THE EFFECTS OF CHILD-CENTERED PLAY THERAPY TRAINING
ON TRAINEES

DISSERTATION

Presented to the Graduate Council of the
University of North Texas in Partial
Fulfillment of the Requirements

For the Degree of

DOCTOR OF PHILOSOPHY

BY

Shu-Chen Kao, B.A., M.Ed.
Denton, Texas
December, 1996
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This study was designed to determine the effects of child-centered play therapy as a play therapy training model for beginning play therapy students. The purpose of this study was to determine the effects of child-centered play therapy training on play therapy trainees in (a) improving positive attitudes and beliefs toward children; (b) improving knowledge of child-centered play therapy; (c) improving confidence in applying child-centered play therapy skills; (d) reducing dominance tendencies in trainees' personality as measured by the California Psychological Inventory; and (e) increasing tolerance levels in trainees' personality as measured by the CPI.

The experimental group, consisting of 37 counseling graduate students with a specialty in child counseling, received 45 clock hours of introduction to play therapy graduate course training at the University of North Texas, Denton. The control group, consisting of 29 counseling graduate students with a specialty in child counseling, received other counseling graduate courses training but no play therapy training at the time of their participation in
this study at the University of North Texas. Both experimental and control group students completed the pretest and the posttest on the Play Therapy Attitude Knowledge Skills Survey and the California Psychological Inventory at the beginning and the end of the semester terms of Fall 1995, Spring 1996, and Summer 1996.

Analyses of covariance revealed that students in the experimental group demonstrated (a) a significant improvement in their positive attitudes and beliefs toward children; (b) a significant improvement in their child-centered play therapy knowledge; (c) a significant improvement in their confidence in applying child-centered play therapy skills; and (d) a significant reduction in their dominance tendency. An insignificant result was found in their tolerance level.

This study suggests that child-centered play therapy training is a viable training model for prospective and beginning play therapists.
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CHAPTER ONE

INTRODUCTION

Historically, children have been powerless, and their needs have often been given less attention than the needs of more vocal groups (Johnson, 1994). All children experience certain stresses and strains over the course of normal growth and development that result in specific needs. Furthermore, today’s children are more likely to be exposed to poverty and family disruption than were the offspring of the previous generation of parents (Wagner, 1994). Although mental health programs for children have been expanded during the past 20 years, the need for clinical services continues to exceed available resources even though professionals are increasingly aware of the importance of responding to the emotional problems of children (Cohen, 1995; Lovacs & Lohr, 1995; Stern & Newland, 1994; Wagner, 1994). According to recent studies, large numbers of children and adolescents with emotional or behavioral disorders receive either no mental health treatment or treatment inappropriate to their needs (Collins & Collins, 1994). It is estimated that approximately 15 percent to 19 percent of U.S. children and youth possibly are in need of mental health treatment (Tuma, 1989, cited in Wagner, 1994).
Since the treatment of choice in many of these cases is play therapy, counselor training programs are increasingly providing play therapy training (Center for Play Therapy, 1995; Kranz, Lund, & Kottman, 1996).

Although play therapy was first utilized as a therapeutic procedure in the early 1900s, it is currently one of the fastest growing professions in the mental health field. Over the past 13 years, the Association for Play Therapy has grown in membership from the initial two dozen to more than 3700. Recognition of the therapeutic healing potential in play therapy has also reached dynamic proportions in recent years (Berner, Duke, Guillory, & Oe, 1994). An important body of scientific literature already is available to document the efficacy of play therapy for children (Kottman, 1993; Landreth, 1991; Landreth, Homeyer, Bratton, & Kale, 1995; Landreth, Homeyer, Glover, & Sweeney, 1996; Phillips, 1985; Schaefer & O'Connor, 1983).

Within the possible approaches to play therapy, child-centered play therapy is the most clearly articulated practice presented in the literature (Kottman, 1987; Gurney, 1983; Landreth & Sweeney, In press) and has been in the mainstream of the development of play therapy. A national survey found that 25 percent of practicing play therapists use a child-centered approach in their practice of play therapy (Phillips & Landreth, 1995). Outcome research in child-centered play therapy has consistently demonstrated

One concern of professionals in the field of play therapy is that treatment should be provided by expert clinicians who are trained in established play therapy procedures to ensure that children receive high-quality help from competent play therapists (Brady & Friedrich, 1982; Cohen, 1995; Landreth, 1991). A recent large and comprehensive survey of the play therapy field found that most play therapists had not received explicit graduate-level training in play therapy, and this was more evident among those newer to the field (Phillips & Landreth, 1995).

A noticeable shortage in the play therapy literature is the lack of discussion related to play therapist training issues: the development of student play therapists, their perceptions of self, their roles in the therapeutic process, and their inner struggle to learn what play therapy really is (Kranz, 1978). Since counseling children requires special knowledge and skills (Brady & Friedrich, 1982; Guerney, 1983; Kaczmarek & Wagner, 1994; Kranz & Lund, 1994; Landreth, 1991), the training of professional play therapists is an important issue in the establishment of the credibility of play therapy among counseling professionals (Kranz, Lund, & Kottman, 1996).

Play therapy educators often declare that the supervised practice of play therapy facilitates the self-
insight of play therapist trainees and suggest that supervised experiences in play therapy cannot be overemphasized (Guerney, 1978; Kranz, 1978; Kranz & Lund, 1994; Landreth, 1991). However, little research has been developed to identify the specific aspects of play therapy training that may facilitate the supervisory process in guiding the professional development of play therapists (Arnold, 1976; Kranz, 1978; Kottman, 1987; Kranz & Lund, 1994).

It is generally accepted that play therapy training assists counselors in becoming more effective service providers in their work with children. Fundamentally, play therapy training has the potential to foster both the professional and personal development of play therapy trainees in many unique and powerful ways. One common misconception about play therapy training is that the trainee brings to the process therapeutic skills developed through life experience (Kranz, 1978). In fact, learning to be a play therapist requires sincere self-examination, self-understanding, and self-acceptance since the expectation is that prospective play therapists will learn to incorporate their evolving philosophical beliefs about children into their working belief system. These evolving beliefs and attitudes become a way of interacting wherever children are encountered (Landreth & Sweeney, 1995); thus, individuals entering training in play therapy often experience personal
struggles before they learn how to function as play therapists. Therefore, individuals in training need appropriate supervision as well as training in play therapy to ensure both personal and professional growth (Kranz, 1978; Kranz & Lund, 1994; Landreth, 1991; Moustakas, 1959).

Important components in the training of play therapists may include an openness to the approach, high-quality training and supervision, possession of certain personal qualities, the ability to self-explore, and receptivity toward acquiring self-awareness (Guerney, 1983). To promote and standardize training in play therapy, the Association for Play Therapy, an international organization, has established criteria for becoming a registered play therapist and a registered play therapist-supervisor (APT Newsletter, 1992). A review of the literature reveals that some play therapy training models have been presented by play therapy educators, such as Brady and Friedrich (1982), Guerney (1978), and Landreth (1991). However, the effects of these training models on trainees has not been researched.

The Council on Postsecondary Accreditation has stated that the Council for Accreditation of Counseling and Related Educational Programs should increase the attention given to measures of student outcomes from preparation programs (Haight, 1992). Previous studies which have focused on the training of specific play therapy skills have suggested further study of the dimensions of personality, attitudes,
and play skill behaviors of those receiving play therapy training (Arnold, 1976; Olley, 1985) as well as a number of other factors involved in training play therapists (Kottman, 1987). However, the effects of play therapy training in general and specifically the effects of child-centered play therapy training on play therapy trainees has not been investigated.

**Purpose of the Study**

This study was designed to determine the effects of child-centered play therapy as a play therapy training model for beginning play therapy students. The purpose of this study was to determine the effects of child-centered play therapy training on play therapy trainees in (a) improving positive attitudes and beliefs toward children; (b) improving child-centered play therapy knowledge; (c) improving confidence in applying child-centered play therapy skills; (d) reducing dominance tendencies in trainees; and (e) increasing tolerance levels in trainees.

**Limitations**

Subjects for this study were limited to those volunteer graduate students who focused on child counseling and who were enrolled in the Counseling, Development, and Higher Education Department at the University of North Texas, Denton during the semester terms of Fall 1995, Spring 1996, and Summer 1996. Subjects in the experimental group were limited to volunteers from the Introduction to Play Therapy
course within one academic year. Subjects in the experimental and control groups were not balanced for age, sex, or race.

Synthesis of Related Literature

The following review is a synthesis of theoretical constructs and research related to four major areas: (a) counselor training; (b) outcome of counselor training; (c) child-centered play therapy; and (d) the training of play therapists.

Counselor Training

Prior to 1955, the issue of counselor training was not yet clearly formulated. Counselor training was in an "exploratory phase" because of the essentially undeveloped level of explication. In the 1960s, the education of counselors in general and their supervision in particular became important issues. The Association of Counselor Education and Supervision, formed in the early 1960s, began to focus considerable attention on the presentation of papers relative to counselor education and supervision. Two issues were dominant in many of the papers. The first of these was concern with outcomes— the end result of an intervention; the second was with process— the variables that produce change or improvement (Seligman & Baldwin, 1972).

One aspect of counselor education that has received extended attention is the matter of professional training
standards. In 1981, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) was established. The development of CACREP was significant for the counseling profession because it has helped establish counseling as a credible profession. The CACREP accreditation process represents one level of control over access to the profession. Today, CACREP's national standards are a benchmark for credentialing criteria and, thus, influence counselor training. To ensure that prospective counselors become effective professionals, CACREP has begun to develop new specialized study areas in its accreditation program. For example, marriage and family counseling and therapy standards have already been adopted. This development of specific standards for various specialties will help prospective consumers to identify those persons who are properly prepared to offer the specific counseling service (Haight, 1992; Sweeney, 1992).

**Outcome of Counselor Training**

Outcome research in counselor education indicates that counselor trainees tend to improve their knowledge, skills, and attitudes, and to change certain aspects of their personalities after training. Teaching methods have also been found to affect training outcomes. As an outcome of counselor training, effective counselors tend to share some personality characteristics.
Attitude, Knowledge, And Skill

A variety of counselor education studies have found that counselors tend to improve their knowledge, skills and attitudes after training. Kottman (1987) studied the effects of training counselors to incorporate the concepts and techniques of Individual Psychology into play therapy. Nine doctoral students enrolled in either a doctoral practicum or doctoral internship were subjects for this ethnographic study of an Adlerian play therapy training program. Transcripts of the training program and of three individual interviews with the nine subjects were made. These transcripts and the journals in which the subjects were asked to chronicle their personal experiences and reactions to the training were qualitatively analyzed. Most of the subjects in the study reported that their attitudes toward play therapy, toward themselves as play therapists, and toward their play therapy clients had changed after their participation in the Adlerian play therapy training. The majority of subjects also reported that they perceived that their behavior in their play therapy sessions had changed, frequently in the direction of including more creative and active techniques. However, qualitative analysis of the actual taped play sessions did not support the subjects' perception that their behaviors had been affected by their participation in the training.

Kees (1988) reported that grief counseling training
helps subjects to feel significantly more prepared and comfortable with grief counseling situations. D'andrea, Daniels, and Heck (1991) found, that after participants completed a full semester of multicultural counseling graduate courses, participants significantly increased their awareness, knowledge, and skill in multicultural counseling. Rudolph (1989) investigated the impact of workshop training in counseling homosexual clients and found that it resulted in significant and enduring positive attitude modification. Isaacs (1981) found that family therapy trainees increased their rates of instructing, praising, and informing parents after completing a training program.

Herrick (1987) studied the effects of internship experience and participant modeling on the skill development and psychological adjustment of rehabilitation education interns. After completing an internship, counselor interns rated themselves lower in anxiety, higher in perceived self-efficacy, and higher in general and specific skills.

Ofsthun (1987) studied the effectiveness of a teaching model in enhancing the moral sensitivity and practical moral reasoning of counseling psychology students. The results of his study lend support to the endeavors of the counseling profession to teach students to explore their own value systems and to build a rationale for making ethical decisions as a means of enabling them to function in a professionally ethical and responsible manner.
Mackrell (1983) investigated the differential effects of didactic and experiential styles of supervision on the improvement of trainees' empathic understanding and found that (a) empathic understanding can improve after receiving supervision; and (b) didactic supervision is more effective than experiential supervision for trainees with low level empathic skill development.

**Personality**

Various personality dimensions have also been found to be impacted by counseling training. Fitch (1990) studied the relationship between the strength of authoritarian attitudes and the level of professional education of counselors and counselors in training. He found that beginning counseling students scored higher in a more authoritarian direction than did the advanced students. Secondly, results also suggested that individuals with low authoritarian/low dogmatic attitudes are attracted to and enter counselor education programs, whereas other individuals may not enroll.

Olley (1984) explored 20 personality variables, 7 parenting attitude variables, and 21 adult–child play behaviors of undergraduate students in filial therapy, play therapy and parent education training. Correlational analysis of pretest data showed significant correlations between personality and adult's play behaviors, i.e., "affiliation" and "play" correlated positively with "takes
lead without giving option." T-test analysis indicated that "willingness to follow child's lead," "endurance," and "coping" increased significantly. Correlational analysis between changes in attitudes and in play skills found that as students increased in their "willingness to follow the child's lead" they increased their belief that they were more able to cope with the child's demands. No control group was used in this study.

Leeson (1985) assessed the effects of different intervention procedures for developing cross-cultural sensitivity for counselor education students and found that an affective training component could increase tolerance even in advanced counselor education students in a relatively short time.

Tucker (1989) evaluated the clinical training program of a counseling center and found that trainees showed a significant increase in self-awareness as a result of their training. Borders and Fong (1989) studied ego development during training and found that, as a result of counseling skills training, students expanded perceptions of the self and others, an outcome that is similar to the goals of deliberate psychological education.

Miller (1990) found that counselors who exhibited high needs for order received significantly lower counselor performance ratings than counselors who exhibited low needs for order.
Ohlsen (1970) summarized research findings related to the differences between most and least effective counselors: effective counselors were higher on nurturance, deference, and affiliation and lower on autonomy, abasement, and aggression than ineffective counselors; effective counselors were more apt to exhibit high scores for the social-service block occupations than were ineffective counselors.

Teaching Models

Various teaching models have been found to make a difference in the outcome of counselor training. Arnold (1976) investigated the effectiveness of a microcounseling paradigm in training the three basic play therapy skills, i.e. limit setting, reflection of behavior statements, and reflection of feeling statements. Fourteen subjects were master's level counseling students enrolled in a beginning play-media counseling course and were randomly assigned to either the experimental microcounseling training group or the traditional training group. The subjects all participated in a treatment period lasting two hours. This time involved four five-minute experiences with a child and three thirty-minute training periods, each interfaced with the other. The microcounseling subjects were taught limit setting, how to make reflection of behavior and feeling statements to a child. During the training periods, the traditionally trained subjects, with their supervisor, spent the time listening to their tape of the session, discussing
their performance or discussing the child. They received no specific training in the skills taught to the microcounseling subjects. Results showed that microcounseling trained subjects exhibit a higher frequency of reflection of behavior statements and reflection of feeling statements immediately after training than the traditionally trained subjects. However, no significant difference existed at the two week and six week follow-up study.

Young (1993) compared microskills training to mental practice training to determine which is the better method for training counselors to work with addicted populations and concluded that microskills training may be more effective.

Klein (1983) compared an experiential versus a didactic approach to training counselors in interpersonal conflict management. Results indicated that the experiential approach was the more effective method of teaching conflict-management skills. The didactic approach, however, was shown to be better than no training at all. In contrast, Mackrell (1983) found that didactic supervision was more effective than experiential supervision for trainees with low-level empathic skill development.

Leeson (1986) assessed the effects of different intervention procedures -- the affective approach, the cognitive approach, and the affective-cognitive approach --
for developing cross-cultural sensitivity in counselor education students. Results showed that a curricular strategy based on only one component is likely to produce changes only in that domain. The fact that the affective-cognitive component produced significant changes in both areas showed that the combined approach was a superior curricular strategy for counselor education students.

**Personal Characteristics of Effective Counselors**

The major goal of counselor education is to train effective counselors for the mental health field. While effective counseling requires certain behaviors or core conditions, the personal traits of the counselor are also extremely important variables. Counselor training programs often expect prospective counselors to acquire certain personality characteristics. The personality variables accepting, warm, open, empathic, genuine, flexible, and sincere are most often used to describe effective counselors (George & Cristiani, 1986; Shilling, 1984).

The Association for Counselor Education and Supervision (1964, cited in George & Cristiani, 1986) stated that the counselor should possess six basic qualities: belief in each individual, commitment to individual human values, alertness to the world, open-mindedness, understanding of self, and professional commitment. Furthermore, according to Corey (1991), therapeutic counselors are willing and able to tolerate ambiguity. They make mistakes and are willing to
admit them, and they are able to reinvent themselves.

Personality characteristics associated with self-actualization have been found to be related to communication of respect or positive regard and also to facilitative genuineness (Foulds, 1969, cited in Pietrofesa, Leonard, & Hoose, 1973). Some observable behavioral characteristics of self-actualizing counselors are: (a) emphasizes experiential knowledge rather than systems of concepts or abstract categories; (b) utilizes different measures which are most helpful in achieving self-actualization in that client; (c) express him/herself freely, without feeling guilty or anxious about each statement; (d) has satisfied personality needs and is engaged in the satisfaction of his/her need for "self-actualization"; (e) being as well as becoming; (f) concern with professionalization; (f) concentrate on the stimuli in the environment; (g) willing to accept knowledge about the environment, other people, and him/herself; and (h) commitment to the profession (Pietrofesa, Leonard, Hoose, 1970).

Child-Centered Play Therapy

Virginia Axline translated the philosophy and principles of Carl Rogers' nondirective counseling approach to work with children and published the first nondirective play therapy text, Play Therapy: The Inner Dynamics of Childhood, in 1947. Rogers' approach is now referred to as person-centered therapy and, for working with children, it
is called **child-centered play therapy** (Landreth, 1993).

**Personality Development and Behavior**

Child-centered play therapy "is based upon the assumption that the individual has within himself, not only the ability to solve his own problems satisfactorily, but also this growth impulse that makes mature behavior more satisfying than immature behavior" (Axline, 1947, p.15). Individual development is viewed as a flowing, fluid, maturing process of becoming (Landreth & Sweeney, In press). Perry (1993) has summarized the person-centered therapy propositions for child-centered play therapy as:

- Each child lives in a continually changing world of experience of which she is the center. ... The child reacts to the experiential field as the field is perceived; this perceptual field is "reality" to the child. ... The child responds as an organized whole to the experiential field. ... The child has one basic need--to actualize, maintain, and enhance herself. ... Behavior is the goal-directed attempt of the child to satisfy her needs as experienced in the field she perceives. ... Emotions accompany and usually facilitate the child's goal-directed behavior. ... Behavior is best understood from the internal frame of reference of the child herself. ... Gradually a part of the perceptual field becomes the self. (pp. 7-9)
Maladjustment and Adjustment

In the child-centered approach, diagnosis of maladjustment is not a prerequisite for starting a therapeutic relationship with the child. From the child-centered approach perspective, "all maladjustments are viewed as resulting from an incongruence between what the child actually experienced and the child's concept of self" (Landreth & Sweeny, In press). Axline (1947) described maladjusted children as those who lack sufficient self-confidence and in whom "the seeking-effort to satisfy the needs is blocked, [so that] devious paths are taken to bring about satisfaction" (p.12). Maladjusted children may appear to be aggressive, disturbing, noisy, withdrawn, nervous, or handicapped. Their problems can be behavior problems, study problems, speech problems, or reading problems (Axline, 1947). Regardless of different presenting problems, in the child-centered approach, the child and not the problem is the point of focus. "When we focus on the problem, we lose sight of the person of the child" (Landreth & Sweeney, in press).

On the other hand, adjusted children are those who can "consciously and purposefully direct their behavior by evaluation, selectivity, and application to achieve their ultimate goal in life--complete self-realization" (Axline, 1947, p.13). When the child's concept of self is roughly congruent with his/her own experiences, psychological
adjustment appears. Furthermore, when the child perceives and accepts all his/her experiences, the child will become more understanding of others and accept others as separate individuals (Perry, 1993).

**Symbolic Play**

With consideration for the language and cognitive developmental factors of childhood, the child-centered play therapist uses play therapy because play is the child’s symbolic language of self-expression. The symbolic function of children’s play is basic to the child-centered approach. "Play gives concrete form and expression to children’s inner world" (Landreth, 1991, p.9) and "provides children with opportunities for learning to cope by engaging in self-directed exploration" (p.10). To different children, objects have different meanings and may symbolize many things to children. The play therapist accepts the child’s symbolism exactly as it is and does not in any way try to enforce society’s labels on children’s play (Moustakas, 1953). In this natural and dynamic play process, children are given opportunities to play out their experiences and feelings; thus, children are engaged in a self-healing process (Gabel, Oster, & Pfeffer, 1988; Landreth, 1991).

**The Child-Centered Therapeutic Relationship**

Child-centered play therapy is a way of being with children. It is a basic philosophy rather than simply a set of techniques to be applied in the playroom (Landreth &
Sweeney, In press). Based on the belief that there is a powerful force within each child that strives continuously for complete self-realization, the child-centered play therapist allows the child to move at a pace of growth determined by the child and offers the child the opportunity to experience growth under the most favorable conditions, that of complete acceptance and permission to be him/herself (Axline, 1947; Gurney, 1983; Landreth, 1991). The therapeutic process does not occur automatically. It becomes possible only in a relationship where the adult responds in constant sensitivity to the child's feelings, accepts his/her attitudes, and maintains a sincere belief in him/her (Moustakas, 1959).

The eight basic principles that Axline (1947) outlined for child-centered play therapists serve as a guide for therapeutic contact with the child. The therapist

(1) must develop a warm, friendly relationship with the child. . . . (2) accepts the child exactly as he is. . . . (3) establishes a feeling of permissiveness in the relationship. . . . (4) is alert to recognize the feelings the child is expressing and reflects those feelings back to the child. . . . (5) maintains a deep respect for the child's ability to solve his or her own problems if given an opportunity to do so. . . . (6) does not attempt to direct the child's actions or conversation in any manner. . . . (7) does not attempt
to hurry the therapy along. ... [and] (8) establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship. (pp. 73-74)

The Child-Centered Play Therapist

Relationship building skills. From the child-centered play therapy perspective, a therapeutic relationship is essential for the child's emotional growth (Axline, 1947; Landreth, 1991; Moustakas, 1959). The relationship between the child and the therapist "is the deciding factor in the success or failure of the therapy" (Axline, 1947, p.74). This kind of relationship provides children with safety, acceptance, and consistency, which are necessary for children to feel the freedom and security to express self and discover their own strengths. In such a therapeutic relationship, children are regarded as individuals with resources for their own self-development rather than as helpless victims (Axline, 1947; Landreth, 1991; Moustakas, 1959). In child-centered play therapy, the relationship is always focused on the following areas:

Person rather than problem; present rather than past; feelings rather than thoughts or acts; understanding rather than explaining; accepting rather than correcting; child's direction rather than therapist's instruction; child's wisdom rather than therapist's
knowledge. (Landreth, 1991, p.79)

The objectives of the child-centered play therapy relationship are clarified by Landreth (1991) as follows:

1. To establish an atmosphere of safety for the child.
2. To understand and accept the child's world.
3. To encourage the expression of the child's emotional world.
4. To establish a feeling of permissiveness.
5. To facilitate decision making by the child.
6. To provide the child with an opportunity to assume responsibility and to develop a feeling of control. (pp. 154-155)

For child-centered play therapy, important relationship building skills include basic attitude, structuring skill, and empathic responses.

1. Basic attitude: Rigid techniques are not helpful in building relationships. The important element is the therapist's underlying attitude both toward children and toward therapy. The presence of an accepting, understanding, friendly play therapist will give the child a sense of security (Axline, 1947). According to Moustakas (1953), play therapy may be thought of as a set of attitudes in which children feel free enough to express themselves in their own way. Eventually, children achieve feelings of security, adequacy, and worthiness through emotional insight. "The belief is that these attitudes are communicable. ... The three basic attitudes in child-centered play therapy are
faith, acceptance, and respect" (p.2).

Faith is known largely through feelings, not through intellectualizations. The therapist should convey a consistent and sincere belief in the child. Children will become aware of the feelings the therapist has toward them. As a result, children who have faith in themselves believe in themselves. Acceptance implies that the therapist actively accepts the child's feelings, personal meanings, and perceptions. The therapist accepts the child exactly as he/she is. The therapist conveys respect in the way children are greeted, in the way he/she empathetically follows children in their play, and in the way children are shown understanding of their feelings (Moustakas, 1953).

A sincere attitude on the part of the play therapist also includes alertness, sensitivity, and an ever-present appreciation of what the child is doing and saying. The play therapist is intentional about creating a permissive and accepting atmosphere for the child. The play therapist's attitude toward children should be kind, patient, understanding, steady, respectful, accepting, and caring. These attitudes must be an integral part of the play therapist's personality (Axline, 1947; Landreth, 1991).

2. Structuring skill: Although child-centered play therapy is generally considered unstructured, structuring is an important process during the early phases of therapy to ensure that the child gains an understanding of the nature
of this relationship. It involves introducing the child to the playroom and creating a warm, permissive relationship (Moustakas, 1953, 1959). According to Axline (1947), the word *structuring* means "the building-up of the relationship according to the foregoing principles so that the child understands the nature of the therapy contacts and is thus able to use them fully" (p. 74). Structuring statements are defined as "the providing of information or the arranging of the environment to facilitate situation-appropriate responses from the child" (Guerney, 1983, p. 37), such as how long the session will last, how often the sessions will take place, what the child can do, and what the therapist will do (Guerney, 1983). The play therapist conveys attitudes of faith, acceptance, and respect to the child through the structured relationship and "the child is able to achieve a clear understanding of his freedom and to state himself in his own terms" (Moustakas, 1953, p.14).

3. Empathic responses: In child-centered play therapy, empathic responses are key elements in demonstrating the play therapist's understanding of the child. The highest level empathic response "addresses the feelings that underlie or accompany a thought or action" (Guerney, 1983, p. 36). The therapist maintains a listening attitude. Listening requires careful attention and consideration not merely to content but, more significantly, to the feelings. Listening is an active process. This empathetic sharing of
an experience shows the child that his/her feelings are understood and accepted (Moustakas, 1953).

A sensitive understanding of a child's world seems to have a magnetic impact on the child. Sensitive understanding "means the play therapist is in full emotional contact with the perceptual experiential world of reality of the child" (Landreth, 1991, p. 71). As children feel understood, they feel safe enough to go deeper into the relationship and to initiate a cycle of change in their perceptions.

Stover, Guerney, and O'Connell (1971) described play therapists' empathic responses in three major areas: communication of acceptance, allowing self-direction, and involvement. A high level of communication of acceptance shows verbal recognition and acceptance of feelings as well as behaviors. A high level of allowing the child self-direction is demonstrated by willingness to follow the child's lead. A high level of involvement means being fully observant of the child's behavior and exhibiting a high level of attention.

Limit setting. The limitations, few as they are, add to this feeling of security and reality (Axline, 1947). Effective child-centered play therapists must know how to set limits and how to deal with broken limits in the therapeutic relationship because limits define the boundaries of the relationship and anchor play therapy sessions to reality (Axline, 1947; Dorfman, 1951; Guerney,
1983; Landreth, 1991; Moustakes, 1959). Landreth and Sweeney (In press) summarize the purposes for setting limits as follows:

1) Limits define the boundaries of the therapeutic relationship; (2) Limits provide security and safety for the child, both physically and emotionally; (3) Limits demonstrate the therapist's intent to provide safety for the child; (4) Limits anchor the session to reality; (5) Limits allow the therapist to maintain a positive and accepting attitude toward the child; (6) Limits allow the child to express negative feelings without causing harm, and the subsequent fear of retaliation; (7) Limits offer stability and consistency; (8) Limits promote and enhance the child's sense of self-responsibility and self-control; (9) Limits protect the play therapy room; and (10) Limits provide for the maintenance of legal, ethical and professional standards. (p.16)

The child-centered play therapist does not set limits until the need for introducing the limitations arises. In addition, the child's feelings are always acceptable, but not all the child's behaviors (Landreth, 1991). Since the boundaries have been determined in the therapeutic relationship, the play therapist can be consistent and predictable in setting limits. It is within this structure that "the feeling of permissiveness is more important than
actual permissiveness" (Landreth & Sweeny, In press, p.17).

Limits are set in a way that allow the child to bring himself under control. Landreth (1991) suggests a three-step procedure in therapeutic limit setting:

[Step 1] A— Acknowledge the child’s feelings, wishes, and wants.
[Step 2] C— Communicate the limit.
[Step 3] T— Target acceptable alternatives. (p. 223)

Attitude toward children. The following tenets developed by Landreth (1991) for relating to children express the child-centered attitude:

1. Children are not miniature adults.
2. Children are people.
3. Children are unique and worthy of respect.
4. Children are resilient.
5. Children have an inherent tendency toward growth and maturity.
6. Children are capable of positive self-direction.
7. Children’s natural language is play.
8. Children have a right to remain silent.
9. Children will take the therapeutic experience to where they need to be.
10. Children’s growth cannot be speeded up. (p. 50)

Based on a belief that behaviors are the way children solve their problems and also on a belief in children’s capacity for self-help, the child-centered play therapist
encourages children to face themselves and to regain contact with their real feelings. Through the relationship, children feel a sense of self and self-value; thus, they come to regard themselves as an important person and to honor their own way of expressing themselves. Child-centered play therapists believe that the value of a person lies within the children, and they can use this value in effecting their own growth (Moustakas, 1959). Once the child has undergone some personal change, the child’s environmental situation is no longer the same. Thus, the play therapist trusts that the child can initiate a cycle of change (Dorfman, 1951).

Characteristics of child-centered play therapists. To work with children in a therapeutic relationship, the play therapist must like children and really know them (Axline, 1947). The child-centered play therapist needs to have the ability to enter a new relationship with confidence and relaxation because children are very sensitive to adults. The therapist maintains a deep concern for the growth of the child, a special interest in the child’s individuality, and an educated talent for sensing, feeling, understanding, examining, and exploring the child’s experience with the child (Moustakas, 1959). The confident play therapist is comfortable with various challenges from the child and is able to handle them in a therapeutic way. The relaxed play therapist does not overwhelm the child by showing too much affection or concern, which may become a new problem for the
child. Therefore, a play therapist is not ready to start the relationship with a child until "she has developed self-discipline, restraint, and a deep respect for the personality of the child" (Axline, 1947, p. 64).

Because the person of the therapist is more important than articulated techniques in the playroom (Landreth & Sweeney, In press), the play therapist should have sincere self-understanding and must accept self, both strengths and weaknesses. This self-understanding and accompanying self-acceptance enables the therapist to wait expectantly for the emerging self within the child (Landreth, 1991). The crucial factors regarding the effectiveness of child-centered play therapists are:

their ability to enter into a significant relationship with a child and to bring to the therapy meetings a blend of personal and professional talents and skills, a natural integration of knowledge, understanding, and experience. It demands of the individual immediacy, presence, and responsibility within a concrete relationship. It requires a willingness to participate spontaneously and share with another person a vital, unique, emerging process of life and growth, offering one's self as a human being but waiting for the child to come to his own fulfillment in his own time and way. (Moustakas, 1959, p.318)
Training of Play Therapists

Several research projects have been conducted to validate the positive effects of training paraprofessionals as play therapy agents. Studies indicate positive results in using the filial training model to train parents (Bratton, 1994; Chau, 1996; Glass, 1986; Guerney, 1976; Guerney & Guerney, 1985; Harris, 1995; Lobaugh, 1991; VanFleet, 1992), teachers (Bach, 1968; Foley, 1970; Guerney & Flumen, 1970; Ross, 1972; Schiffer, 1958), hospital specialists (Harvey, 1984; Ouellet, 1960), and college students (Linden & Stollak, 1969; Stollak, 1969, 1975) to become play therapy agents with children. Results of these studies have indicated that paraprofessionals can be taught to adopt a child-centered philosophy and to use play skills successfully with children.

Research is noticeably lacking concerning the training and development of prospective professional play therapists. This could be a result of the fact that play therapy is a relatively recent addition to counselor education curriculum and only a limited number of universities offer play therapy training (Center for Play Therapy, 1995; Kranz, Lund, & Kottman, 1996). A national survey of play therapy training programs in the United States and Canada conducted by the Center for Play Therapy at the University of North Texas in 1995 found that only 46 universities offer one or more courses in play therapy as a component of counselor
education or educational psychology programs and that 24 universities offer play therapy units as a part of another course.

To many persons, child-centered play therapy has seemed easy to learn, pleasant to undertake, and gratifying in its results (Lebo, 1953). A common misconception concerns the nature of the process. The idea of working with children mistakenly suggests a therapeutic task easier than that of working with adults. In fact, even the most experienced and effective adult counselors often have difficulty transferring their therapeutic skills to play therapy sessions with small children (Landreth, 1991; Lebo, 1953). Therefore, the professional standards required for utilizing play therapy in counseling with children should be no less than those required for working with adults in a counseling relationship (Landreth, 1991).

Professionally speaking, play therapy training is often designed to increase counselors' self-awareness, extend their knowledge base, and expand their repertoire of counseling competencies. In doing so, it is anticipated that counselors will be able to better differentiate their child-clients' needs and intervene more effectively and appropriately (Kranz & Lund, 1994; Landreth, 1991).

Training Guidelines

According to Moustakas (1959), the preliminary experiences needed to train individuals for work as a child
therapist include the following:

The orientation to and development of a theory; observation in therapy of a number of children of different ages; discussion of the process of child therapy as reflected in completed cases; study of initial, middle, and terminal interviews through tape recordings and observations; and reading experiences of theory, practice, and research in child therapy. (pp. 233)

Landreth (1991) also suggested important guidelines for those involved in the training of play therapists:

[The individual should have a] master's degree in an area of the helping professions; content areas of study in child development, theories of counseling and psychotherapy, clinical counseling skills, and group counseling; content area of study in play therapy equivalent to 45 clock hours of instruction; personal counseling or other pertinent experience which provides opportunities to examine self over an extended period of time; observation and case analysis of children from the normal population as well as maladjusted children; observation of experienced play therapists with opportunity to discuss and critique the sessions; and supervised experience in play therapy by a professional who has experience in play therapy. (pp. 105-106)

The current minimum application criteria for registered
play therapists, established by the Association for Play Therapy, specifies that applicants should have required academic training (master's degree in an appropriate medical or mental health profession and a minimum of 150 clock hours of instruction in play therapy); clinical experience (a minimum of 2 years of related clinical practice, 500 direct play therapy contact hours, and a minimum of 75 hours of play therapy supervision); and continuing education (35 hours of APT approved continuing education every 3 years) (APT Newsletter, 1992). These criteria serve as guidelines for training qualified play therapists.

**Play Therapy Training Model**

A play therapy training model utilized by Guerney (1978) to train master's and doctoral-level students extended over three consecutive semester terms. In the first term, students learned play therapy skills through being taught how to conduct client-centered play sessions and via readings on theory and technique; students received three types of supervision, including peer supervision, supervision from experienced supervisors, and self-supervision. All supervision was provided in a positive reinforcement manner. In the second term, students served as teacher consultants as well as play session supervisors to undergraduate students who were learning play therapy principles as part of family development course requirements. This design attempted to solidify students'
theoretical knowledge and skills regarding play sessions and to prepare students for the role of filial group leader. In the third term, students chose to lead a remedial, preventative, or educational filial group. The class meeting for this term consisted of presentations of tapes or verbal reports of students' groups.

Brady and Friedrich (1982) presented a play therapy training model based on a developmental perspective. They divided the play therapy process into four levels of intervention and students are taught to articulate these four levels of intervention: Level 1, physical interventions, physical presence, and nonverbal gestures; Level 2, reflecting or paraphrasing, following and attending; Level 3, third-person interpretations, and Level 4, direct interpretations. Brady and Friedrich concluded that each level can be taught as a skill, with the outcome being that the therapist trainee has both a perspective and some tools to utilize in doing play therapy.

Landreth (1991), founder of the Center for Play Therapy at the University of North Texas, Denton, offers play therapy training in the following areas: master's and doctoral courses in play therapy; supervised play therapy practicums and internships; play therapy summer institute workshops; an annual play therapy conference; and play therapy forums. This training model provides entry-level graduate students with various learning experiences.
including lectures, discussions, reading and writing papers related to various aspects of play therapy; observation of advanced students' play therapy practicum sessions; observation of the instructor's play therapy sessions; live demonstration; role playing with the instructor and peers; practice play sessions with volunteer adjusted children with self-critiques of these play sessions; and micro play therapy practicum experiences with volunteer adjusted children in the playroom, which are supervised by experienced play therapists. Landreth's child-centered play therapy model was the focus of this study.

**Summary**

Because counseling children requires special knowledge and skills (Brady & Friedrich, 1982; Guerney, 1983; Kaczmarek & Wagner, 1994; Kranz & Lund, 1994; Landreth, 1991), and counseling service for children is an important issue for counseling professionals (Collins & Collins, 1994; Johnson, 1994; Landreth, 1991; Stern & Newland, 1994; Wagner, 1994), counseling students need appropriate training and supervision in learning play therapy to ensure both personal and professional growth (Guerney, 1983; Kranz & Lund, 1994; Kranz, Lund, & Kottman, 1996; Landreth, 1991; Moustakas, 1959).

Child-centered play therapy has been a mainstream approach in the development of play therapy (Kottman, 1987; Guerney, 1983; Landreth, 1991; Landreth & Sweeney, In
press). In learning to be a child-centered play therapist, the student needs to obtain necessary relationship-building skills (structuring skills, important basic attitudes, empathic responses, and setting limitations) and to hold essential beliefs about children (Axline, 1947; Guerney, 1983; Landreth, 1991; Landreth & Sweeney, In press; Moustakas, 1953, 1959).

Previous research on the effect of counselor training has found that counselors tend to change certain personality dimensions and to improve their knowledge, skills, and attitudes after receiving training. There is an absence of research in the literature concerning the effects of play therapy training on trainees (Arnold, 1975; Kottman, 1987; Kranz & Lund, 1994). The purpose of this study was to examine the effects of child-centered play therapy training on play therapy trainees.
CHAPTER TWO

METHODS AND PROCEDURES

The purpose of this study was to determine the effects of child-centered play therapy training on beginning play therapists in three areas: 1) increasing play therapy attitude, knowledge, and skills; 2) reducing the dominance level of play therapy trainees; and, 3) increasing the tolerance level of play therapy trainees. This chapter will address definition of terms, hypotheses, instrumentation, selection of subjects, the child-centered play therapy training treatment course, collection of data, and statistical analysis.

Definition of Terms

Play Therapy was defined as:
A dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self (feelings, thoughts, experiences, and behaviors) through the child's natural medium of communication, play. (Landreth, 1991, p. 14)

Child-Centered Play Therapy Training is a teaching model that utilizes the person-centered theory in
conceptualizing and teaching play therapy. For the purposes of this study, child-centered play therapy training was an introductory play therapy graduate course offered by the Counseling, Development, and Higher Education Department at the University of North Texas, Denton and taught by Dr. Garry Landreth.

Play Therapists in Training are graduate students focused on child counseling who plan to work with children in a play therapy context in the future. For the purposes of this study, play therapists in training were students enrolled in the Introduction to Play Therapy course in the Department of Counseling, Development, and Higher Education at the University of North Texas.

Attitude is a basic belief about and a way of being with children. For the purposes of this study, play therapist attitude was operationally defined as the score on the Attitude subscale of the Play Therapy Attitude-Knowledge-Skills Survey.

Knowledge refers to fundamental knowledge of child-centered play therapy, including a view of children, the counseling approach with children, and important child-centered play therapy concepts and terms. For the purposes of this study, play therapist knowledge was operationally defined as the score on the Knowledge subscale of the Play Therapy Attitude-Knowledge-Skills Survey.

Skills refers to the ability of the play therapist to
transfer play therapy knowledge into skills and confidence in applying those skills. For the purposes of this study, play therapy skill was operationally defined as the score on the skill subscale of the Play Therapy Attitude–Knowledge–Skills Survey.

Dominance is confident, assertive, task-oriented, forceful, and assuming. For the purposes of this study, the play therapist’s dominance was operationally defined as the score on the Dominance Scale of the California Psychological Inventory.

Tolerance is being understanding of others’ beliefs and values, even when different from or counter to one’s own beliefs. For the purposes of this study, the play therapist’s tolerance was operationally defined as the score on the Tolerance Scale of the California Psychological Inventory.

Hypotheses

To carry out the purposes of this study, the following hypotheses were formulated:

1. The experimental group will attain a significantly higher mean total score on the Play Therapy Attitude–Knowledge–Skills Survey (PTAKSS) posttest than will the control group.

(a) The experimental group will attain a significantly higher mean score on the Play Therapy Attitude subscale of the PTAKSS posttest than will the
control group.

(b) The experimental group will attain a significantly higher mean score on the Play Therapy Knowledge subscale of the PTAKSS posttest than will the control group.

(c) The experimental group will attain a significantly higher mean score on the Play Therapy Skills subscale of the PTAKSS posttest than will the control group.

2. Subjects in the experimental group will attain a significantly lower mean score on the Dominance Scale of the California Psychological Inventory posttest than will subjects in the control group.

3. Subjects in the experimental group will attain a significantly higher mean score on the Tolerance Scale of the California Psychological Inventory posttest than will subjects in the control group.

Instruments

The Play Therapy Attitude-Knowledge-Skills Survey

The Play Therapy Attitude-Knowledge-Skills Survey (PTAKSS) is a self-administered written test developed for the purposes of this study by Garry Landreth and the researcher (See Appendix A). Three areas were defined by considering the important objectives of child-centered play therapy training for beginning-level graduate students. Items in the attitude subscale refer to essential belief and
interaction patterns that trainees are expected to obtain from child-centered play therapy training. Items in the knowledge subscale refer to what trainees should know as a result of attending the child-centered play therapy training. Items in the skill subscale evaluate trainees' confidence in applying child-centered play therapy skills.

Test items were developed based on two main child-centered play therapy texts: *Play therapy* (Axline, 1947) and *Play therapy: The art of the relationship* (Landreth, 1991). The researcher read through these two textbooks and located related concepts to form a pool of tentative test items. A group of 4 advanced play therapists who were doctoral students, each had completed at least three graduate play therapy courses and a supervised play therapy doctoral internship, brain-stormed and added to the pool of test items. Landreth double checked the test items for appropriate child-centered content, excluded unrelated descriptions, added missing concepts and refined unclear items. The test items were worded in both positive and negative ways to avoid participants' awareness of preferred answers. Ambiguous items and vague descriptions were either excluded or modified as the result of feedback from participants in a pilot study to ensure the clarity of this instrument.

The PTAKSS consists of three subscales— the play therapy attitude scale, the play therapy knowledge scale,
and the play therapy skill scale. The PTAKSS is an 88-item Likert scale format on which 5 indicates high agreement or ability, and 1 indicates low agreement or ability. The attitude scale consists of 33 items which are items #1 to #33. The knowledge scale consists of 21 items which are items #34 to #54. The skill scale consists of 34 items which are items #55 to #88. The scoring for items, #5, 13, 17, 20, 22, 23, 26, 28, 29, 31, 33, 34, 35, 36, 37, 38, 39, 42, had to be reversed at the Likert scale because a low scale was the preferred answer. For example, item 5: “I usually provide too many answers to children.” Rating 1 (never) is the preferred rating than rating 5 (always) and thus should receive the high score. The PTAKSS has 4 different scores: the total score, attitude score, knowledge score, and skills score. Participants took approximately 20 minutes to complete the scale in a pilot test.

Since the PTAKSS is a new research instrument, some discussion of its reliability and validity is warranted. The content validity of the PTAKSS was investigated by using a panel of four expert judges who have a Ph.D degree in counseling, are considered to be experts in the field of play therapy and are Registered Play Therapist-Supervisors. Two of these judges were teaching play therapy in universities. One judge worked as a private play therapy practitioner and served as a board member of the Association for Play Therapy. One judge worked in a children’s hospital
using play therapy. This panel of judges rated each item on a continuum of 1 representing low value to 5 representing high value. Agreement was achieved on eighty-seven of eighty-eight items with scores of 4 to 5 among at least three of the four judges. The greatest disagreement among the judges was a distance of three scale points (2 to 5), on items 16, 24, 27, 33 and 54. Mean scores for the four judges were total scale 4.66, attitude subscale 4.52, knowledge subscale 4.68, and skill subscales 4.78.

Pilot Study of the PTKSS

A pilot study was conducted on the PTKSS. Eighteen students enrolled in an introduction to play therapy graduate course in the summer 1995 term served as beginning play therapy trainees, and twenty-seven students enrolled in an advanced play therapy graduate course in the spring 1995 term, who had already completed two play therapy graduate courses, served as advanced play therapy trainees. The purpose of the pilot study was to answer the question, "Is the PTKSS mean score of advanced play therapy trainees significantly higher than the PTKSS mean score of beginning play therapy trainees?" The pilot study also investigated the effects of child-centered play therapy training on beginning play therapy trainees through the pretest and posttest of the PTKSS.

Table 1 presents the means and standard deviations for the advanced play therapy trainees (Group 1) and beginning
play therapy trainees (Group 2) on the total scale, knowledge scale, and skill scale. Table 2 presents the results of independent t tests between the advanced play therapy trainees (Group 1) and beginning play therapy trainees (Group 2) mean scores on the total scale, knowledge scale, and skill scale.

Table 1
Mean Scores for the PTKSS of Advanced and Beginning Students

<table>
<thead>
<tr>
<th>Variable</th>
<th>Cases</th>
<th>Mean (Total)</th>
<th>SD</th>
<th>Mean (Knowledge)</th>
<th>SD</th>
<th>Mean (Skill)</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1</td>
<td>27</td>
<td>4.3119</td>
<td>.301</td>
<td>4.3904</td>
<td>.261</td>
<td>4.2565</td>
<td>.370</td>
</tr>
<tr>
<td>Group 2</td>
<td>18</td>
<td>3.0252</td>
<td>.491</td>
<td>3.2011</td>
<td>.419</td>
<td>2.9170</td>
<td>.610</td>
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</tbody>
</table>

Table 2
t-test for Mean Scores on PTKSS of Advanced vs. Beginning Students

<table>
<thead>
<tr>
<th>Variable</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total score</td>
<td>9.94*</td>
</tr>
<tr>
<td>Knowledge score</td>
<td>10.73*</td>
</tr>
<tr>
<td>Skill score</td>
<td>8.16*</td>
</tr>
</tbody>
</table>

* p < .0001
Results indicate that advanced play therapy trainees report significantly more knowledge and skills than beginning play therapy trainees based on the PTKSS.

A t-test was conducted on the PTKSS pretest and posttest scores of beginning play therapy trainees to determine the effect of child-centered play therapy training. Table 3 presents the mean scores and standard deviations for the total scale, knowledge scale, and skill scale. Table 4 presents the t-tests for paired samples of the pretest and posttest of the beginning play therapy trainees' PTKSS results.

Table 3
Mean Scores for the PTKSS on Pretest and Posttest of Beginning Students

<table>
<thead>
<tr>
<th>Variable</th>
<th>Cases</th>
<th>Mean</th>
<th>SD</th>
<th>Mean</th>
<th>SD</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pretest</td>
<td>17</td>
<td>3.0074</td>
<td>.503</td>
<td>3.1933</td>
<td>.431</td>
<td>2.8927</td>
<td>.605</td>
</tr>
<tr>
<td>Posttest</td>
<td>17</td>
<td>4.1465</td>
<td>.211</td>
<td>4.2913</td>
<td>.240</td>
<td>4.0571</td>
<td>.252</td>
</tr>
</tbody>
</table>
Table 4

**t Tests for Paired Differences Between Pretest and Posttest of Beginning Students**

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total score</td>
<td>17</td>
<td>-8.28*</td>
</tr>
<tr>
<td>Knowledge score</td>
<td>17</td>
<td>-8.55*</td>
</tr>
<tr>
<td>Skill score</td>
<td>17</td>
<td>-7.06*</td>
</tr>
</tbody>
</table>

* p < .0001

Table 4 shows a significant increase in beginning play therapy trainees' knowledge and skills after they completed child-centered play therapy training. No control group was used in the pilot study, a further examination of the effects of child-centered play therapy training used pretest-posttest-control group research design in this research.

The attitude scale was not well developed at the time of the pilot study and was, therefore, not included in the pilot study. The attitude scale items were refined and completed after the pilot study and were subjected to the same development process as the other two scales after the pilot study was completed.

**Field Test of PTAKSS**

One hundred and four graduate students who were
majoring in counselor education with a specialty in child counseling served as the sample group for the field test (Long, Convey, & Chwalek, 1985). Twenty-seven of these one hundred and four graduate students were advanced play therapy students, who had completed at least two three-hour graduate credit play therapy courses. Thirty-seven were beginning level play therapy students, who had completed only one introduction to play therapy graduate course. Forty were prospective play therapy students, who had not received any formal graduate play therapy course training. Field testing was done on the complete PTAKSS consisting of the attitude scale, knowledge scale and skills scale. Reliability coefficients (Cronbach's alpha) for the PTAKSS are total scale .98, attitude scale .73, knowledge scale .94, and skill scale .99.

A criteria validity test was calculated by using correlation coefficients. Each participant was given a criteria score by calculating the participant's graduate play therapy course training, e.g. one play therapy graduate course counts for one score for criteria score, two play therapy graduate courses count for two scores for the criteria score, etc. Each participant's criteria score was correlated with the total score of the PTKSS and its subscales to determine whether significant differences existed. The correlation coefficients were total scale .70 (P < .0001), attitude scale .34 (P < .0001), knowledge scale
Statistically, the PTAKSS appears to be a valid measurement of play therapy attitude, knowledge, and skills.

Summary. The pilot study of the PTAKSS indicated that PTAKSS is a sensitive instrument that can distinguish advanced play therapy trainees from beginning play therapy trainees as well as test the effects of child-centered play therapy training on changing the play therapy knowledge and skills of beginning play therapy trainees. Analysis of the content validity, criteria validity, and Cronbach's alpha reliability for the PTAKSS supports the use of the PTAKSS.

California Psychological Inventory: The Empathy Scale and Tolerance Scale

The California Psychological Inventory (CPI) was developed by Harrison Gough to assess personality traits within the general population. It was published first in 1956 and then revised in 1987 (Hutton, 1990). This is a self-report true/false questionnaire that measures 20 features of normal personality: Dominance, Capacity for Status, Sociability, Social Presence, Self-acceptance, Independence, Empathy, Responsibility, Socialization, Self-control, Good Impression, Communality, Well-being, Tolerance, Achievement via Conformance, Achievement via Independence, Intellectual Efficiency, Psychological-mindedness, Flexibility, and Femininity/Masculinity (Gough, 1987). The intercorrelations among the 20 folk concept
scales range from -.15 to .83, with a median of .44. Gough's goal for the CPI was to develop an instrument that would describe the respondent's salient personality characteristics and predict his/her behavior in specific situations (Hutton, 1990). In this study, two subscales were emphasized, the Dominance (Do) scale and the Tolerance (To) scale.

The Dominance scale was originally derived in connection with a project on political participation to identify strong, dominant, influential, and ascendant individuals who are able to take the initiative and exercise leadership (Megargee, 1972). The present Dominance scale consists of thirty-six items. People who are high in dominance describe themselves as take-charge people who are willing to be leaders, and indicate they are verbally fluent and persuasive. The Dominance scale is one of the better-validated CPI scales and is one of the few personality scales for which predictive validity has been established (Megargee, 1972). The Alpha coefficient for the Dominance scale is .79, parallel forms reliability is .69 (male) and .68 (female), and test-retest reliability is .62 (male) and .68 (female) (Gough, 1987).

The purpose of the Tolerance scale is the identification of permissive, accepting, and nonjudgmental social beliefs and attitudes. A higher Tolerance score "is tolerant of others' beliefs and values, even when different
from or counter to [one's] own beliefs" (Gough, 1987, p. 6). Thirty-two items were included in this scale. The manifest content of the items reflects openness and flexibility as opposed to rigidity or dogmatism. Most of the evidence for the validity of the Tolerance scale comes from studies in which it has been correlated with various test measures of prejudice. Studying the correlations with the California F (Authoritarianism), Gough reported a correlation of -.46 in a sample of 100 military officers and one of -.48 in a sample of 419 college students (Megargee, 1972). Alpha coefficients for the Tolerance scale is .68, parallel forms reliability is .71 (male) and .63 (female), and test-retest reliability is .73 (male) and .69 (female) (Gough, 1987).

Subjects

To ensure the findings of this study were the result of training and not from either heterogeneous background or pre-existing conditions, subjects in this study were selected from a similar training background. Therefore, only graduate students majoring in counseling with a specialty in child counseling were selected to be subjects in this study. The subjects for this research project were graduate students who were taking counseling-related courses from the Department of Counseling, Development, and Higher Education at the University of North Texas, Denton during the Fall 1995, Spring 1996 and Summer 1996 terms. The subjects were counseling students specializing in working with children
and had no previous play therapy training or play therapy experience.

The experimental group consisted of thirty-nine graduate students enrolled in the Introduction to Play Therapy course in the Fall 1995 and Spring 1996 terms who volunteered to participate. Thirty-seven of these students completed the pretest and posttest. All of the experimental group subjects were female.

The control group consisted of twenty-nine volunteers from comparable-level non-play therapy courses such as Counseling Theories, Human Development, Career Development and Information Resources, Family and Parenting Counseling, and Counseling the Culturally and Ethnically Different Client. Control group subjects were enrolled in these courses during the spring 1996 and Summer 1996 terms. These students had received no play therapy training and were not enrolled in a play therapy course at the time of their participation in this study. The control group was comprised of twenty-five female and four male subjects.

Treatment

The treatment was a comprehensive child-centered play therapy training model designed and taught by Garry Landreth for beginning play therapy trainees. This course, Introduction to Play Therapy, is a 3-hour graduate level course, taught once a week for fifteen weeks for a total of 45 clock hours of training. The course is offered every
semester, including spring, summer, and fall, by the Department of Counseling, Development, and Higher Education at the University of North Texas. This course provides entry-level graduate students with various learning experiences including lectures, discussions, reading and writing papers related to various aspects of play therapy; observation of advanced students' play therapy practicum sessions; observation of the instructor's play therapy sessions; live demonstration in the class; role playing with the instructor and peers; practice play sessions with volunteer adjusted children outside the classes with self-critiques of these play sessions; and micro play therapy practicum experiences with volunteer adjusted children in the playroom, which are supervised by experienced play therapists.

According to the instructor's syllabus, this course focuses on enhancing the counseling relationship with children by using play media to facilitate expression, self-understanding, and personal growth and development. Observation of, and supervised experience in play therapy with children are integral parts of the course. The major objectives of the course are to provide students an opportunity to understand and demonstrate competencies in (a) learning the basic theoretical approaches to play therapy; (b) developing a philosophy of and approach to play therapy that is effective for the student; (c) perceiving
the child’s world as viewed by the child; (d) communicating effectively with children at a feeling/emotional level; (e) understanding the meaning and implications of children’s behavior; (f) establishing a helping/facilitative relationship with a child in a play therapy experience; and (g) learning self-exploration, which promotes self-understanding (See Appendix B).

Collection of Data

Volunteer subjects were asked to complete the Play Therapy Attitude-Knowledge-Skills Survey and the California Psychological Inventory at the beginning of the semester and at the end of the semester.

The test packet contained a cover letter (See Appendix C), the Play Therapy Attitude-Knowledge-Skills Survey, California Psychological Inventory (CPI) booklet, CPI answering sheet, and self-addressed envelope for requesting the results of CPI (optional). Each subject was assured of anonymity and was identified by a four digit home phone number.

Analysis of Data

Following the collection of the pretest and posttest data, the two self-report instruments were scored, double checked, and the scores were keyed into the computer by the researcher. For the design of the statistical method, analysis of covariance, pretest and posttest scores were paired according to a four digit identification number. The
data was analyzed by the researcher using SPSS for MS

An analysis of covariance (ANCOVA) was computed to test the significance of the difference between the experimental group and the control group on the adjusted posttest means for hypotheses 1, 2, and 3 (Hinkle, Wiersma, & Durs, 1994). To establish preliminary conditions for the research, it was necessary to give each participant in both the experimental group and the control group a pretest. Two instruments (the PTAKSS and the CPI) were used as pretests to determine existing levels of play therapy attitude, knowledge, and skill, and the dominance and tolerance levels of the experimental and control groups. The posttest specified in each of the hypotheses was used as the dependent variable, and the pretest, as the covariant. ANCOVA was used to adjust the group means on the posttest on the basis of the pretest, thus statistically equating the control and experimental group. Significance of difference between means was tested at the .05 level. On the basis of the ANCOVA, the hypotheses were either retained or rejected.
CHAPTER III

RESULTS AND DISCUSSION

This chapter presents the results of the analysis of the data for each hypothesis tested in this study. Included also is a discussion of the results, implications, and recommendations for further research.

Results

The results of this study are presented in the order the hypotheses were tested. Analyses of covariance were performed on all hypotheses and a level of significance of .05 was established as the criterion for either retaining or rejecting the hypotheses.

Hypothesis 1

The experimental group will attain a significantly higher mean total score on the Play Therapy Attitude-Knowledge-Skills Survey (PTAKSS) posttest than will the control group.

Table 5 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 6 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.
Table 5

Mean scores for the total PTAKSS

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=37)</th>
<th>Control (n=29)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>3.11</td>
<td>4.04</td>
</tr>
<tr>
<td>SD</td>
<td>0.30</td>
<td>0.22</td>
</tr>
</tbody>
</table>

Total cases = 66

Table 6

Analysis of covariance for the total scores on the PTAKSS

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariates</td>
<td>2.141</td>
<td>1</td>
<td>2.141</td>
<td>28.456</td>
</tr>
<tr>
<td>Main effects</td>
<td>15.184</td>
<td>1</td>
<td>15.184</td>
<td>201.767***</td>
</tr>
<tr>
<td>Error</td>
<td>4.741</td>
<td>63</td>
<td>0.075</td>
<td></td>
</tr>
</tbody>
</table>

Total cases = 66

***F < .0001

Table 6 shows the F ratio for the main effects was significant to the <.0001 level indicating a significant increase in the experimental group's total score on the PTAKSS. On the basis of this data, hypothesis 1 was retained.
Hypothesis 1 (a)

The experimental group will attain a significantly higher mean score on the Play Therapy Attitude subscale of the PTAKSS than will the control group.

Table 7 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 8 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 7
Mean scores on the PTAKSS Attitude subscale

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=37)</th>
<th>Control (n=29)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>3.37</td>
<td>3.92</td>
</tr>
<tr>
<td>SD</td>
<td>0.21</td>
<td>0.28</td>
</tr>
<tr>
<td>Total cases = 66</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 8

Analysis of covariance for the PTAKSS Attitude subscale

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>Sum of Square</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariates</td>
<td>0.873</td>
<td>1</td>
<td>0.873</td>
<td>15.435</td>
</tr>
<tr>
<td>Main Effects</td>
<td>2.213</td>
<td>1</td>
<td>2.213</td>
<td>39.126***</td>
</tr>
<tr>
<td>Error</td>
<td>3.564</td>
<td>63</td>
<td>0.057</td>
<td></td>
</tr>
<tr>
<td>Total cases = 66</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

***p < .0001

Table 8 shows the F ratio for the main effects was significant to the <.001 level indicating a significant increase in the experimental group's play therapy attitude as measured by the PTAKSS. On the basis of this data, hypothesis 1 (a) was retained.

Hypothesis 1 (b)

The experimental group will attain a significantly higher mean score on the Play Therapy Knowledge subscale of the PTAKSS than will the control group.

Table 9 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 10 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.
Table 9

Mean scores on the PTAKSS Knowledge subscale

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=37)</th>
<th>Control (n=29)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>3.28</td>
<td>4.30</td>
</tr>
<tr>
<td>SD</td>
<td>0.35</td>
<td>0.29</td>
</tr>
</tbody>
</table>

Total cases = 66

Table 10

Analysis of covariance for the PTAKSS Knowledge subscale

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>Sum of Square</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariates</td>
<td>1.884</td>
<td>1</td>
<td>1.884</td>
<td>18.415</td>
</tr>
<tr>
<td>Main Effects</td>
<td>18.804</td>
<td>1</td>
<td>18.804</td>
<td>183.788***</td>
</tr>
<tr>
<td>Error</td>
<td>6.446</td>
<td>63</td>
<td>0.102</td>
<td></td>
</tr>
</tbody>
</table>

Total cases = 66

***P < .0001

Table 10 shows the F ratio for the main effects was significant to the <.0001 level indicating a significant increase in the experimental group's play therapy knowledge.
as measured by the PTAKSS. On the basis of this data, hypothesis 1 (b) was retained.

**Hypothesis 1 (c)**

The experimental group will attain a significantly higher mean score on the Play Therapy Skills subscale of the PTAKSS than will the control group.

Table 11 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 12 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

Table 11

**Mean scores on the PTAKSS Skills subscale**

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=37)</th>
<th>Control (n=29)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>2.76</td>
<td>3.98</td>
</tr>
<tr>
<td>SD</td>
<td>0.64</td>
<td>0.35</td>
</tr>
<tr>
<td>Total cases</td>
<td>66</td>
<td></td>
</tr>
</tbody>
</table>
Table 12

**Analysis of covariance for the PTAKSS Skills subscale**

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariates</td>
<td>10.693</td>
<td>1</td>
<td>10.693</td>
<td>42.758</td>
</tr>
<tr>
<td>Main Effects</td>
<td>29.202</td>
<td>1</td>
<td>29.202</td>
<td>116.772***</td>
</tr>
<tr>
<td>Error</td>
<td>15.755</td>
<td>63</td>
<td>0.250</td>
<td></td>
</tr>
</tbody>
</table>

Total cases = 66

***p < .0001

Table 12 shows the F ratio for the main effects was significant to the <.0001 level indicating a significant increase in the experimental group's play therapy skills as measured by the PTAKSS. On the basis of this data, hypothesis 1 (c) was retained.

**Hypothesis 2**

Subjects in the experimental group will attain a significantly lower mean score on the Dominance Scale of the California Psychological Inventory posttest than will subjects in the control group.

Table 13 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 14 presents the analysis of covariance data, showing the level of significance of the difference between the
experimental group's and control group's posttest mean scores.

Table 13

Mean scores for the CPI Dominance Scale

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariates</td>
<td>4393.723</td>
<td>1</td>
<td>4393.723</td>
<td>107.843</td>
</tr>
<tr>
<td>Main Effects</td>
<td>160.206</td>
<td>1</td>
<td>160.206</td>
<td>3.932*</td>
</tr>
<tr>
<td>Error</td>
<td>2566.746</td>
<td>63</td>
<td>40.742</td>
<td></td>
</tr>
</tbody>
</table>

Total cases = 66

* p = .05
Table 14 shows the $F$ ratio for the main effects was significant to the $= .05$ level indicating a significant decrease in the experimental groups' dominance as measured by the CPI. On the basis of this data, hypothesis 2 was retained.

**Hypothesis 3**

Subjects in the experimental group will attain a significantly higher mean score on the Tolerance Scale of the California Psychological Inventory posttest than will subjects in the control group.

Table 15 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 16 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest mean scores.

**Table 15**

**Mean scores on the CPI Tolerance Scale**

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=37)</th>
<th>Control (n=29)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>55.19</td>
<td>56.00</td>
</tr>
<tr>
<td></td>
<td>57.26</td>
<td>57.66</td>
</tr>
<tr>
<td>SD</td>
<td>8.24</td>
<td>7.60</td>
</tr>
<tr>
<td></td>
<td>5.95</td>
<td>7.23</td>
</tr>
<tr>
<td>Total cases = 66</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 16

Analysis of covariance for the CPI Tolerance Scale

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariates</td>
<td>2034.145</td>
<td>1</td>
<td>2034.145</td>
<td>84.845</td>
</tr>
<tr>
<td>Main Effects</td>
<td>0.038</td>
<td>1</td>
<td>0.038</td>
<td>0.002</td>
</tr>
<tr>
<td>Error</td>
<td>1510.407</td>
<td>63</td>
<td>23.975</td>
<td></td>
</tr>
</tbody>
</table>

Total cases = 66

Table 16 shows the F ratio for the main effects was not significant to the <.05 level indicating that there was no significant difference between the experimental and control groups' posttest scores on the CPI Tolerance Scale. On the basis of this data, hypothesis 3 was rejected.

Related Findings

One other area of the California Psychological Inventory, the Intellectual Efficiency Scale (further information in the Discussion section), showed significant change. Table 17 presents the pre and posttest means and standard deviations of the CPI Intellectual Efficiency score for the experimental and control groups. Table 18 presents the analysis of covariance data, showing the level of significance of the difference between the experimental and control groups' posttest Intellectual Efficiency mean scores.
Table 17

Mean scores for the CPI Intellectual Efficiency Scale

<table>
<thead>
<tr>
<th>Source</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariates</td>
<td>1933.161</td>
<td>1</td>
<td>1933.161</td>
<td>111.357</td>
</tr>
<tr>
<td>Main Effects</td>
<td>82.464</td>
<td>1</td>
<td>82.464</td>
<td>4.750*</td>
</tr>
<tr>
<td>Error</td>
<td>1093.680</td>
<td>63</td>
<td>17.360</td>
<td></td>
</tr>
</tbody>
</table>

Total cases = 66

Table 18

Analysis of covariance for the mean scores on the CPI Intellectual Efficiency

Table 18 shows the F ratio for the main effects was significant to the < .05 level indicating a significant decrease in the experimental group's intellectual efficiency.
as measured by the CPI.

A profile (See Appendix D) of the CPI 20 features of personality was developed for the experimental group to tentatively describe this group of beginning play therapists.

Discussion

The results of this study point to the positive effect of child-centered play therapy in changing trainees' attitudes and beliefs toward children and in increasing their play therapy knowledge and confidence in applying play therapy skills. Two personality dimensions, dominance and intellectual efficiency, were found to be changed after training. Significant results were found on two of the three hypotheses in this study. The meaning of these results is discussed below.

Play Therapy Attitude

The students in the experimental group showed a significant positive increase ($p < .0001$) in their play therapy attitude as indicated by the PTAKSS Attitude subscale scores. This can be interpreted to mean that, after training, these students held more positive beliefs about children. A positive attitude about children and a belief in children is essential in child-centered play therapy. Students' comments about this learning experience also indicated a positive change in their attitude and belief about children. Some typical responses from the experimental
group students were:

1. "It (the course) reinforced and added to my belief that children are capable when given the chance to be in control. I also now feel like I can learn from the child. I have deeper respect for children now."

2. "Training taught me how a permissive attitude toward children can be so facilitative, and my views about children were much stricter before the class."

3. "[Prior to this course,] when children were sad, I always tried to cheer them up. I didn’t let children experience their negative feelings. I always tried to make them 'feel better.' Now, I accept the feelings of children, especially the 'negative' feelings."

A positive change in attitude may be due to a student’s self-awareness and self-acceptance, which are important factors in the process of learning to be effective play therapists (Landreth, 1991). One student wrote:

Each time when I was in class, I could feel "the food for thought." I am not learning the skill. I am learning to be a real person, to be a genuine person—me. I feel more comfortable with children when the real me is present with children. I can communicate to them my true feelings of love, sadness, and happiness without pretending or preaching.

Another student had a similar experience:

My point of view about children and myself is different
now. I used to feel sad and hurt when a child rejected me or was rude to me. Although it still feels uncomfortable, I can accept this as a part of me, just as I can accept the child. I need to accept myself more as I am. I can't be perfect. It has become more easy for me to express my feelings to a child.

Changed attitudes bring students to a new level of freedom in their interaction with children. One student shared this experience:

I don't exactly know how to explain it, but I feel so much more freedom in working with my students at school and in dealing with my own children at home. Perhaps this is due in part to reaching a new level of interaction with them.

Two possible explanations for the training factors that contributed to these new positive attitudes could be: (a) the influence of incorporating the foundational philosophy of child-centered play therapy, and (b) the instructor's personal teaching style. The powerful influence of this new attitude was summarized by a student as, "This learning experience made me even more committed to working with children." With 30 years of play therapy teaching experience, the instructor has many vivid examples to use in planting the "new attitude seed" into students' hearts and to cultivate the seed in a subtle way throughout the whole semester. It is the researcher's experience and observation
that the instructor has a strong personal mission to spread play therapy out into the whole world and that he uses himself as an example to influence and encourage his students to share the mission with him. This could be a factor that contributed to the change in students’ attitudes.

Play Therapy Knowledge

The experimental group students showed a significant positive increase ($p < .0001$) in their play therapy knowledge, as indicated by the PTAKSS Knowledge subscale scores. This can be interpreted to mean that, after training, these students become more knowledgeable in the play therapy field. Students also commented on how the child-centered play therapy training helped them to improve their knowledge in working with children. Most students agreed that the micropracticum and observation of play therapy sessions were the two most helpful class activities. This reaction is consistent with the training suggestion that supervised play therapy experience is a crucial factor in learning to be a play therapist (Landreth, 1991). One student commented:

The most helpful part of this course was experiencing hands-on play therapy. Being able to actually be in a playroom, performing a session, is an experience I know I will never forget. I am so much more aware now of children and how they think and interpret adults
reactions and responses to them.

Another student said: "The supervised play sessions were quite helpful, but they were only helpful because they were the culmination of all the other experiences—observations, role-playing, videos and discussion, etc. All components of the curriculum were vital."

Play therapy knowledge can help students to better conceptualize their child clients in a therapeutic manner. A student described her own change: "I had had a lot of experience with children but didn't know how to be therapeutic. I now trust children more and understand their mode of communication much better. This course has enhanced my effectiveness."

Some possible explanations for the training factors that cause the increased play therapy knowledge could be:


2. Class lectures and discussions that focus specifically on how children view their world, fundamental knowledge of child-centered play therapy concepts, and how to establish emotional contact with children.

3. Two exploratory papers require extensive reading in the play therapy field. It is the researcher's experiences and observations that almost every student in the class
complains about the heavy reading but feels rewarded after they have completed the requirements.

**Play Therapy Skills**

The experimental group students showed a significant positive increase \( p < .0001 \) in their confidence in applying play therapy skills as indicated by the PTAKSS Skills subscale. This can be interpreted to mean that, after training, these students became more confident and comfortable with newly learned play therapy interaction skills. Students' overall feedback also indicated that they have much more confidence in therapeutic interactions/interventions with children. A typical response concerning this learning experience is one student's comment: "I feel so much more joy in working with children and so much more confidence in dealing with them and my capabilities than I've ever had before."

Students' confidence and enthusiasm about play therapy was demonstrated in their responses. One mentioned that this course "makes me want to find a job working with children now or hurry to finish my degree so I can do this play therapy soon." Another said, "I never thought I would enjoy working with children. Now I can't think of anything I would enjoy more than working with children."

The following are possible explanations for the increased confidence in the application of play therapy skills:
1. The well-established learning environment includes well-equipped playrooms and experienced play therapy supervisors to help with the play therapy micropracticums.

2. Observing real play therapy sessions outside the class, watching demonstration tapes, and role playing with the instructor and peers in the class are all helpful ways in preparing for the transfer of play therapy knowledge to practice.

3. The two practice and self-critique home play sessions with a normal child help students to gain a basic experience in using child-centered play therapy interaction skills with children.

4. The two play therapy micropracticums in the well-equipped playrooms with a normal child provide students with an opportunity to practice their skills and to receive immediate feedback about their performance from experienced play therapists.

Dominance

The experimental group students showed a significant decrease ($p = .05$) in dominance as indicated by the CPI Dominance subscale scores. This can be interpreted to mean that, after training, these students reduced their dominance tendency and became less assuming and forceful (Gough, 1987). A lower level of dominance is consistent with the philosophy of child-centered play therapy. Students' feedback also indicated a positive change in their dominance
tendency. Some typical responses regarding interaction with children are listed below:

1. "I now am able to stand back and give children the opportunity to work things through themselves. I try not to rush in to rescue them. I believe they can do it themselves."

2. "The training has allowed me to see through a child's eyes. I now see the great importance in allowing a child to be in control, to create the play situation they need to heal themselves."

3. "I am less rigid with children. I now am able to see the benefits from both the child's perspective and my own. I am also less rigid with myself too. I now do not put as many unattainable expectations on myself."

4. "I have changed most in my thinking process. I have more confidence in all people to guide themselves and take care of their own needs. I have learned to let go of my need to control."

Possible explanations for the training factors that contributed to the decrease in dominance tendencies are similar to those that affect students' attitude change; e.g., the influence of the child-centered play therapy philosophy and the instructor's personal teaching style. The newly learned nondirective play therapy skills could also help students to become less dominant in their daily life interactions.
Tolerance

In the area of tolerance, the experimental group students showed a positive increase in tolerance in the posttest as indicated by the CPI Tolerance subscale, but the change was not significant at the 0.05 level. The intended implication of the higher Tolerance score is that the individual "is tolerant of other's beliefs and values, even when different from or counter to [one's] own beliefs" (Gough, 1987, p.6), which is consistent with overall counselor training goals. Because both the experimental and control group students were all receiving some kind of counseling course training, the similar training goals shared by the two groups could be a major factor in the insignificant results of hypothesis 3.

Intellectual Efficiency

The experimental group students showed a significant decrease ($p = .03$) in intellectual efficiency as indicated by the CPI Intellectual Efficiency subscale scores. Although the result seems unfavorable, closer examination of the Intellectual Efficiency Scale reveals logical reasons for this result. A lower Intellectual Efficiency score implies that the individual "has a hard time getting started on things, and seeing them through to completion" (Gough, 1987, p.7). In child-centered play therapy, trainees are expected to follow a child's lead instead of making decisions for the child and to foster independence and responsibility within
the child instead of offering direct answers or unnecessary help (Landreth, 1991). Learning this new attitude is not as easy as reading a textbook. Many students were struggling to change their communication styles with children. One student described the most difficult part of this learning experience:

[It is the] letting go of the need to answer questions and do things for children. Letting go of the need to entertain, amuse and distract children (when they're doing something I don't particularly like). Letting go of the knee-jerk, impulse reaction of wanting to be a mother to every child.

Another student said: "I'm learning to 'listen' better without rushing to conclusions. I've realized the importance of just being 'with' the child, as opposed to having answers."

A Q-sort study conducted on the Intellectual Efficiency scale (Gough, 1987) found that the highest correlation item for interviewers was "uses wide and varied vocabulary" (p. 69); Q-sorts by spouses showed that the second highest correlation item was "verbally fluent, expresses self easily and with clarity" (p. 69); and the Q-sorts by assessment staff members showed that the fifth highest correlation item was "is verbally fluent, can express ideas well" (p. 69). In child-centered play therapy training, students are expected to learn new ways of interaction with children, including a
new language in communication, such as limit setting, tracking, reflecting of feelings, and giving choices (Landreth, 1991). Learning a new way of communication can be a struggle, as many students experienced in the learning process. Some typical responses include the following:

1. "The most difficult part of the training for me is learning the language! The retraining of my speech has been the biggest problem!!"

2. "I am aware of my language when speaking with children--to encourage and use self-esteem building statements instead of evaluation/praise."

3. "The most difficult part is learning to stop myself from asking questions (as a teacher, open-ended questions are natural) or trying to reflect a child's feelings without a question at the end. It was hard to break myself of that habit."

The reactions above provide a possible interpretation regarding the significant reduction in the experimental group's Intellectual Efficiency posttest mean score. It is the researcher's observation and experience that, while a short-term struggle is understandable, students tend to be more creative and effective in communication after they master this new language pattern. A student described her change in using the new language: "It's hard for me to learn the phrasing and words to use--it felt very awkward at first but now I'm even using the language--example: it's for you.
to decide—with my husband." Another student wrote, "I have changed the way I talk with adults as well as kids, not just at work, counseling, but also in my personal life." Further research on intellectual efficiency is needed to determine the long term effect on child-centered play therapists.

Possible explanations for the training factors that contributed to the change in students' scores on the CPI Intellectual Efficiency scale could be: (a) The demand of intensive learning of the nondirective communication pattern, e.g., the non-directive play therapy skills, including tracking behaviors, reflection of feelings, choice giving, and limit setting; (b) the difficulty for beginning play therapists in putting knowledge and skills together in supervised play sessions.

Among the 20 features of normal personality as measured by the CPI, only two subscales changed significantly, the Dominance scale and Intellectual Efficiency scale. One possible explanation could be the homogeneous background of the experimental and control groups; the subjects were all counseling major graduate students with a specialty in child counseling. Because of the homogeneous background, subjects may already share similar traits and focus their attention on absorbing similar experiences in their lives. Further research is needed to investigate the adult-focused and child-focused student counselors' differences on the CPI 20 folk concepts.
Recommendations

Based on the results of this study, the following recommendations are offered:

1. The **Play Therapy Attitude-Knowledge-Skills Survey** is a new instrument, and although the reliability coefficients for the whole instrument (.98), knowledge scale (.94), and skill scale (.99) were very high, there was a somewhat lower reliability coefficient for the attitude scale (.73). Further evaluation for the attitude scale is recommended.

2. Further research is needed to standardize the Play Therapy Attitude Knowledge Skills Survey.

3. A follow-up study to investigate the long-term effect of child-centered play therapy with trainees is needed.

4. Videotaped play therapy sessions are needed to investigate actual play therapy performance to confirm the results of this paper-pencil study.

5. Further research is needed to compare the effects of different play therapy training models.

6. Compatible standardized personality inventories should be used to compare results with the California Psychological Inventory.

Concluding Remarks

This study has demonstrated the positive effects of child-centered play therapy training on counseling students. Results show that child-centered play therapy training can
help students to gain more positive beliefs about children, as well as to be more supportive and less dominant in children’s live. Child-centered play therapy training also increased students’ play therapy knowledge and their confidence in applying play therapy skills.

Because of the positive results of this study, two main suggestions are made:

1. The child-centered play therapy course training outline developed by Dr. Landreth is recommended as an effective child-centered play therapy course training model.

2. Beginning and prospective play therapy students are urged to learn the child-centered play therapy approach because of the effectiveness of building students’ positive basic attitude toward children, increasing their play therapy knowledge, and increasing their confidence in applying play therapy skills.
APPENDIX A

PLAY THERAPY ATTITUDE–KNOWLEDGE–SKILLS SURVEY
Play Therapy Attitude-Knowledge-Skills Survey

This survey is designed to provide the play therapy trainer information regarding the attitude, knowledge and skills of a group of trainees. It is not a test. No grade will be given as a result of completing this survey. Please read each statement/question carefully. From the available choices, circle the one that best fits your reaction to each statement/question. Thank you for your cooperation.

Male_______ Female_______ Age_______

Courses taken in play therapy field: 0___ 1___ 2___ 3___
More than 3___

Clinical experience in play therapy: None___ Under 1yr___
1yr___ 2yrs___ 3yrs___ More than 3yrs___

Play therapy workshop attended: 0___ 1-3days___ 4-6days___
7-10days___ More than 10days___

Work experience with children: None___ School teacher___
Child Care___ Other________________________(Specify)

On the following statements, please indicate your response with each statement in the following manner:

1 ---- Never
2 ---- Seldom
3 ---- Sometimes
4 ---- Often
5 ---- Always

1. I enjoy being child-like sometimes. 1 2 3 4 5
2. I am accepting of the child part of myself. 1 2 3 4 5
3. I enter new relationship with children with confidence and relaxation.
4. I am a warm and friendly person to children. 1 2 3 4 5
5. I usually provide too many answers to children. 1 2 3 4 5
6. I have a high tolerance for ambiguity. 1 2 3 4 5
7. I am vulnerable and make mistakes at times. 1 2 3 4 5
8. I know myself and accept myself as who I am. 1 2 3 4 5
9. I have a sense that children trust me. 1 2 3 4 5
10. I appreciate my childhood. 1 2 3 4 5

On the following statements, please indicate your agreement or disagreement with each statement in the following manner:

1 --- Strongly Disagree
2 --- Disagree
3 --- Undecided
4 --- Agree
5 --- Strongly Agree

11. Children's behavior is usually unpredictable. 1 2 3 4 5
12. The underlying motivation of children's behavior can be understood. 1 2 3 4 5
13. Children are basically miniature adults. 1 2 3 4 5
14. Children are irresponsible. 1 2 3 4 5
15. Children possess a tremendous capacity to overcome obstacles and circumstances in their lives. 1 2 3 4 5
16. Children's behavior is usually explainable. 1 2 3 4 5
17. Since children are in the process of developing, they do not usually experience the depth of emotional pain adults are capable of experiencing. 1 2 3 4 5
18. Children are capable of positive self-direction if given an opportunity to do so. 1 2 3 4 5
19. How things seem to children is more important than what has actually happened. 1 2 3 4 5
20. Children's behavior needs to be molded and directed for optimal growth and adjustment. 1 2 3 4 5
21. Children's behavior is usually understandable.  
22. Children can be helped to grow and mature faster.  
23. Children usually need considerable structure and direction since they are still learning and developing.  
24. Children are capable of figuring things out.  
25. Children are resourceful.  
26. Children are unkind.  
27. Children tend to make the right decision.  
28. Children need a capable adult to point them in the right direction.  
29. Children think before they act.  
30. Children are capable of insight into their own behaviors.  
31. Children are unfeeling.  
32. Children can be trusted.  
33. Children will outgrow most of their problems.  
34. Most children are able to express their feelings, frustrations, and personal problems through verbal expression.  
35. Adjusted and maladjusted children express similar types of negative attitudes.  
36. Most children need direction from a counselor to work out solutions to their own problems in a counseling relationship.  
37. Typically, an adult must intervene physically or directly to stop most children's aggressive and/or destructive behavior.  
38. Children communicate in much the same way as adults.
39. Adult counselors and play therapists use similar techniques.  
40. Children's natural medium of communication is play and activity.  
41. How the therapist feels about the child is more important than what the therapist knows about the child.  
42. Children do not have emotional disturbance problems. They just lack education and training.  

On the following statements, please indicate your response with each statement in the following manner:  

1 ---- None  
2 ---- Very Limited  
3 ---- Limited  
4 ---- Good  
5 ---- Very Good  

43. In general, how would you rate your knowledge of play therapy as an approach for counseling with children?  
44. How would you rate your understanding of the reasons for selecting and excluding toys and materials in play therapy?  
45. How would you rate your awareness of your own feelings when you are relating to children?  
46. In general, how would you rate your knowledge of how children communicate?  
47. In general, how would you rate your knowledge of identifying areas where limits should be set.  

At the present time, how would you rate your own understanding of the following terms:  

48. "Play theme"  
49. "Tracking"
50. "Returning responsibility" 1 2 3 4 5
51. "Therapeutic limit setting" 1 2 3 4 5
52. "Choice giving" 1 2 3 4 5
53. "Play materials" 1 2 3 4 5
54. "Play therapy" 1 2 3 4 5
55. How would you rate your ability to conduct a play therapy session with a child? 1 2 3 4 5
56. How would you rate your ability to effectively assess the mental health needs of a child? 1 2 3 4 5
57. How well would you rate your ability to distinguish differences in counseling adults and children? 1 2 3 4 5
58. How would you rate your ability to identify the strengths and weaknesses of verbal therapy in terms of their use with different age children? 1 2 3 4 5
59. How would you rate your overall ability to relate to children? 1 2 3 4 5
60. How would you rate your ability to achieve the frame of reference of a child? 1 2 3 4 5
61. In general, how would you rate yourself in terms of being able to effectively deal with a silent child in play therapy? 1 2 3 4 5
62. How would you rate yourself in terms of being able to effectively deal with an aggressive child in play therapy? 1 2 3 4 5
63. How would you rate yourself in terms of being able to effectively deal with a reluctant anxious child in play therapy? 1 2 3 4 5
64. How well would you rate your ability to discuss the issue of confidentiality with parents? 1 2 3 4 5
65. How would you rate your ability to help parents understand their children? 1 2 3 4 5
66. In general, how would you rate your ability to accurately articulate a child's problem?  

67. How would you rate your ability to critique a play therapy session?  

68. How well do you think you could identify play themes in a play therapy situation?  

69. In general, how would you rate your skill level in terms of being able to provide appropriate counseling services to children?  

70. How would you rate your ability to effectively consult with another mental health professional concerning the mental health needs of a child?  

71. Rate your ability to communicate to a child your understanding of the child's feelings and play activity in play therapy.  

72. Rate your ability to select appropriate toys for play therapy.  

73. Rate your ability to identify children's emotions in play therapy.  

74. Rate your ability to structure the play therapy relationship.  

75. Rate your ability to understand symbolic play in play therapy.  

76. Rate your ability to understand the meaning of children's questions.  

77. Rate your ability to communicate the steps in therapeutic limit setting.  

78. Rate your ability to set limits on children's behavior in play therapy.  

79. Rate your ability to establish a facilitative relationship with a child in play therapy.  

80. Rate your ability to build children's self-esteem without causing dependency in play therapy.
81. Rate your ability to track a child's behaviors in play therapy.

82. Rate your ability to reflect children's feelings in play therapy.

83. Rate your ability to reflect the content of children's play in play therapy.

84. Rate your ability to facilitate children's spontaneity and creativity in play therapy.

85. Rate your ability to facilitate decision making and responsibility by children in play therapy.

86. Rate your ability to verbally match the affective and activity pace of a child in play therapy.

87. Rate your ability to be succinct and specific in communicating with children in play therapy.

88. Rate your ability for self-supervision of counseling relationships with children.
APPENDIX  B

TREATMENT COURSE OUTLINE

EDSS 5700

INTRODUCTION TO PLAY THERAPY
EDSS 5700

INTRODUCTION TO PLAY THERAPY

This course focuses on enhancing the counseling relationship with children by using play media to facilitate expression, self understanding, and personal growth and development. Observation of and supervised experience in play therapy with children are integral parts of the course.

Objectives

The major objectives of the course are to provide students an opportunity to understand and demonstrate competencies in:

1. The basic theoretical approaches to play therapy.
2. Developing a philosophy of and approach to play therapy that is effective for the student.
3. Perceiving the child’s world as viewed by the child.
4. Communicating effectively with children at a feeling/emotional level.
5. Understanding the meaning and implications of children’s behavior.
6. Establishing a helping/facilitative relationship with a child in a play therapy experience.
7. Self-exploration which promotes self-understanding.

Requirements

1. Critique of facilitative responses: class members will critique and respond to excerpts from three partial play therapy protocols.
2. Play therapy micro-practicum: two play therapy sessions, arranged under the supervision of class
members and the instructor provide an opportunity to implement what has been discussed in class. A minimum of four other play therapy sessions will be observed.

3. Self-directed reading: each student is required to turn in a minimum of 20 annotated readings.

4. Exploration papers: two short papers (two to four pages) in which the student explores topics which range from "What characteristics make the play therapist a different adult?" to "characteristics of helpful responses" or other areas that relate to practical concerns.

5. Research paper: the final assignment requires an in-depth synthesis and analysis of class discussions, readings, and library research.

6. Observation of experienced play therapists: each student has an opportunity to observe play therapy sessions in the Child and Family Resource Clinic and also to observe the instructor working with a child.

7. Exam: there is a mid-term exam.

8. Class attendance: since a large part of what we will do in class is experiential, class attendance is considered to be crucial.

Activities

1. Lecture-discussion
2. Group work
3. Role playing
4. Films - tape recordings - video tape
5. Observation of and involvement in play therapy sessions
6. Extensive reading in the field - exploratory papers
Course Outline

I. Rational for Play Therapy
   A. Play and meaning
   B. How children communicate
   C. Differential uses of play

II. The Child’s World
   A. Perception
   B. Understanding children
   C. Children’s needs

III. The Counselor
   A. Personality
   B. Needs
   C. Qualifications
   D. Self understanding
   E. Counselor use of self
   F. Role play

IV. Theoretical Approaches to Play Therapy
   A. Development of play therapy
   B. Basic overview of theories
   C. Significant contributors and their contribution
   D. Common elements of various theories

V. Toys and Materials
   A. Purpose and objectives
   B. Rationale for toy selection
C. Recommended toys and materials

1. Play room

2. Modified setting

D. How children use items in play therapy and meaning

VI. Communicating With Children

A. Active listening

B. Facilitative words and phrases

C. Happenings in the play room

D. Role play

VII. Limits and Handling Aggression

A. Rationale for setting limits

B. Therapeutic limits

C. Situational limits

1. Room

2. Toys

3. Time

4. Counselor

D. Steps in setting limits

E. Role play

VIII. The Play Therapy Hour

A. Initial contact

B. Potential problems with parents

C. Establishing the relationship

D. Children’s questions

E. Problems in the play room
F. Role play

G. Video tape

IX. Play Therapy Micro Practicum

X. Stages of Development in the Play Therapy Process
   A. Recognizing developmental phases
   B. What to expect and when
   C. Termination
   D. Video tape

XI. Play Therapy Micro Practicum

XII. Lessons from Play Therapy
   A. For classroom use
   B. For parents
   C. Implications for counseling with teen-agers and adults

XIII. Play Therapy Micro Practicum

XIV. Evaluating Progress
   A. Providing teachers with feedback
   B. Confidentiality
   C. Working with parents
APPENDIX C

COVER LETTER

RESEARCH INFORMATION FOR SUBJECTS
Dear Participant,

My name is Shu-Chen Kao. I am conducting a research project for my doctoral dissertation that is designed to study how play therapy training influences counselors. This study consists of 2 instruments, the Play Therapy Attitude-Knowledge-Skills Survey and California Psychological Inventory (CPI), that will take approximately 75 to 90 minutes to complete all of them.

Please Remember:

* Your participation in this study is voluntary.
* Your decision whether or not to participate will in no way affect you standing in this class.
* All of your information will remain confidential.
* Please do not sign your name on the instruments.
* Please give the last 4 digits of your home phone as an identifying code. If not applicable, please give the birth day and month instead.
* You may withdraw at any time without affecting your class standing.

If you choose to do so, please:

1) Complete the questionnaires -- Please answer ALL of the questions to the best of your knowledge.

2) Give the questionnaire directly to the researcher or return it in the envelope (a third party will collect it).

3) If you would like to receive the detail report (3 pages) of your California Psychological Inventory. You may use the enclosed envelope and write down your address and a name, number, or any characters identical with characters that you prefer to put on the CPI answering sheet. After I finish this project, I will mail it to you as soon as possible.

At the conclusion of the study, a summary of group results will be made available to all interested participants. Should you have any questions or desire further information, please feel free to call me at (817)484-5198.

THANK YOU IN ADVANCE FOR YOUR TIME AND PARTICIPATION
This project has been reviewed and approved by the UNT Committee for the protection of Human Subjects.
APPENDIX D

CPI PROFILE OF BEGINNING PLAY THERAPISTS
Mean scores of 20 CPI scales:

Dominance: 59.73
Capacity for Status: 53.89
Sociability: 54.65
Social Presence: 53.46
Self-acceptance: 56.00
Independence: 56.59
Empathy: 55.57
Responsibility: 53.95
Socialization: 51.62
Self-control: 52.97
Good Impression: 49.89
Communality: 56.16
Well-being: 50.81
Tolerance: 56.00
Achievement/Conformance: 56.81
Achievement/Independence: 58.59
Intellectual Efficiency: 51.62
Psychological-mindedness: 56.22
Flexibility: 52.22
Femininity/Masculinity: 47.57
REFERENCES


Fitch, J. L. (1991). Exploring the relationship between the strength of authoritarian attitudes and the stage of professional education of counselors and counselors in training (Doctoral dissertation, University of Wisconsin-


