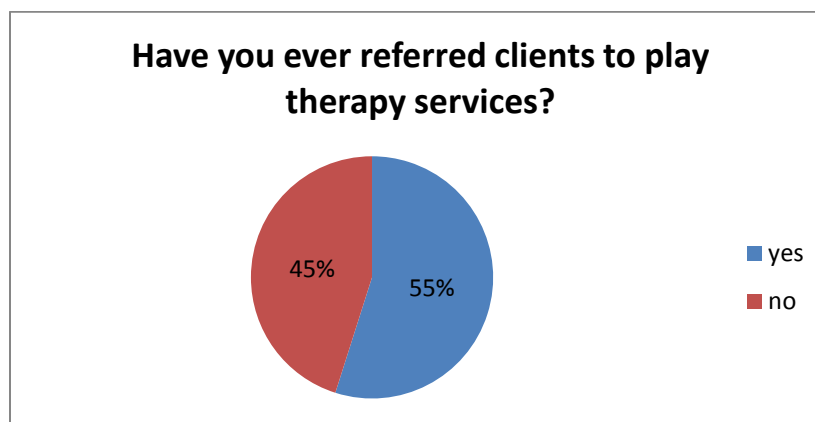
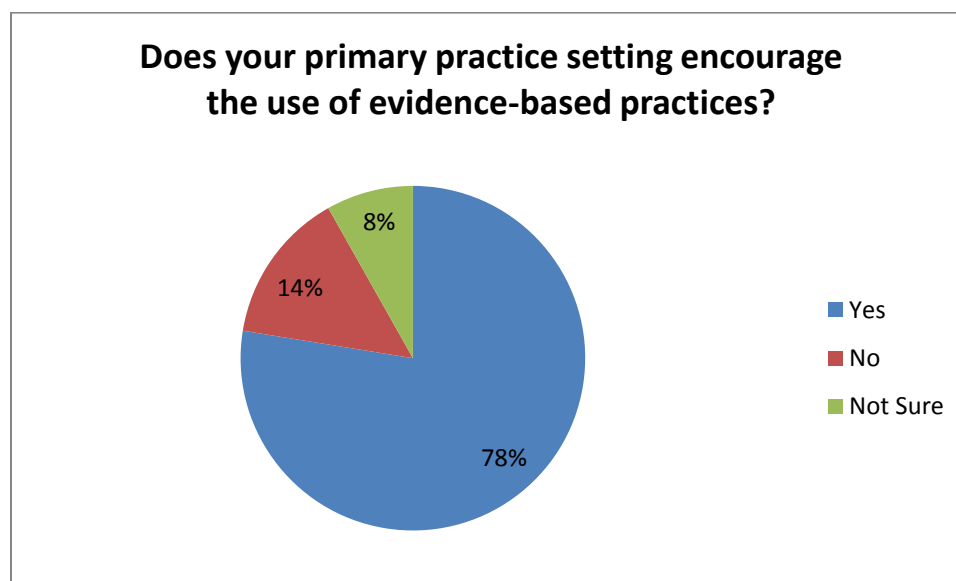


Table 8. Reasons respondents do not use play therapy

Respondents' reasons for not using play therapy		
Reasons for not using play therapy.	# of responses	% of responses
I do not work with children.	26	74%
I do not feel adequately trained in play therapy.	9	26%
Other	5	14%
I do not have enough time during the day.	1	3%
I do not feel that play therapy is an effective form of intervention.	0	0%

*Note: Responses for this question were based on n=35, as only those respondents who said they did not use play therapy were asked to answer this question. Responses for "other" included: my job doesn't require that; I work with teens/older adolescents, I'm a county worker; and while I use play to engage kids in therapy, I wouldn't call it play therapy.

Figure 3. Does primary practice setting encourage evidence-based practice?



This study also examined respondents' level of experience in providing play therapy services. While the majority of respondents had not practiced play therapy, 21% (n=9) had been practicing play therapy for 1-5 years; only 10% of respondents had been practicing play therapy for more than 10 years. Data also revealed that respondents had very little exposure to play therapy in their graduate coursework, continuing education courses and professional supervision. Only 28% (n=14) of participants had taken a graduate-level course in play therapy; additionally, only 34% (n=17) had any exposure to play therapy through continuing education and just 26% (n=13) had received some measure of professional supervision in play therapy.

Table 9. Years spent providing mental health and play therapy services

Years Spent Providing Mental Health Services		
# of Years	# of Responses	% of Responses
0 years	9	18
1-5 years	15	29
6-10 years	12	23
11-15 years	8	16
more than 15 years	7	14
Total	51	100%

Years Spent Providing Play Therapy		
# of Years	# of Responses	% of Responses
0 years	30	69
1-5 years	9	21
6-10 years	0	0
11-15 years	2	5
more than 15 years	2	5
Total	43	100%

Table 10. Hours of play therapy continuing education

Hours of Play Therapy Continuing Education		
# of Hours	# of Respondents	% of Respondents
0 hours	33	66
1-15 hours	9	18
16-30 hours	1	2
more than 30 hours	7	14
Total	50	100%

Table 11. Hours of play therapy supervision

Hours of Play Therapy Supervision		
# of Hours	# of Respondents	% of Respondents
0 hours	37	74
1-50 hours	9	18
51-100 hours	2	4
101-150 hours	0	0
150+ hours	2	4
Total	50	100%

Table 12. Graduate-level play therapy & child-development courses taken

Graduate-level Play Therapy Courses Taken		
# of Courses	# of Responses	% of Responses
0 courses	37	72
1-2 courses	10	20
3-4 courses	2	4
more than 4 courses	2	4
Total	51	100%

Graduate-level Child Development Courses Taken		
# of Courses	# of Responses	% of Responses
0 courses	25	49
1-2 courses	16	31
3-4 courses	7	14
more than 4 courses	3	6
Total	51	100%

Data also demonstrated the criteria seen as most important in choosing to use play therapy as an intervention with children. Results indicated that the age of the child was the most important factor in determining whether or not to use play therapy; the type of disorder, child's verbal ability and history of the problem were also seen as important factors to consider. Additionally, the relationship between the child and therapist was rated as the most important factor in determining the effectiveness of play therapy, with 60% (n=29) of respondents indicating that this was the top factor in determining success. This finding supports Phillips and Landreth's (1998) extensive survey on play therapy practice which also found that the relationship between the child and therapist was the most important factor in determining the success of play therapy. However, Phillips and Landreth (1998) also found that the involvement of parents/family in treatment was a crucial factor in determining the success of play therapy; this study did support that finding, however results were not as definitive.

Results of this study indicated that play therapy is seen as an effective intervention with a wide variety of disorders. Respondents indicated that play therapy would be most effective for clients struggling with 1) grief/loss 2) attachment/relationship difficulties and 3) physical/sexual abuse. These findings support previous research which indicates that play therapy is effective with a wide range of client's presenting problems (Bromfield, 2003; Glazer, 2010; Guerney, 2003; McCalla, 1994, Schaefer, 2010). Glazer (2010) highlighted the effectiveness of play therapy with grieving preschool children and Bromfield demonstrated play therapy's success in helping children to overcome trauma. Results of this study also support Phillips and Landreth's (1998) research in which practitioners listed physical/sexual abuse as one of the presenting problems most likely to benefit from play therapy; however Phillips and Landreth's (1998) study additionally indicated that depression/withdrawal, acting out/impulse control and academic difficulties would benefit greatly from play therapy.

Table 13. Top 3 most important selection criteria for play therapy with children

Item	# of respondents	% of total respondents
Most Important Criteria		
Age of child	25	52
Type of disorder	8	17
Verbal ability of child	7	15
Intensity of disorder	3	6
History of problem(s)	2	4
Other	2	4
Intelligence level of child	1	2
Sex of child	0	0
Total	48	100%
Second Most Important Criteria		
Age of child	9	19
Type of disorder	7	15
Verbal ability of child	11	23
Intensity of disorder	3	6
History of problem(s)	14	29
Other	1	2
Intelligence level of child	3	6
Sex of child	0	0
Total	48	100%
Third Most Important Criteria		
Age of child	7	15
Type of disorder	8	17
Verbal ability of child	5	10
Intensity of disorder	8	17
History of problem(s)	15	31
Other	1	2
Intelligence level of child	4	8
Sex of child	0	0
Total	48	100%

*Note: Responses to “Other” included: interest in play, developmental age and developmental ability.

Table 14. Top 3 factors influencing the effectiveness of play therapy

Item	# of respondents	% of total respondents
Most Important Factor		
Relationship between child/therapist	29	60
Involvement of parent/family in treatment	4	8
Experience of therapist	4	8
Child's willingness to play	4	8
Type of disorder	3	6
Therapist's willingness to play	2	4
Intact/supportive family	1	2
Frequency of therapy sessions	1	2
Child's awareness of problem	0	0
Intelligence level of the child	0	0
Child's verbal ability	0	0
Socioeconomic status of family	0	0
Other	0	0
Total	48	100%
Second Most Important Factor		
Relationship between child/therapist	8	17
Involvement of parent/family in treatment	10	21
Experience of therapist	10	21
Child's willingness to play	8	17
Type of disorder	4	8
Therapist's willingness to play	5	10
Intact/supportive family	1	2
Frequency of therapy sessions	1	2
Child's awareness of problem	0	0
Intelligence level of the child	1	2
Child's verbal ability	0	0
Socioeconomic status of family	0	0
Other	0	0
Total	48	100%
Third Most Important Factor		
Relationship between child/therapist	3	6
Involvement of parent/family in treatment	7	15
Experience of therapist	9	19
Child's willingness to play	7	15

Type of disorder	3	6
Therapist's willingness to play	5	10
Intact/supportive family	2	4
Frequency of therapy sessions	6	13
Child's awareness of problem	2	4
Intelligence level of the child	1	2
Child's verbal ability	2	4
Socioeconomic status of family	0	0
Other	1	2
Total	48	100%

*Note: Responses to "Other" included: If the child is safe - if trauma is ongoing, effectiveness can vary.

Table 15. Disorders most amenable to play therapy

Disorders most amenable to play therapy		
Client condition	# of responses	% of responses
Grief/loss	45	94%
Attachment/relationship difficulties	41	85%
Physical/sexual abuse	39	81%
Trauma	37	77%
Anxiety	33	69%
Depression/withdrawal	30	63%
Acting out/impulse control	28	58%
Medical procedures	23	48%
Oppositional defiant disorder	23	48%
Phobias	23	48%
School adjustment/academic difficulties	22	46%
Problems associated with autism spectrum disorders	17	35%
Cognitive delays	15	31%
Enuresis/encopresis	13	27%
Other	1	2%

*Note: Responses for "other" included: disruptive behavior disorder.

Perceptions of Effectiveness

A number of Likert scale measures were used in this study in order to gauge how effective respondents feel that play therapy is as an intervention with children. Results overwhelmingly illustrated that respondents believe play therapy is effective, as 90% (n=43) of respondents either agreed or strongly agreed with this statement. Additionally, 90% (n=43) of respondents indicated that play therapy is an important part of social work practice with children. However, while 63% (n=31) of respondents believed that education in basic play therapy interventions should be a part of all social workers undergraduate/graduate education, only 8% (n=4) of respondents felt that their education actually prepared them to effectively conduct play therapy. Finally, results strongly supported Landreth's (2002) assertion that play is children's natural form of communication; 98% (n=47) of participants agreed with this statement.

Figure 4. Preparation for practicing play therapy

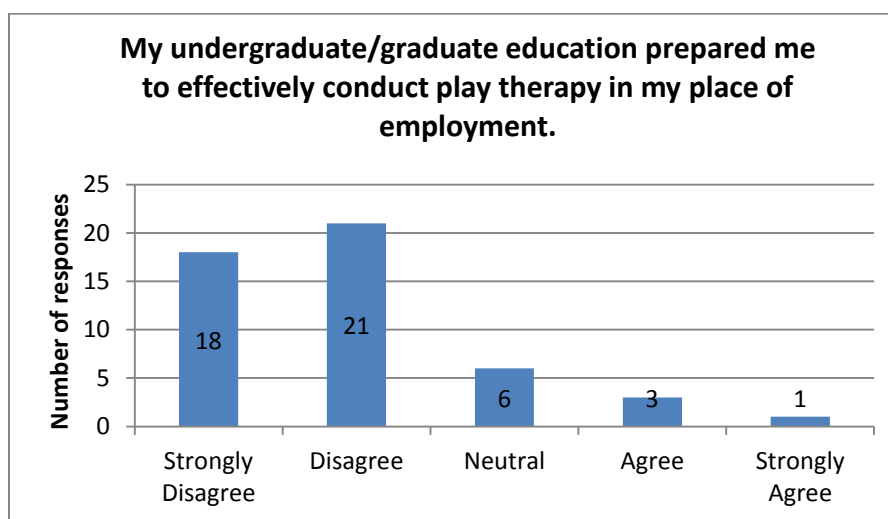


Figure 5. Play therapy education

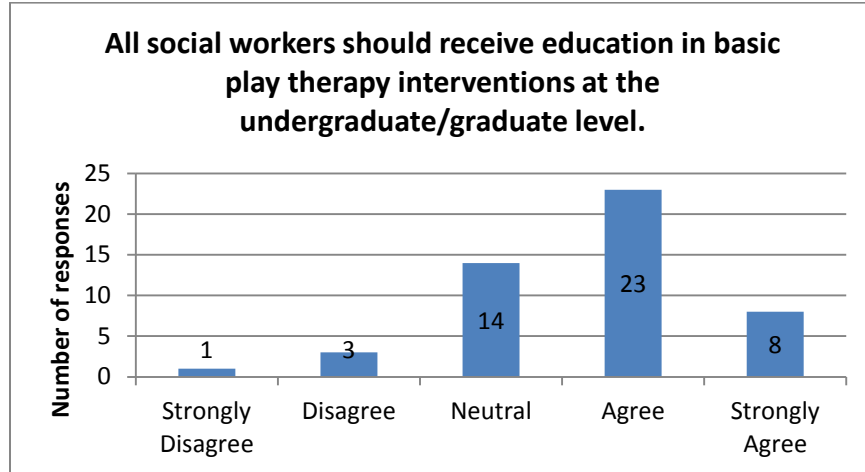


Figure 6. Importance of play therapy with children

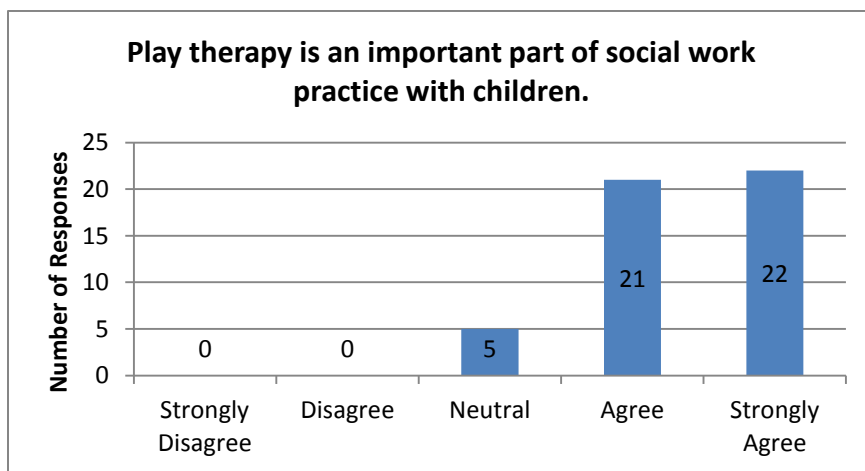


Figure 7. Play therapy as an effective intervention

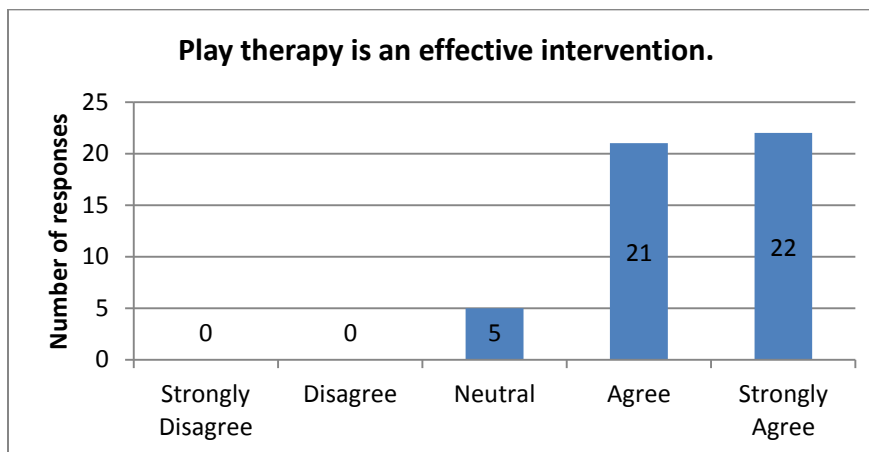


Figure 8. Play as a natural form of communication

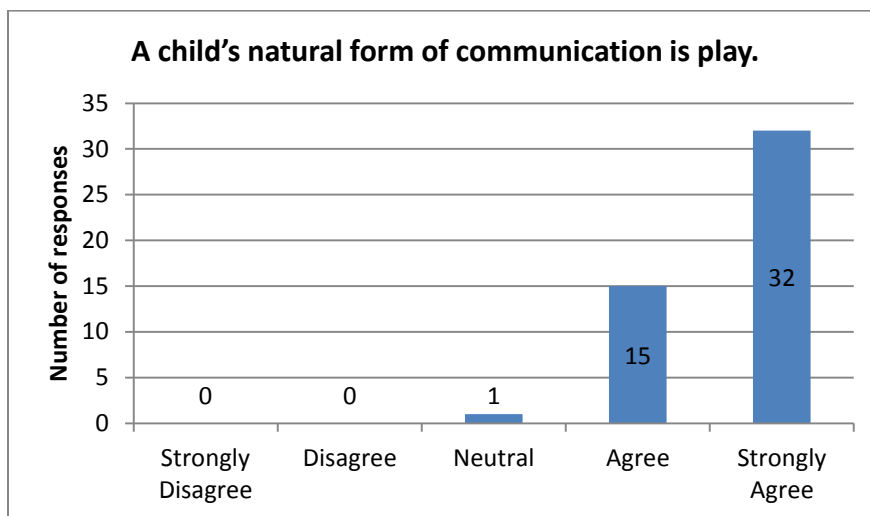
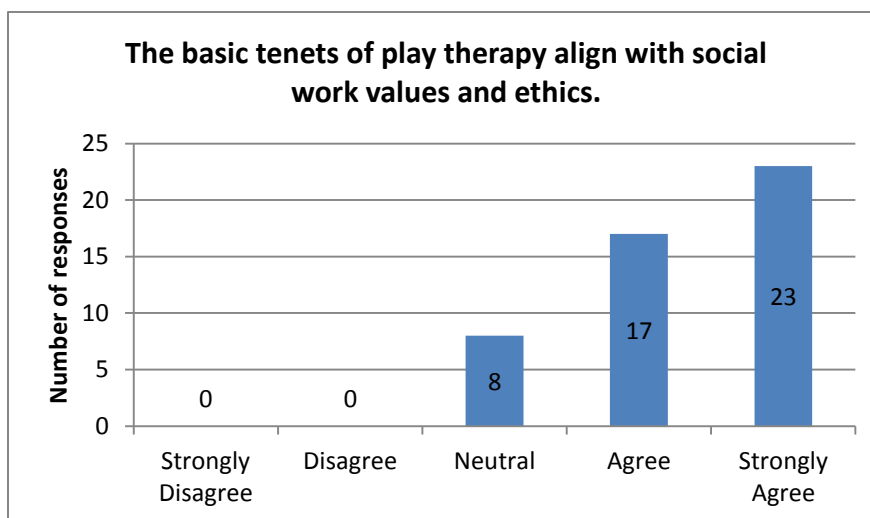


Figure 9. Play therapy and social work



Discussion

Implications for Social Work Policy

This study illustrates an opportunity for schools of social work to be more proactive in educating students on the tenets and benefits of play therapy. This study revealed that 69% of respondents were not practicing play therapy, and 26% of that group did not use play therapy because they did not feel adequately trained to do so.

Additionally, approximately 73% of respondents indicated that they had no graduate coursework in play therapy and 66% had received no continuing education in play therapy. While future studies would benefit from surveying a wider population of social workers to determine if the findings of this study are representative of the wider population, this study does suggest a large gap in social workers' exposure to play therapy training in the educational and professional realm.

Only 8% of respondents to this survey felt that their undergraduate/graduate education prepared them to effectively practice play therapy in their place of employment; and although the majority of respondents to this survey had not received any training in play therapy, 63% agreed that all social workers should receive education in basic play therapy interventions. These findings clearly suggest that the social workers surveyed would value more emphasis on play therapy in the academic setting. Social workers cannot be expected to participate in the field of play therapy or to educate their clients about the benefits of its use if they are not trained to do so. By determining how the tenets of play therapy fit into the wider social work curriculum, schools of social work can 1) increase the knowledge base of their students 2) increase the percentage of social workers who utilize play therapy with their clients and 3) encourage students to broaden research supporting play therapy's effectiveness.

Implications for Social Work Practice

This research indicates several implications for social work practice. First, this study indicates that while a majority of social workers (90%) feel that play therapy is an effective form of intervention, most social workers (69%) are not using it. Even when the 43% of respondents who do not work with children at all is accounted for, there is

still a large number of social workers who are not practicing play therapy. Additionally, just over half of respondents had referred clients to play therapy services in the past, indicating that while these social workers felt play therapy would be beneficial to their clients, they did not know enough about it to practice play therapy themselves. It appears that the key barrier to practicing play therapy for many professionals is a lack of knowledge; although professionals feel that play therapy is effective form of intervention, they simply are not trained to utilize it with their clients and therefore do not use play therapy in their practice. Social workers need more exposure to play therapy in the academic arena as well as in their continuing education offerings in order to fully participate in this field.

Second, this study reveals that social workers are overwhelmingly being called upon to use evidence-based practices; 78% of respondents indicated that their primary practice setting encouraged the use of empirically supported treatment methods. Whether for third-party billing purposes or in order to provide the best treatment available to their clients, more and more social workers are being held accountable for justifying the work they do with their clients. Research has increasingly established play therapy as an effective form of intervention with children and, therefore, a viable form of intervention for social workers who must demonstrate use of the best available interventions with their clients (Bratton and Ray, 2000; Bratton et al., 2005; Phillips & Landreth, 1998; Ray et al., 2001). Social workers can use the existing body of research on play therapy to support and enhance their practice with their clients and to prove the validity of their approach to employers, insurance companies, clients and parents who want the best and most cost-effective form of intervention for children.

Implications for Social Work Research

Although this study examined only a small population of social workers, findings of this research can serve as a starting point for additional research 1) to make social workers more visible in their delivery of play therapy services and 2) to educate social workers about the positive benefits of using play therapy with their clients. Previous research indicated that approximately 20% of professionals who practice play therapy are social workers, yet almost nothing is known about this population (Lambert et al., 2005). More research is needed to determine how social workers learn play therapy techniques, what benefits they feel it brings their clients and what needs to be done to better train future social workers to provide play therapy services.

Future studies would also benefit from exploring what makes social workers' provision of play therapy unique in comparison with their psychologist counterparts so that social workers can be more recognized for their contributions to the field. In a field dominated by psychologists, social workers have received only the slightest mention in existing research on play therapy; social workers must conduct and publish more studies about practicing play therapy through the lens of social work in order to be considered an integral part of the play therapy community (Phillips and Landreth, 1995; Phillips and Landreth, 1998; Lambert et al., 2005). This research could also 1) explore the benefits of using play therapy with client populations other than children 2) add to the body of knowledge of play therapy's effectiveness with various diagnoses and 3) help to further establish play therapy as a best practice in psychotherapy with children.

Strengths and Limitations

There were several strengths to the approach used in this study. First, the study was strengthened by directly surveying social workers about their opinions of play therapy; because data was gathered directly from the population in question, it is more likely to be an accurate representation of social workers feelings on play therapy. The professionals who participated in the survey were also licensed professionals currently practicing in the field and were, therefore, able to offer up to date information on their experiences in the field. Second, although the MSWPPT survey was created for this study, many of the questions included were based on those of previous researchers. The large sample sizes obtained by Ebrahim (2008) and Phillips and Landreth (1995 & 1998) lend validity to the use of their survey questions and strengthen the credibility of results gained through the MSWPPT survey.

Additionally, the use of a quantitative research design in this study allowed for the inclusion of a large sample population and ensured greater protection of participants through the collection of data in an anonymous manner. The online survey also utilized technology to speed up data collection process and allowed participants to more quickly complete the survey. Lastly, this study is valuable because it provided new information to the field of social work. Research on the role of social workers in the delivery of play therapy is nearly non-existent and the data generated from this study will hopefully act as a starting point for future research on this topic. While play therapy research has historically been dominated by psychologists, many social workers practice play therapy or refer their clients to play therapy services and this research took some initial steps in

measuring 1) how social workers feel about play therapy and 2) how many social workers use play therapy in their practice.

This study also had several limitations. First, because the study had a low response rate (16%) with only 51 participants responding to the survey, the results cannot be generalized to the entire social work community. This small population made it difficult to run an advanced statistical analysis of the data collected because there simply were not enough responses for the analysis to be considered statistically reliable. Second, participants in this study were a very homogeneous group, with 90% of respondents identifying as female and 94% identifying as Caucasian. While this may be representative of the population of social workers in the area where the survey was conducted, it is very unlikely that it is a true representation of the broader social work community. Third, a majority of participants (69%) did not practice play therapy with their clients; while it was the intent of this study to gather the opinions on play therapy of all social workers, a more comprehensive study of just those professionals who do use play therapy would have given a better picture of what this population of social workers looks like and why they incorporate play therapy into their practice.

Lastly, because there was no existing research on social workers and play therapy, a new survey tool was created for this study. The limited timeframe of the study did not allow for pre-testing the survey instrument and measures of validity and reliability are not available for this new data collection tool. Several additional improvements could be made to enhance future research in this area. First, data results could be more widely generalized if a larger and more diverse population was surveyed. Second, the inclusion of a larger group of social workers who are currently practicing social work would offer a

more complete picture of this population and would allow for comparisons between social workers who practice play therapy and those who do not. Lastly, the addition of open-ended questions or interviews would provide a more comprehensive body of data and, therefore, the opportunity for a richer understanding of the role social workers play in delivering play therapy services to children.

Conclusion

This study examined social workers' perceptions of the use of play therapy with children, a largely unexamined field of research. Findings showed that while 90% of respondents agreed that play therapy is an effective form of intervention, only 31% of respondents used play therapy with their clients. Additionally, results indicated that a majority of participants had little exposure to play therapy in graduate school or through continuing education, yet 63% of respondents agreed that all social workers should receive training in basic play therapy skills. Future research would benefit from examining accessibility of play therapy training, mentoring and hands-on practice for social workers in order to determine 1) how social workers learn to provide play therapy services 2) how to increase social workers' knowledge of play therapy interventions and 3) distinguish the unique role of social workers in this psychologically dominated field.

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Appendix A: Cover Letter to Prospective Participants

ST. CATHERINE UNIVERSITY/UNIVERSITY OF ST. THOMAS SCHOOL OF SOCIAL WORK Social Workers' Role in the Delivery of Play Therapy to Children Study

Dear Fellow Social Workers:

My name is Sara Weil and I am a graduate student in the social work program at St. Catherine University/University of St. Thomas in St. Paul, Minnesota. I am currently conducting research examining the role of social workers in the delivery of play therapy to children. Current research discussing the connection of social workers to the delivery of play therapy services is nearly nonexistent. My hope is that this study will provide new insights into the unique role of social workers in the provision of play therapy and lay a foundation for future research in this area.

Your participation in this study is completely voluntary and anonymous in nature. You were selected as a potential participant in this study because of your membership in the Minnesota chapter of the National Board of Social Work, from which participants were selected at random. The Minnesota Board of Social Work has no affiliation to this research. If you choose to participate in this study, your involvement will entail answering a 22 question survey regarding your knowledge of and beliefs about the effectiveness of play therapy and general demographic and professional information. The survey will be completed online and should take approximately 10 minutes of your time to complete.

Information obtained through this survey will be anonymous; results to your survey will be stored in Qualtrics Survey Software and kept completely anonymous. Information obtained will be reported in a group format and no identifying information will be reported. If you have any questions or concerns as a result of your participation in this study, I would be happy to speak with you by phone or email. If you are willing to participate in this survey, please fill out the online questionnaire as soon as possible. Should you wish to withdraw your participation in this study, you may do so at any time.

I greatly appreciate your time and consideration of participation this study. Please feel free to contact me at (omitted), or via my faculty advisor, Keith DeRaad at (omitted). This research project was approved by the St. Thomas University Institutional Review Board. If interested, you may request further information on the study and its results at a later date.

Thank you for your time and consideration of this study. Your participation is greatly appreciated.

Sincerely,

Sara Weil
Graduate Social Work Student-St. Catherine University/University of St. Thomas

Appendix B: Consent Form

ST. CATHERINE UNIVERSITY/ UNIVERSITY OF ST. THOMAS

Social Workers' Role in the Delivery of Play Therapy to Children

You are invited to participate in a research study investigating social workers' role in the delivery of play therapy to children. You were selected as a possible participant in this research because of your membership in either the Minnesota Board of Social Workers or the Minnesota Chapter of the Association for Play Therapy (APT). Please read this form and ask questions you may have before deciding to participate in this study.

This study is being conducted by Sara B. Weil, a graduate student in the School of Social Work, St. Catherine University/University of St. Thomas, and supervised by Dr. Keith DeRaad.

Background Information:

The purpose of this study is to gain a better understanding of the role that social workers play in the in delivery of play therapy interventions to children. This study aims to add to the body of research on play therapy by exploring social workers' knowledge and delivery of play therapy, a traditionally psychologically based intervention. Approximately 300 social workers will have the opportunity to participate in this research.

Procedures:

If you decide to participate in this study, you will be asked to log on to www.qualtrics.com to complete a survey. The survey consists of 22 questions including demographic information, information on your professional background and general questions regarding play therapy. The survey will take approximately 10 minutes to complete. The information provided will be compiled into a research report and presented at a research seminar on May 14, 2012 at the University of St. Thomas.

Risks and Benefits:

There are no anticipated risks to participating in this study. There are no direct benefits to participating in this study; however your participation will benefit play therapy research by adding to the existing body of knowledge.

Confidentiality:

Any information obtained in connection with this study will be kept strictly confidential. Once you log-in to participate in the survey, there will be no way for the researcher to identify you based on your survey responses or determine whether or not you have participated in the study. Research participants will not be identified in any reports or publications of this study and only group data will be collected. Research records will be kept on a password protected computer. Research finding will be presented at the above mentioned seminar and I will then destroy all original survey reports.

Voluntary nature of the study:

Your participation in this study is completely voluntary. You may skip any questions you do not wish to answer and may stop the survey at any time. If you decide to participate, you are free to withdraw at any time without penalty. Your decision whether or not to participate will not affect your future relations with St. Catherine University, the University of St. Thomas, the School of Social Work or any cooperating institutions in any way.

Contacts and questions:

If you have any questions, please feel free to contact me, Sara B. Weil, at (omitted). You may also contact my faculty advisor, Dr. Keith DeRaad at (omitted) or contact the University of St. Thomas Institutional Review Board at (651)-962-6017 with any questions or concerns.

Please keep a copy of this form for your records.

Statement of Consent:

Your decision to participate in this study is completely voluntary. Once you log-on to the online survey, any data provided will be used in this study. Your participation in the online survey will represent your consent to take part in this study. Your participation indicates that you have read all information provided regarding this study and that any questions you may have, have been answered.

Appendix C: Survey

Measure of Social Workers' Perceptions of Play Therapy (MSWPPT)

Q1 Gender.

- Male (1)
- Female (2)
- Transgender (3)

Q2 Age.

- 21-30 years (1)
- 31-40 years (2)
- 41-50 years (3)
- 51-60 years (4)
- 60+ years (5)

Q3 Ethnicity.

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

Q4 Highest Degree Earned.

- Bachelors Degree (1)
- Masters Degree (2)
- Doctorate Degree (3)

Q5 At the current time, approximately how many years have you been providing each of the following?

	0 years (1)	1-5 years (2)	6-10 years (3)	11-15 years (4)	More than 15 years (5)
Mental Health Services (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Play Therapy Services (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Q6 Professional Licensure.

- LSW (Licensed Social Worker) (1)
- LGSW (Licensed Graduate Social Worker) (2)
- LISW (Licensed Independent Social Worker) (3)
- LICSW (Licensed Independent Clinical Social Worker) (4)
- Other (5) _____

Q7 What is your primary area of social work expertise?

- Administration/Supervision (1)
- Children/Adolescents (2)
- Child Welfare (3)
- Criminal Justice (4)
- Families (5)
- Gerontology (6)
- Health Care (7)
- Mental Health (8)
- Play Therapy (9)
- Private Practice (10)
- School Social Work (11)
- Substance Abuse (12)
- Other (13) _____

Q8 What is your primary practice setting?

- Mental Health Center/Community Agency (1)
- Private Practice (2)
- State/Local Government (3)
- Hospital (4)
- School (5)
- Day Treatment Center (6)
- Residential Treatment Center (7)
- Other (8) _____

Q9 Does your primary practice setting encourage the use of evidence-based practices?

- Yes (1)
- No (2)
- Not Sure (3)

Q10 During what percentage of hours in a typical week do you participate in social work services with children?

- 0% (1)
- 1-25% (2)
- 26-50% (3)
- 51-75% (4)
- 76-100% (5)

Q11 Approximately how many:

	0 classes (1)	1-2 courses (2)	3-4 courses (3)	More than 4 courses (4)
Graduate-level play therapy course have you taken? (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Graduate-level child development courses have you taken? (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Q12 Approximately how many hours of play therapy continuing education have you received?

- 0 hours (1)
- 1-15 hours (2)
- 16-30 hours (3)
- more than 30 hours (4)

Q13 Approximately how many hours of professional play therapy supervision have you received?

- 0 hours (1)
- 1-50 hours (2)
- 51-100 hours (3)
- 101-150 hours (4)
- more than 150 hours (5)

Q14 Do you use play therapy with your clients?

- Yes (1)
- No (2)

Answer Below If Do you use play therapy with your clients? No Is Selected

Q14b I do not use play therapy with my clients because: (Please check all that apply.)

- I do not work with children. (1)
- I do not have enough time during the day. (2)
- I do not feel adequately trained in play therapy. (3)
- I do not feel that play therapy is an effective form of intervention. (4)
- Other (5) _____

Q15 Have you ever referred clients to play therapy services?

- Yes (1)
- No (2)

Q16 Please read the following statements regarding your beliefs about play therapy and indicate the extent to which you agree or disagree. Your selections should reflect your own personal opinions about play therapy. You will rate each item on a scale of 1 to 5, with 1 being “strongly disagree” and 5 being “strongly agree.”

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
My undergraduate/graduate education prepared me to effectively conduct play therapy in my place of employment. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
All social workers should receive education in basic play therapy interventions at the undergraduate/graduate level. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Play therapy is an important part of social work practice with children. (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Play therapy is an effective intervention. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A child’s natural form of communication is play. (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The basic tenets of play therapy align with social work values and ethics. (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Q17 What do you feel are the most important criteria in selecting the use of play therapy for a child? (Please rank your top three choices from 1 to 3, with 1 being the most important.)

- _____ Age of child (1)
- _____ Type of disorder (2)
- _____ History of problem(s) (3)
- _____ Intensity of disorder (4)
- _____ Verbal ability of child (5)
- _____ Intelligence level of child (6)
- _____ Sex of child (7)
- _____ Other (8)

Q18 What do you feel are the factors that most influence the effectiveness of play therapy? (Please rank your top three choices from numbers 1-3, with 1 being the most important.)

- _____ Relationship between child and therapist (1)
- _____ Involvement of parents/family in treatment (2)
- _____ Intact, supportive family (3)
- _____ Type of disorder (4)
- _____ Experience of therapist (5)
- _____ Child's willingness to play (6)
- _____ Therapist's willingness to play (7)
- _____ Frequency of therapy sessions (8)
- _____ Child's awareness of problem (9)
- _____ Intelligence of child (10)
- _____ Child's verbal ability (11)
- _____ Socioeconomic status of family (12)
- _____ Other (13)

Q19 What disorders do you feel are most amenable to play therapy? (Please select as many as apply.)

- Acting out/impulse control (1)
- Anxiety (2)
- Attachment/relationship difficulties (3)
- Cognitive delays (4)
- Depression/withdrawal (5)
- Enuresis/encopresis (6)
- Grief/loss (7)
- Medical procedures (8)
- Oppositional defiant disorder (9)
- Phobias (10)
- Physical/sexual abuse (11)
- Problems associated with autism spectrum disorders (12)

- School adjustment/academic difficulties (13)
- Trauma (14)
- Other (15) _____

Q20 Thank you for your participation in this survey.

Appendix D: Mailing List Request

Sara Weil
1000 Main Street
Sometown, MN xxxxx

December 14, 2011

Minnesota Board of Social Workers
2829 University Ave SE, Suite 340
Minneapolis, MN 55414-3239

To Whom It May Concern:

My name is Sara Weil and I am a graduate student in the School of Social Work at St. Catherine University/University of St. Thomas. I am currently participating in a graduate research seminar and am writing to request contact information for a random sampling of licensed social workers for use in my research study.

I would like to request contact information, in the form of email addresses, for a random sample of 300 active licensed social workers. If email addresses are unavailable, I would appreciate the contact information to be sent to me in the form of mailing addresses.

If you have any questions, please feel free to call me at (omitted) or email me at (omitted). You may also contact my faculty advisor, Dr. Keith DeRaad at (omitted). Thank you for your assistance.

Sincerely,

Sara Weil