CHILD-CENTERED PLAY THERAPY PARENT SERVICES:

A Q-METHODOLOGICAL INVESTIGATION

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Child-centered play therapy (CCPT) is an empirically supported and developmentally appropriate counseling intervention for young children. Despite the clinical effectiveness of CCPT with children, no known study has been conducted in which parents were surveyed or interviewed regarding the services they have received as a part of their children's participation in CCPT. Therefore, this study was designed to gain a better understanding of parents' reported needs and expectations in CCPT. This study utilized Q-methodology in which participants completed a Q-sort by actively sorting 40 items on a continuum of least important to most important. Items included services and processes regarded by CCPT scholars and child therapy practitioners as being important to working with parents. Data was collected from 19 parents of children receiving CCPT services in a community-based counseling clinic. Participants included 16 females and 3 males; 15 Caucasian and 4 Hispanic; and 14 biological parents, 2 adoptive parents, and 3 other biological caregivers. Data was analyzed using centroid factor analysis, and results revealed a one factor solution representing 18 of the 19 participants. Eighteen parents reported similar beliefs regarding the processes they consider most and least important to their experience in working with child-centered play therapists. In general, parents' beliefs aligned with CCPT philosophy, particularly in regards to respecting children's natural pace of development and healing. Furthermore, parents shared preferences for play therapists who demonstrate expert knowledge and training and who understand the individual needs of their children. Discussion includes implications for the practice of CCPT and training of future play therapists, limitations of the study, and implications for future research.

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CHAPTER 1

INTRODUCTION

Child-centered play therapy (CCPT) is a counseling intervention used most widely for children 3-9 years old (Cochran, Nordling, & Cochran, 2010; Landreth, 2012; Ray, 2011; VanFleet, Sywulak, & Sniscak, 2010; Wilson & Ryan, 2005). CCPT was first conceptualized by Virginia Axline who was a student of Carl Rogers (Axline, 1974). In CCPT, play therapists follow the core principles of Carl Rogers' person-centered theory while incorporating the power of play. Play is considered the most natural method of communication for children (Axline, 1974). Landreth (2012) explained that play is the language of children and toys are their words. Because young children lack the ability to think abstractly, relying solely on verbal communication restricts ability to fully express their thoughts and feelings and connect with others. Play allows play therapists to communicate with children in a developmentally appropriate way.

In CCPT, play therapists create therapeutic relationships in which children feel safe to be themselves and access their self-healing tendencies toward growth and development. Landreth (2012) clarified, "Child-centered play therapy is a complete therapeutic system, not just the application of a few rapport building techniques, and is based on a deep and abiding belief in the capacity and resiliency of children to be constructively self-directing" (p. 53). It is the relationship a play therapist creates with a child that determines the success of the therapy process. Landreth (2012) and Ray (2011) described core conditions of CCPT which facilitate the creation of therapeutic relationships with children. Landreth emphasized the importance of play therapists expressing realness, warm caring and acceptance, and a sensitive understanding toward children. Similarly, Ray emphasized the importance of play therapists expressing

empathic understanding, unconditional positive regard, and congruence in their relationships with children. Ultimately, “child-centered play therapy is an attitude, a philosophy, and a way of being with children rather than a way of doing something to or for children” (Landreth, 2012, p. 54).

CCPT is focused on facilitation of internal, rather than specific behavioral, change for the child. The intent behind CCPT is to help children strive toward self-actualization and discover their internal strengths (Landreth, 2012). Through CCPT, children:

develop a more positive self-concept, assume greater self-responsibility, become more self-directing, become more self-accepting, become more self-reliant, engage in self-determined decision making, experience a feeling of control, become sensitive to the process of coping, develop an internal source of evaluation, and become more trusting of himself. (p. 85)

Although, internal change is emphasized, empirical evidence has demonstrated CCPT to be an effective and culturally sensitive intervention for a wide variety of children’s problems (Baggerly, Ray, & Bratton, 2010; Lin & Bratton, in press). CCPT has shown effectiveness in improving children’s externalizing disruptive behaviors, internalizing behavior problems, anxiety, depression, self-concept, self-esteem, social behavior, moral reasoning, and teacher-student relationships (Baggerly et al., 2010). Four meta-analyses (Bratton, Ray, Rhine, & Jones, 2005; LeBlanc & Ritchie, 2001; Lin & Bratton, in press; Ray, Armstrong, Balkin, & Jayne, 2014) provided consistent results regarding the effectiveness of play therapy, reporting moderate to large treatment effect sizes. Additionally, greater effectiveness was reported for studies in which parents were involved in play therapy interventions.

According to child-centered theory, parent involvement is not necessary for play therapy to be effective. Child-centered play therapists believe children are inherently capable of positive growth within a therapeutic environment, with or without a parent’s participation in the process

(Axline, 1947). However, most CCPT scholars believe, and research supports (Bratton et al., 2005), parents can play an important role in CCPT and can often be helpful in further facilitating a child's growth and development (Cochran et al., 2010; Landreth, 2012; Ray, 2011; VanFleet et al., 2010; Wilson & Ryan, 2005). Furthermore, CCPT scholars have stressed the importance of play therapists developing positive working relationships with parents whenever possible, and many have provided extensive guidelines for integrating parents into the process of CCPT (Cochran et al., 2010; Landreth, 2012; Ray, 2011; VanFleet et al., 2010; Wilson & Ryan, 2005).

Statement of the Problem

Engaging parents in CCPT can be an important component to the effectiveness of therapy (Cochran et al., 2010; Landreth, 2012; Ray, 2011; VanFleet et al., 2010; Wilson & Ryan, 2005). However, play therapists often view “working with parents or guardians as the most challenging aspect of counseling with children” (Ray, 2011, p. 141), particularly for those new to play therapy. Child-centered play therapists with more experience typically incorporate parents into play therapy by utilizing the advice of scholars along with their own clinical judgment. Despite the stated importance of involving parents in CCPT, research-informed strategies for parent consultations have not been established, and the process of successfully involving parents is unclear (Bornsheuer & Watts, 2012; Ray, 2011). Although several studies have indicated the need for more research to be completed in order to better understand the needs and expectations of parents and how to successfully incorporate them into the process of CCPT (e.g., Brumfield & Christensen, 2011; Campbell, Baker, & Bratton, 2000; Lolan, 2011), there continues to be a void in the CCPT research literature regarding the perspectives of parents.

Significance of the Study

The purpose of this study is to investigate the views of parents whose children are participating in CCPT. Apart from recommendations and suggestions from CCPT scholars, little

is known about what parents need and expect from child-centered play therapists. No known study has been conducted in which parents were surveyed or interviewed regarding the services they have received as a part of their children's participation in CCPT. Due to the lack of research in this area, this study seeks to understand parents' perceptions regarding the roles of play therapists in working with parents in CCPT. The objective of this study is to gain a more accurate perception regarding the needs of parents in CCPT. The information gained can be used by practitioners to directly impact the practice of CCPT and by university faculty to influence the training of future play therapists. Furthermore, researchers may use the results to guide future studies to establish findings from a broader representation of parents.

Question to be Addressed

This study was conducted in a university-based counseling clinic providing services to the community. Participants included parents of children receiving child-centered play therapy services. This main research question was addressed: What processes/services provided by play therapists are valued by parents of children who are participating in child-centered play therapy?

CHAPTER 2

REVIEW OF LITERATURE

This chapter includes a summary of the literature regarding child-centered play therapy (CCPT), attending specifically to the importance of the therapeutic relationship and non-directive play. Research on CCPT, parent involvement in CCPT, parent involvement and play therapy is reviewed. This chapter concludes with an overview describing Q-methodology, the research design utilized in this study.

Child-Centered Play Therapy

Therapeutic Relationship

Non-directive play therapy, now known as child-centered play therapy (CCPT), originated in the work of Virginia Axline who was a student of Carl Rogers. In her 1947 groundbreaking text, *Play Therapy*, Axline adapted Rogers' non-directive person-centered therapy to her work with children. Axline (1974) explained that play is the natural medium of communication for children, and non-directive play therapy allows children to play out their thoughts and feelings. By playing out their feelings, children are able to face them and process through them. This therapeutic process helps children learn to think for themselves, make their own decisions, and become more psychologically mature. Axline developed eight basic principles to serve as guidelines for facilitating non-directive play therapy with children. These eight basic principles included:

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
4. The therapist is alert to recognize the *feelings* the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behavior.

5. The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
8. The therapist 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)

Because relationships play therapists create with children determine the success of the therapeutic process, play therapists who conduct CCPT sincerely accept the spirit of these eight principles and use them to govern all interactions with children.

Garry Landreth, strongly influenced by the work of Axline and Rogers, as well as Clark Moustakas (1955a; 1955b), further developed the non-directive, child-centered approach to play therapy. Since Landreth's first play therapy text was published in 1982, the field of CCPT has continued to grow and has been conceptualized in depth in multiple texts (i.e., Cochran et al., 2010; Ray, 2011; VanFleet et al., 2010; Wilson & Ryan, 2005). In the third edition of his seminal text, *Play Therapy: The Art of the Relationship* (2012), Landreth described CCPT as being based on the person-centered belief that children have an innate self-directed capacity to strive toward self-actualization when provided with positive growth experiences within genuine, warm, and empathic relationships. Landreth (2012) defined CCPT as:

a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child (or person of any age) to fully express and explore self (feelings, thoughts, experiences, and behaviors) through play, the child's natural medium of communication, for optimal growth and development. (p. 11)

In CCPT, the therapeutic relationship is the primary healing factor for children. Several therapeutic dimensions are necessary in creating a growth-promoting relationship with a child.

For example, play therapists offer respect and acceptance toward children by believing in their abilities to set their own direction to make their own choices. Play therapists focus on the child's need, hear the inner child, and show patience with the healing process. A play therapist's main objective is to create relationships in which children feel safe and free to draw on their innate striving toward growth, self-healing, and constructive self-direction.

In 2011, Dee Ray became the first to devote an entire book to advanced concepts in the practice of CCPT. In *Advanced Play Therapy: Essential Conditions, Knowledge, and Skills for Child Practice* (2011), Ray drew from the work of Rogers, Axline, Landreth, and other person-centered scholars to more thoroughly explain the theoretical connections between Carl Rogers' person-centered theory and CCPT. Ray was the first to explain Rogers' 19 propositions of human development and six necessary and sufficient conditions for therapeutic change as they manifest in the process of CCPT. Like Axline and Landreth, Ray further asserted the importance of a child-centered play therapist embodying the attitudinal qualities of empathic understanding, unconditional positive regard, and congruence. Ray described the necessary core conditions of CCPT as:

(a) empathy – the play therapist must get within the child's world and seek to live the attitudes expressed; (b) unconditional positive regard – a warmth and acceptance of the child; (c) congruence – the play therapist is willing to express any personal feelings that exist within the relationship; and (d) implied conditions such as psychological contact between the play therapist and the child, the child experiencing incongruence, and the child experiencing conditions offered by the play therapist. (p. 297)

It is these core conditions developed within therapeutic relationships between play therapists and children that empower children to access their self-enhancing tendencies.

Non-Directive Play

In CCPT, the therapeutic relationship is provided within the developmentally appropriate environment of the playroom, allowing children to use their natural medium of communication,

play. Play is the language of children, and toys are used as their words (Axline, 1974; Landreth, 2012). According to child-centered theory, play is vital to the therapeutic process and essential to the healthy development of children. Relying solely on verbal communication restricts a child's ability to connect with the play therapist and therefore inhibits the development of the therapeutic relationship. Communicating through play allows the therapist to engage on the child's level (Axline, 1974; Landreth, 2012).

The atmosphere of the playroom is crucial to the effectiveness of CCPT (Landreth, 2012). It is vital that the playroom be warm and inviting for children, encouraging them to freely express themselves. Toys should be carefully selected, not collected. All toys in the playroom should be developmentally appropriate, engaging of children's interests, and facilitate a wide variety of creative and emotional expression. Above all, toys should be selected based on the extent to which they are consistent with the theoretical rationale of CCPT (Landreth, 2012).

Unstructured, self-initiated play allows the opportunity for children to more fully express themselves, unleashing their self-healing tendencies (Axline, 1974; Landreth, 2012). By not directing the child's play, the play therapist allows the opportunity for children to express independent thoughts and actions, resolve conflicts, and communicate their feelings. Typically, children younger than 11 years old are unable to think and reason abstractly and to fully express their thoughts and emotions verbally. Play allows children to concretely express themselves and therefore cope with their worlds (Landreth, 2012).

Objectives

At the heart of CCPT lies the creation of a therapeutic relationship between the child and play therapist within the context of an environment that allows the child to freely express herself through non-directed play. This process allows the child to experience positive growth in several

areas. The overarching goal of CCPT is the child's striving toward self-actualization by discovering internal strengths (Landreth, 2012). Landreth (2012) described objectives of CCPT as helping the child to:

develop a more positive self-concept, assume greater self-responsibility, become more self-directing, become more self-accepting, become more self-reliant, engage in self-determined decision making, experience a feeling of control, become sensitive to the process of coping, develop an internal source of evaluation, and become more trusting of himself. (p. 85)

These objectives are focused on the person of the child rather than specific behaviors or diagnostic criteria. What is most powerful about CCPT is the intuitive learning process that children experience, more so than cognitive learning. Specific objectives are not imposed by the play therapist; rather, what the child learns is dependent upon each child's individual experience and self-direction (Landreth, 2012).

Research on Child-Centered Play Therapy

Empirical evidence has demonstrated CCPT to be an effective intervention for a wide variety of children's problems. Play therapy research dates back over 60 years, and four meta-analyses (Bratton et al., 2005; LeBlanc & Ritchie, 2001; Lin & Bratton, in press; Ray et al., 2014) provided consistent summaries of the effectiveness of play therapy, each reporting moderate to large treatment effect sizes. Bratton et al. (2005) specifically examined humanistic play therapy interventions (CCPT and other non-directive play therapy approaches) and reported a large treatment effect size, $ES = 0.92$, across all studies examined. Additionally, Bratton et al. found greater effectiveness for studies in which parents were involved in the play therapy interventions ($ES = 1.15$). Despite a lack of explicit focus on behavioral change, CCPT has shown effectiveness in improving children's externalizing disruptive behaviors, internalizing

behavior problems, anxiety, depression, self-concept, self-esteem, social behavior, moral reasoning, and teacher-student relationships (Baggerly et al., 2010).

Ray et al. (2014) and Lin and Bratton (in press) both conducted meta-analyses specifically examining the effectiveness of CCPT. Ray et al. reviewed 23 experimental outcome studies using CCPT in elementary schools. They found CCPT to be statistically significantly effective for externalizing problems, internalizing problems, total problems, self-efficacy, academic progress, and other behaviors. Lin and Bratton utilized highly stringent research methods to review 52 experimental design studies conducted from 1995 to 2010. They found an overall effect size of 0.47 across all studies examined and concluded CCPT to be an effective counseling intervention for children. This is lower than the effect size found by Bratton et al. (2005); however, they calculated this effect size more stringently utilizing a higher level of methodological rigor which involved using hierarchical linear modeling (HLM). Moreover, they suggested CCPT to be a culturally sensitive approach to working with children. Non-Caucasian children participating in CCPT experienced substantially greater improvements than Caucasian children. Additionally, individual studies have shown CCPT to be effective with Hispanic, Chinese, Puerto Rican, African American, Japanese, Kenyan, and Iranian children (Landreth, 2012).

Parent Involvement in Child-Centered Play Therapy

Axline (1974) was the first to describe the role of parents in CCPT. According to child-centered theory, parent involvement is not necessary for play therapy to be effective. Children are inherently capable of positive growth within a therapeutic environment, with or without a parent's participation in the process. Axline (1974) described, "The capacity within the individual to adjust to the conditions that he is sometimes forced to face is far greater than it is

usually thought to be” (p. 68); therefore, children do not necessarily need a parent’s direct support to aid in their adjustment. However, parents can indeed help therapy to move faster and create a larger impact on the child. Parents who show a willingness to participate in their children’s therapy can be helpful, and their participation is desired, though not essential, in CCPT. Therefore, Axline did not provide specific suggestions or procedures for involving parents in CCPT.

Establishing Relationships with Parents

Landreth (1991) was among the first to thoroughly discuss the role of parents in CCPT. Landreth (2012) agreed with Axline that children can grow and heal through play therapy without their parents being involved. However, Landreth further described parent involvement as being crucial to the overall success of CCPT, and he considered it a primary role of the play therapist to facilitate a parent’s involvement in CCPT. Landreth suggested that, first and foremost, play therapists should work diligently to build trusting relationships with parents, focusing on their needs, and conveying their importance to their child’s therapy. Any attempt to be helpful to a child should begin with consideration of establishing a relationship with the parents.

Like Landreth, many CCPT scholars have continued to stress the importance of developing positive relationships with parents (Cochran et al., 2010; Ray, 2011; VanFleet et al., 2010; Wilson & Ryan, 2005). Cochran et al. (2010) repeatedly stressed the importance of play therapists conveying “deep empathy,” genuineness, and unconditional positive regard toward parents (p. 287). The most prominent problem frequently faced by child-centered play therapists is “skipping the step of building an empathic relationship and alliance with these key caregivers

in the child's world" (p. 286), and failing to create a working alliance with parents may jeopardize the play therapy process.

When parents seek play therapy services, they often feel overwhelmed, and may feel inadequate or helpless to support their children. Further, they may feel confused, anxious, ashamed, or embarrassed about seeking help (Wilson & Ryan, 2005). Landreth (2012) urged play therapists to focus on parents' emotional needs by explaining that it is essential for parents to feel heard and understood by play therapists. If a play therapist fails to create emotional contact with a parent at the beginning of therapy, the parent may be less likely to trust the therapist, be less consistent in bringing the child to sessions, or terminate therapy prematurely. Because the relationship between parent and play therapist can be foundational to the effectiveness of CCPT, CCPT theorists encourage play therapists to work to create safe environments in which parents can trust play therapists.

Initial Meetings with Parents

In addition to establishing working alliances with parents, CCPT scholars have outlined multiple tasks for play therapists to complete during an initial meeting with a parent (Cochran et al., 2010; Landreth, 2012; Ray, 2011; VanFleet et al., 2010; Wilson & Ryan, 2005).

Emphasizing the importance of the relationship, Cochran et al. (2010) delineated five truths that should be conveyed by child-centered play therapists to all parents whose children participate in CCPT. The authors recommended that all parents, when leaving their first meeting with a play therapist, should know the following:

1. A parent should know that you care for him and his child.
2. A parent needs to know that you understand her and her child's situation in order to trust you with her child.
3. A parent needs to know that you see the underlying positive in who he is as a parent.
4. A parent needs to know that you have a plan, that you know what you are doing, and can follow procedures known to work.

5. A parent needs to know that follow-up communication will be a part of your work. (pp. 259-260)

If parents begin CCPT without trusting these essential components, they may be less invested in the therapy process and could terminate services prematurely.

Other important tasks that should be completed during initial meetings with parents include an explanation of play therapy, how CCPT works, and what parents can expect during the process of CCPT (Cochran et al., 2010; Landreth, 2012; Ray, 2011; VanFleet et al., 2010; Wilson & Ryan, 2005). CCPT scholars have repeatedly stressed the importance of parents understanding the play therapy process, and most texts contain sample dialogue as examples to help play therapists explain CCPT in parent-friendly language. Further, logistical issues such as scheduling future meetings with parents and helping parents respond to potential concerns such as separation anxiety may also need to be discussed in the initial meeting (Landreth, 2012). Additionally, play therapists are advised to gather background information sufficient enough to conceptualize the parent's concerns (Cochran et al., 2010; Landreth, 2012; Ray, 2011; VanFleet et al., 2010; Wilson & Ryan, 2005). Ray (2011) provided a detailed developmental history questionnaire that play therapists can use to help clarify parents' concerns for their children and further conceptualize individual children. Moreover, CCPT scholars stressed the importance of addressing ethical and legal issues such as informed consent and confidentiality in initial meetings with parents (Cochran et al., 2010; Landreth, 2012; Ray, 2011; VanFleet et al., 2010; Wilson & Ryan, 2005).

Despite an emphasis on covering the aforementioned tasks during the first meeting with a parent, CCPT scholars continued to stress the importance of focusing on genuinely engaging with the parent and building a strong working alliance (Cochran et al., 2010; Landreth, 2012; Ray, 2011). Ray (2011) asserted definitively, "The first parent consultation has one primary

goal: to develop a relationship with the parent so that the parent brings the child in for a first play therapy session” (p.145). Indeed, if the task of establishing a trusting relationship with a parent is established in the first meeting, future meetings will provide opportunities for all of the other tasks to be revisited. Although all of these tasks are important to structuring CCPT, these other tasks become unnecessary if parents fail to attend future sessions due to a lack of trust in the play therapist. Therefore, CCPT experts advised all of the tasks must be accomplished intentionally with a primary focus on building a relationship with the parent (Cochran et al., 2010; Landreth, 2012; Ray, 2011).

Parent Consultations in CCPT

Ray (2011) described parent consultations in CCPT as consistent communication with parents by play therapists in order to provide support, teach knowledge or skills, and monitor therapeutic progress. Landreth (2012) recommended child-centered play therapists schedule parent consultation sessions at least once every four CCPT sessions for continued communication and relationship-building. CCPT scholars have generally agreed that frequent parent consultations should be held to gather additional information about children and their families, establish and monitor treatment goals, provide feedback to parents regarding their children’s progress, and address parents’ concerns (Cochran et al., 2010; Landreth, 2012; Ray, 2011; VanFleet et al., 2010).

In light of the recommendation that child-centered play therapists establish and monitor goals in CCPT, Post, Ceballos, and Penn (2012) reported that CCPT texts have provided “a lack of attention to how child-centered play therapists can effectively set specific measurable behavioral goals while maintaining the integrity of the philosophical tenants of the child-centered approach” (p. 6). The authors put forth a model of parent consultation designed to help play

therapists collaborate with parents to establish behavioral goals for children in CCPT. Ray (2011) described another approach that could be used by play therapists to guide parent consultation sessions. Ray conceptualized parent consultations as times for listening to parents' concerns, providing feedback regarding the therapy process, and teaching parents new parenting skills. She suggested play therapists enact the following four steps during each parent consultation: (1) Check in with the parent; (2) Inform parent of progress in play therapy; (3) Teach one skill-based concept at a time; and (4) Role-play skills concept (pp. 155-159). Other CCPT scholars have agreed that parent consultations are appropriate for teaching parents new parenting skills to improve communication with their children or respond to behavioral difficulties (Cochran et al., 2010; Landreth, 2012; VanFleet et al., 2010; Wilson & Ryan, 2005).

Landreth (2012) and Ray (2011) suggested child-centered play therapists teach parents basic therapeutic skills used in CCPT, such as reflection of content and feelings, choice-giving, building self-esteem, returning responsibility, and limit setting. According to Landreth, parents should be included in the play therapy process when appropriate due to the significant roles they play in children's lives. Ray (2011) asserted that parents often lack communication skills needed to improve relationships with their children; by teaching new parenting skills, play therapists help parents create environments of growth for the children in addition to what they experience in CCPT. In addition to CCPT skills, Ray suggested play therapists incorporate other parenting skills, specifically effective communication strategies and problem-solving methods, into parent consultations when appropriate. Additionally, VanFleet et al. (2010) asserted that play therapists may sometimes need to help parents with other needs via interventions such as, "establishing good bedtime routines, creative behavior modification programs for chores or morning routines, structuring an environment conducive to doing homework, and so on" (p.114). CCPT scholars

have stressed the importance of understanding and responding to the unique needs of individual children and families, acknowledging different strategies may be more effective with different families.

Landreth (2012) suggested play therapists consider moving beyond teaching parents basic CCPT skills and consider training them in filial therapy. In filial therapy, a parent learns basic CCPT skills and conducts special play sessions with his or her child, thereby becoming the therapeutic agent for the child. In filial therapy, the parent, rather than the play therapist, creates an environment that helps the child reach his or her full potential (Landreth & Bratton, 2006). Landreth and Bratton (2006) further emphasized the benefits of filial therapy for both children and parents, explaining the overall goal of filial therapy is to improve the parent-child relationship by improving communication, improving problem-solving, and increasing feelings of affection, warmth, and trust between the parent and the child.

Cochran et al. (2010) and VanFleet et al. (2010) also strongly encouraged the use of filial therapy as an adjunctive service to CCPT. The authors further suggested that filial can be effectively used as a transitional experience for both parents and children as children begin the process of termination from play therapy. By learning filial therapy skills, parents are able to provide a supportive growth environment for the child apart from therapy.

Play therapists may be unable to meet all the needs of a parent or child (Cochran et al., 2010; Landreth, 2012; Ray, 2011; VanFleet et al., 2010; Wilson & Ryan, 2005). Under these circumstances, parent consultation represents a time in which play therapists may discuss referral options with parents. Typical referrals include personal counseling for the parent (Cochran et al., 2010; Landreth, 2012; Ray, 2011; VanFleet et al., 2010; Wilson & Ryan, 2005), couples counseling for the parents (Cochran et al., 2010), parenting groups for the parents (Wilson &

Ryan, 2005), or other adjunctive services for the child such as medical evaluation, psycho-educational assessment, speech therapy, or occupational therapy. Parent consultations may also be used to explore ways in which play therapists can collaborate with other professionals in the lives of children such as teachers, school counselors, psychiatrists, or other health care professionals (Cochran et al., 2010; Landreth, 2012; Ray, 2011; VanFleet et al., 2010).

Lack of Research on Parent Consultations in CCPT

CCPT has been conceptualized by multiple scholars, all of whom have offered suggestions regarding working with parents in CCPT (Cochran et al., 2010; Landreth, 2012; Ray, 2011; VanFleet et al., 2010; Wilson & Ryan, 2005). However, little research evidence exists to support these suggestions. Further, Ray (2011) explained that play therapists often view “working with parents or guardians as the most challenging aspect of counseling with children” (p. 141). Despite the stated importance of aligning with parents in the process of CCPT:

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

Engaging parents in CCPT is an important component to the effectiveness of therapy; however, research informed practice regarding parent consultation in CCPT is lacking.

Bornsheuer and Watts (2012) recently completed a review of best practices regarding play therapy and parent consultation. The authors reported a lack of literature specifically related to parent consultations in child-centered play therapy. The authors’ intention was to contribute to the literature by summarizing and conceptualizing suggestions for play therapists

conducting parent consultations in CCPT. The authors reviewed the work of CCPT scholars, noting similarities and differences in their advice on working with parents, and they recommended that play therapists utilize multiple models of CCPT parent consultations to best address the individual needs of diverse families. Because the article served primarily as a literature review, it was theoretical in nature, rather than empirical and the authors' suggestions, like those of other CCPT scholars, are not supported by empirical evidence, and thereby further indicate the need for a more thorough examination.

Research on Parents and Play Therapy

Parent involvement in CCPT can be vital to the success of CCPT. CCPT is undoubtedly unsuccessful if parents fail to bring their children to play therapy sessions. Parents may terminate play therapy prematurely for a variety of reasons, for example, a lack of relationship with the play therapist, the parent's perception of play therapy, personal stress, or external variables such as financial concerns, transportation issues, or schedule conflicts. Campbell et al. (2000) investigated drop-out rates of children participating in play therapy in an attempt to understand why some families terminate services prematurely. The researchers examined client records at a community mental health clinic and discovered a drop-out rate of 64%. Results revealed that completion or termination of treatment was related to demographic and family life situation factors. Single mothers under severe stress with children exhibiting externalizing behaviors were more prone to premature termination. Younger mothers and mothers with lower levels of education were also likely to drop out of play therapy early. The authors offered several suggestions for play therapists to reduce drop-out rates. Among them was the suggestion that more time be spent consulting with, training, and involving parents in the play therapy process.

These results are supported by other research studies regarding general child therapy. Several studies have been conducted to examine characteristics related to a child's successful completion of therapy, and many of these findings have been related to parents. Kazdin and Mazurick (1994) found parents who were younger, single-parents, non-biological parents, parents who identified with a minority group, and parents who reported higher levels of stress were more likely to end therapy early. Venable and Thompson (1998) found that parents who were highly self-critical or held feelings of guilt toward their children were more likely to terminate therapy. Nock and Kazdin (2001) found that parents who had very high or very low expectations regarding the therapy process were more likely to complete therapy, whereas parents with moderate expectations were more likely to end early. Each of these studies supports the importance of involving parents in their children's therapy, yet more research is needed to determine the most effective strategies.

Specific to play therapy, Brumfield and Christensen (2011) conducted a phenomenological study in which they interviewed eight African-American caregivers about their attitudes, beliefs, and perceptions regarding play therapy. Results revealed the parents' receptivity to play therapy was related to several facilitative factors and impeding factors. Facilitative factors included elements outside the play therapy process such as perceived support from family and the larger community, reliability of the referral source, and information regarding resources. Several factors influenced parents' decisions not to seek play therapy: (a) negative past experiences in counseling, (b) fears of being judged as a "failure" as a parent, (c) worry about the counselor's ability to maintain confidentiality, (d) negative or inaccurate media portrayals of counseling and those who seek counseling, and (e) cultural perceptions of counseling. The authors concluded, "overall parents seemed in favor of play therapy and

counseling for their children as long as the impending issues were addressed” (p. 217). They further concluded that all eight parents reported their opinions and perceptions of play therapy were related to their perceptions of the play therapist’s competence. They also reported that the parents’ demographic characteristics such as religion, education, and economic status impacted their beliefs about play therapy. Brumfield and Christensen concluded by recommending a quantitative study, such as survey research, to investigate the perceptions of play therapy held by African-American parents as well as other ethno-cultural groups.

Lolan (2011) developed the Caregiver Engagement Inventory (CEI) to investigate play therapists’ perceptions of factors that influence caregiver engagement in play therapy. Lolana’s study was the first to examine interventions used by play therapists to facilitate caregiver involvement in play therapy along with play therapists’ perceptions as to how these interventions affect the child’s outcome. Among the results, play therapists reported their theoretical orientation influenced their approach to caregiver engagement. Fifty-eight percent of the 431 play therapists surveyed identified as practicing CCPT. The play therapists who were surveyed identified their top three caregiver engagement strategies as conducting a psychosocial assessment (63%), obtaining information about the caregiver’s family of origin (52%), and engaging in collateral communication (49%). Play therapists perceived these strategies as being effective; they identified caregiver support groups as being least effective. Sixty-nine percent of those who responded identified that they “strongly agree” with the statement “I believe caregiver involvement is related to the therapeutic outcome for the child client” (p. 142). Play therapists perceived the three most common barriers to play therapy services as financial concerns (51%), caregivers’ lack of education about play therapy (54%), and working with clients who are mandated by an outside party to receive services (40%). Lolana urged play therapists to place

emphasis on understanding parents' perceptions of play therapy and concluded that future research should be aimed at gaining a greater understanding of barriers to caregiver involvement in play therapy and informing training practices for future play therapists.

Introduction to the Research Design: Q-Methodology

Q-methodology was developed in 1935 by William Stephenson (1953) as a means of measuring participants' subjective viewpoints regarding a specific topic. McKeown and Thomas (1988) summarized Q-methodology by stating:

Fundamentally, Q entails a method for the scientific study of human subjectivity. Subjectivity, in the lexicon of Q-methodology, means nothing more than a *person's communication of his or her point of view*. As such, subjectivity is always anchored in *self-reference*, that is, the person's 'internal' frame of reference, but this does not render it inaccessible to rigorous examination. (p. 12)

Thus, Q-methodology allows for "rigorous examination" of participants' perspectives of the topic being investigated. Q-methodology is ideal in circumstances in which little is known about a population's beliefs and values. By using Q-methodology, researchers are able to examine participants' experiences and gain insight into areas previously underexplored.

Q-methodology combines the statistical rigor of factor analysis with a data collection method known as Q-sort in which participants actively engage to express their subjective viewpoints. As such, Q-methodology is considered a mixed methods approach that combines both qualitative and quantitative means to access participants' personal experience, values, and beliefs (Shemmings, 2006).

Watts and Stenner (2012) explained that a well-designed Q study allows researchers to see holistic viewpoints of all participants. Additionally, Q-methodology allows for participants to be sorted, or factored, into groups, identified by the key viewpoints that they share. By combining the Q-sort data collection method with factor analysis, the views of each of the groups

are understood with a high level of qualitative and quantitative detail. It is these qualities that set Q-methodology apart from all other research methodologies. Q-methodologists (Brown, 1996; Ernest, 2011; Sexton, Snyder, Wadsworth, Jardine, & Ernest, 1998) described the method as neither purely quantitative nor qualitative, but rather a combination of the two different research approaches. Due to the unique combination of both research approaches, Q-methodology is considered a robust method for approaching inherent difficulties in studying the beliefs, values, and attitudes of a population (Cross, 2005).

Q-Methodology Research

Q-methodology has been employed in a wide variety of disciplines from political science, communication science, psychology, sociology, nursing, higher education, dream research, tourism research, and public policy analysis, among many others (Watts & Stenner, 2012). Q-methodology is considered a robust method for examining beliefs and values of populations that have been traditionally underexplored. Q-methodologists have claimed the combination of qualitative and quantitative approaches gives Q-methodology an advantage over other methods. Factor analysis allows for the statistical rigor of a purely quantitative approach, while the Q-sort allows participants to share their own unique perspectives (Watts & Stenner, 2012). Papworth and Walker (2008) believed that Q-methodology may assess participants' beliefs more accurately due to decreased opportunities for participants to respond in socially desirable ways. The authors further asserted that the Q-sort method of data collection has advantages over qualitative approaches such as an interview or questionnaire, because participants are actively engaged while responding to each statement in relation to every other statement, providing a more thorough and fluid depiction of their beliefs.

Q-methodology has been utilized in psychotherapy research to examine perspectives of clients and service providers (e.g., Absalom-Hornby, Hare, Gooding, & Tarrier, 2012; Papworth & Walker, 2008; Shinebourne & Adams, 2007). Furthermore, Q-methodology has been repeatedly used to assess parents' perceptions of services received by their children (Ernest, 2011; Sexton et al., 1998; Szente, Hoot, & Ernest, 2002).

Sexton et al. (1998) utilized Q-methodology to explore views of parents of children enrolled in early intervention programs. The study was designed to explore the importance that parents placed on family-centered practices that had been identified by early childhood professional organizations as indicators of program quality. The researchers modified a previously used 71-item Q-sort for use in this study. One example of an item to be sorted by the parents was, "Professionals ask parents what they want before telling them what the program does" (p. 102). Q-sorts from 35 parents from across six early intervention programs were used for data analysis. The results revealed viewpoints from three distinct parent groups.

Each group was, in part, defined by items the participants rated as most important and least important along with other demographic variables. The first group was defined by values that reflected personal communication that was honest and understandable. They preferred to be actively engaged in decision-making and to be encouraged to meet the needs of their children independently. They placed least value on professionals listening and talking positively about them and their children. This group consisted of mostly White mothers with high monthly incomes. The second group consisted mostly of Black and Hispanic mothers with lower monthly incomes. This group most highly valued professionals who convey support for the parents' priorities even when they conflict with those of the professional. They also valued professionals who prepared parents for assessment procedures and ask them what they are doing to

accomplish their established goals. They considered the professionals' attempts to understand their cultural values as relatively unimportant. The third group consisted of mostly White mothers, and they perceived the program to be more valuable to their children than the other two groups of parents. These parents most highly valued professionals who responded positively to their ideas and who told them something positive about their children. They placed least value on testing and assessment procedures in general.

Sexton, et al. (1998) utilized Q-methodology to better understand the perspectives of parents seeking services in early intervention programs. The researchers found the Q-sort to be informative in helping to understand the various needs of parents seeking early intervention services. The authors concluded that Q-methodology proved to be a useful tool in examining parents' beliefs along a continuum of significance. They further asserted Q-methodology could be effectively combined with more traditional quantitative approach to research to further examine the effectiveness of early intervention practices.

Szente et al. (2002) conducted a similar study examining beliefs of Hungarian teachers and parents of children in preschool and first grade. The study was designed to examine parents' and teachers' beliefs regarding developmentally appropriate practices identified by the National Association for the Education of Young Children (NAEYC). In this study, 14 parents and 14 teachers were asked to complete a Q-sort consisting of 30 developmentally appropriate practices and 30 developmentally inappropriate practices along a continuum of most appropriate to most inappropriate. The results indicated three groups representing three distinct viewpoints. The researchers conceptualized these groups as: (1) focusing on children's individual development and learning, (2) focusing on teaching children according to traditional teaching methods, and (3) focusing on respecting diversity in schools, children, and families. The researchers used this

study to support previous findings regarding NAEYC guidelines. Further, they indicated that parents' and teachers' views must be more clearly understood if stakeholders were to foster successful parent and school collaboration as NAEYC guidelines advocated.

Ernest (2011) used the same 60 item Q-sort in England to examine the views of parents, teachers, and teacher candidates regarding developmentally appropriate practices in early childhood education as identified by the NAEYC. Fifteen parents, 23 teachers, and 15 teacher candidates were asked to sort the 60 items along a continuum of most appropriate to most inappropriate. In analyzing the results, the author identified groups representing three views which he conceptualized as: (1) cultural responsiveness, (2) social cohesiveness through communication, and (3) teacher as change agent. The author concluded that if NAEYC guidelines are to be effectively implemented in early childhood programs, "Individuals have to be approached in terms of their own priorities, values, beliefs, and opinions. Q-methodology offers researchers a powerful mixed methods way to provide accounts of this type of subjectivity" (p. 234).

Conducting Q-Methodology

All Q-methodological studies are comprised of at least two distinct parts (Watts & Stenner, 2012). First, participants share their beliefs and values using a Q-sort compiled by the researcher. Secondly, factor analysis is used to analyze data collected from the Q-sorts and determine groups of participants who share similar perspectives.

Q-Sort

In a Q-sort, each participant is presented with a Q-set, a collection of items or statements developed by the researcher. Researchers present the statements to participants and instruct them to sort the statements along a subjective dimension such as most agree to least agree, most

important to least important, or most like me to least like me. For example, a diagram similar to Figure 2.1 would be presented to each participant along with statements printed on individual cards. Participants place one statement card in each square. The size and shape of Q-sort distribution grids vary depending on the number of statements to be sorted; regardless of the number of statements, each participant sorts all statements. By sorting the items, each participant provides a concrete representation of his or her viewpoint of the topic the researcher desires to analyze. Q-sorts can also be administered through electronic software.

Figure 2.1. Sample Q-sort distribution grid.

Ipsative data could be collected by asking participants to rank-order all items individually. If given 40 items, participants would rank each item from 1 to 40, with 1 being most important and 40 being least important. However, the cognitive complexity of this type of task can be uncomfortable and overwhelming for participants (Thompson, 2000). A compromise

between the Q-sort method and a rank-order approach is the mediated Q-sort. A mediated Q-sort involves having participants complete a traditional Q-sort (see Figure 2.1) and then rank-order, with no ties, the items placed in each column. This achieves the same distribution of the data as a rank-order, but it is a less stressful task for participants (Thompson, 2000). Figure 2.2 depicts an example of a completed Q-sort grid, while Table 2.1 illustrates how this data would be depicted in a database if collected in a traditional Q-sort compared to a mediated Q-sort.

Least Important			Neutral		Most Important	
-3	-2	-1	0	+1	+2	+3
2	5	6	13	19	23	26
1	3	8	11	22	25	27
	4	7	12	20	24	
		10	14	21		
		9	17	18		
			15			
			16			

Figure 2.2. Sample completed Q-sort distribution grid.

Table 2.1

Database Entry for Traditional Q-Sort vs. Mediated Q-Sort

Item #	Traditional Q-Sort	Mediated Q-Sort
1	1	2
2	1	1
3	2	5
4	2	3
5	2	4
6	3	6
7	3	8
8	3	7
9	3	10
10	3	9
11	4	13
12	4	11
13	4	12
14	4	14
15	4	17

(table continues)

Table 2.1 (*continued*).

Item #	Traditional Q-Sort	Mediated Q-Sort
16	4	15
17	4	16
18	5	19
19	5	22
20	5	20
21	5	21
22	5	18
23	6	23
24	6	25
25	6	24
26	7	26
27	7	27

In a mediated Q-sort, each sorted item is given an individual rank, in this case 1 to 27. In a traditional Q-sort, items sorted in the same column are given the same rank, in this case, 1 to 7; therefore, the mean and standard deviation of the data are limited. Greater variance in data is desired because greater variance is associated with more reliable and replicable data (Thompson, 2010). In this way, the mediated Q-sort represents a statistical advantage over the traditional Q-sort or rank order (Thompson, 2010).

Factor Analysis

Factor analysis is a frequently employed statistical technique researchers use to analyze relationships among variables. Factor analysis is helpful for understanding how multiple variables group together to form factors, reducing the number of variables to represent a construct more parsimoniously, and assessing the construct validity of a set of variables (Kieffer, 1999). There are six approaches to conducting factor analysis (see Table 2.2); however, most researchers are familiar with only one, R-technique (Thompson, 2000). R-technique is most frequently used in constructing assessments aimed at measuring psychological constructs due to

R-technique's usefulness in assessing relationships across variables. Furthermore, R-technique factor analysis is frequently misused by researchers in the mental health field who are interested in gaining better understandings of people rather than variables (Thompson, 2000). If researchers are interested in understanding relationships among a group of people, another type of factor analysis may be more appropriate (Thompson, 2000). Q-technique factor analysis, the second most frequently utilized approach to factor analysis, is the most useful for researchers who intend to better understand people (Thompson, 2000).

In selecting a specific factor analysis technique, researchers should be guided by the research questions they are attempting to address. Mathematically, each of the six techniques is based on three dimensions of data: a) variables/items/objects, b) individuals/subjects/participants, and c) occasions of measurement (Cattell, 1966). Table 2.2 illustrates how each technique has two defining characteristics: a) the types of data being analyzed (i.e. variables, individuals, and occasions of measurement) and b) the position the data is entered into the data matrix (rows vs. columns). It is the position in which data is entered into the raw data matrix that distinguishes the six techniques; the mathematics of the factor analysis process is the same for all six types (Thompson, 2000). Regardless of the technique selected, researchers must make vital statistical decisions concerning appropriate sample size and factor extraction, rotation, and retention. The uniqueness of each technique lies in the interpretation of the results. Researchers must carefully consider the research questions they are attempting to answer in interpreting the meaning and significance of the results obtained from the analysis (Thompson, 2000).

Table 2.2

Six Two-Mode Factor Analysis Techniques

Technique	Columns (what's being factored)	Rows	Constant
R	Variables	Individuals	Occasions
Q	Individuals	Variables	Occasions
P	Variables	Occasions	Individuals
O	Occasions	Variables	Individuals
T	Occasions	Individuals	Variables
S	Individuals	Occasions	Variables

R-technique, or traditional factor analysis, computes statistics from a raw data matrix in which columns represent variables being measured and rows represent individual's scores. In R-technique, all data are collected at one point in time, thus holding occasions of measurement is held constant, meaning all of the data is collected at one point in time. The columns of the data matrix represent the dimension of data the researcher is intending to factor. In Q-technique, like R-technique, individuals and variables are both analyzed, but they are entered into the data matrix in the opposite way. Q-technique factor analysis results in groups of people, rather than variables, being sorted into factors. Again, data are collected at one point in time.

Q-technique factor analysis is used to analyze data collected from Q-sorts and determine intercorrelations among responses of all participants. Each individual participant produces an individual Q-sort which represents his or her individual beliefs, and the researcher uses factor analysis to investigate similarities and differences among Q-sorts collected from all participants in the study. Factor analysis allows the researcher to “conduct a *direct* and *holistic* comparison” of the completed Q-sorts and see patterns among the participants' viewpoints (Watts & Stenner, 2012, p. 17). Watts and Stenner (2012) explained, “Q-methodology will potentially identify a group of persons who share a similar perspective, viewpoint or attitude about a particular topic,

or who seem to be, in this context at least, of a similar *type*” (p. 18). The end result of the factor analysis is the emergence of one or more groups of participants who share similar beliefs.

Participants who sorted their responses similarly during the Q-sort will factor together to create these factor groups.

PQMethod (Schmolck, 2014) is a statistical software package specifically designed for the purpose of analyzing Q-methodology data. PQMethod requires researchers to enter the items included in the Q-set as well as dimensions for the size and shape of the Q-sort template (i.e. number of columns and number of items under each column). Data are then entered into the database in the same fashion in which they are reported by participants. Although SPSS and other similar statistical software programs are capable of handling Q-methodology data, data must first be transposed to represent traditional R-technique factor analysis in order for the software to recognize this type of analysis, and it is therefore not recommended (Watts & Stenner, 2012).

After data are entered, PQMethod assesses missing and duplicate items for each participant to ensure accuracy. The software then computes a correlation matrix, examining the relationships among all the Q-sorts. The researcher must then decide upon a factor extraction method. PQMethod performs principal component analysis (PCA) and centroid factor analysis. Centroid factor analysis is the most preferred and recommended factor analysis method for extracting factors in Q-methodology (Brown, 1980; Stephenson, 1953; Watts & Stenner, 2012). Centroid factor analysis is rarely used outside of Q-methodology, but it is preferred by Q-methodologists over the more frequently used PCA because it allows researchers more freedom in exploring data. Whereas PCA provides the single best mathematical solution, Q-methodologists prefer centroid factor analysis, which instead leaves all possible solutions open,

allowing researchers to explore the data and make decisions regarding best solutions. Q-methodologists often find that the best mathematical solution is often not the most informative or meaningful for Q-methodological studies (Watts & Stenner, 2012). During the factor extraction process, PQMethod computes a table of factor loadings which includes correlations of each Q-sort to each extracted factor. Researchers examine the factor loadings along with computed eigenvalues in the same method as traditional R-technique factor analysis to determine how many factors to retain and which Q-sorts make-up each factor.

Unlike traditional R-technique factor analysis, the final step in analyzing results of Q-technique requires a qualitative description of each of the factor groups (Thompson, 2000). Creating these descriptions requires researchers to synthesize the groups' beliefs based on items rated most and least important during the Q-sort. Additionally, in order to understand the significance of the resulting factor groups, researchers must look beyond factor scores and report other similarities among the individuals that make up each group. Researchers interpret factor groups by incorporating information they know about the individuals to explain other characteristics the group members share. For example, demographic data such as age, gender, race, ethnicity, economic status, and education achievement is typically collected, along with other information that may be relevant based on the research questions under investigation. Researchers use these data to summarize each of the groups and conceptualize shared beliefs in relation to their demographic characteristics. This information helps researchers further understand similarities and differences among the factor groups.

Participants

Due to its unique data interpretation process, Thompson (2010) suggested that Q-technique is, "especially suited for the intensive study of a small number of especially interesting

people” (p. 33). Therefore, it is vital that participants be carefully selected based on multiple characteristics already known by the researcher. Kerlinger (1986) also advised that Q-methodology is most appropriately used with a small sample of participants carefully chosen for characteristics known to the researcher in order to test theory or hypotheses. In determining appropriate sample size, it is important to select a representative sample that will provide enough diversity to address the questions the researcher is seeking to answer (Thompson, 2000).

Why Q-Methodology?

Watts and Stenner (2012) explained that Q-methodology is used most effectively in addressing research questions in which participants’ viewpoints on a topic are of primary concern, and further, when understanding these viewpoints can create a direct impact by changing the views of others as well as influencing services, programs, or policies (p. 175). Although CCPT has been deemed effective through empirical evidence, there is a lack of research to inform the practice of parent consultations in CCPT. Using Q-methodology to investigate the views of parents whose children are participating in CCPT could directly impact services provided by play therapists, provide directions for future research, and influence the education of play therapists in training.

Secondly, Q-methodology is helpful in enhancing or clarifying currently held beliefs about specific topics (Watts & Stenner, 2012). For example, at times when empirical evidence is lacking, Q-methodology can be used to clarify or support expert opinion currently being used to guide clinical practice, as in the case of CCPT. Although empirical evidence is lacking regarding the practice of parent consultations in CCPT, CCPT scholars have offered numerous recommendations and guidelines for practice based on their knowledge and clinical experience.

In this case, Q-methodology can be used to support and affirm these guidelines or clarify which practices may need to be questioned and examined further in future research.

Summary

CCPT has proven to be a culturally sensitive intervention that is effective for a wide variety of children's problems (Bratton et al., 2005; LeBlanc & Ritchie, 2001; Lin & Bratton, in press; Ray et al., 2014). Despite the clinical effectiveness of CCPT, literature regarding the role of parents in CCPT is limited. Multiple CCPT experts have offered suggestions based on their knowledge and clinical experiences with parents and children; however, empirical evidence to support the practice of parent consultations in CCPT is lacking.

Parental commitment to the child's therapy is often vital to the child receiving therapy. When parents terminate services prematurely, the effectiveness of CCPT is challenged. Because parental involvement is most often essential for children to access and obtain play therapy services, research that examines parents' needs and expectations of the play therapy process is crucial. Q-methodology is a type of mixed methods research methodology that allows researchers to measure participants' subjective viewpoints regarding a specific topic; therefore, Q-methodology represents an ideal technique for investigating parents' perspectives regarding parent consultation in CCPT.

CHAPTER 3

METHOD AND PROCEDURES

The purpose of this study was to better understand the beliefs and attitudes of parents of children receiving child-centered play therapy (CCPT) services at a university-based counseling clinic providing services to the community. Q-methodology was utilized to study parents' perceptions regarding the roles of play therapists in working with parents of child clients. By using Q-methodology, commonly held beliefs and needs among the parents were identified. This chapter includes descriptions of the following: research questions, definition of terms, selection of participants, instruments, procedures, and data analysis.

Research Question

The purpose of this study was to investigate the following research question regarding the experiences of parents receiving CCPT services at a university-based counseling clinic providing services to the community: What processes/services provided by play therapists are valued by parents of children who are participating in CCPT?

Definition of Terms

For the purposes of this study, the following terms are defined.

Child-Centered Play Therapy

Child-centered play therapy (CCPT) will be defined by Landreth (2012) as,

a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child (or person of any age) to fully express and explore self (feelings, thoughts, experiences, and behaviors) through play, the child's natural medium of communication, for optimal growth and development. (p. 11)

Play Therapist

Play therapist refers to the counselor who provided weekly CCPT to the children of the parents selected to participate in this study.

Children Participating in CCPT

Children participating in CCPT refers to the children who were receiving weekly CCPT services at the university-based counseling clinic in which this study was conducted.

Parent

Parent refers to the primary caregiver who gave legal consent for the child to participate in CCPT and who agreed to be a participant in this study.

Processes/Services

For the purposes of this study, processes/services are operationalized by the individual items listed in the final Q-set that was given to parents to sort according to the degree to which the parents valued each item. The Q-set items described knowledge, attitudes, skills, and specific behaviors commonly performed by play therapists during consultation sessions and other interactions with parents throughout the course of therapy.

Selection of Participants

In Q-methodology studies, participants must be carefully, rather than randomly, selected (Watts & Stenner, 2012). Participants must be selected based on their abilities to provide viewpoints that are important to addressing the research questions under investigation (Brown, 1980). For this study, the sample consisted of 19 parents of children who were receiving CCPT services at a community based counseling clinic located on a university campus in a metropolitan area in the Southwest United States. The clinic offered counseling and assessment services for children, adolescents, adults, couples, and families, and served approximately 150-200 clients

each week. Services were offered on an income-based sliding scale, and almost all clients qualified for substantially reduced fees. Over 60% of clients were below the age of 12 years old. Children who were brought for play therapy clinical services by their parents or guardians were typically referred due to concerns related to behavioral and/or emotional problems. CCPT was the most commonly utilized approach for facilitating play therapy in this clinic. Play therapists saw most children weekly for individual sessions and provided parent consultation sessions every three to five weeks.

In order to participate in the study, each parent must have met the following criteria: a) the parent had at least one child who was receiving CCPT services at the clinic; b) the parent had met with the child's play therapist for at least two parent consultation sessions; c) the parent gave consent to participate in this study; and d) the parent was able to read and speak English fluently.

Regarding sample size, Thompson (2010) described Q-technique as being best suited for the intensive study of a small group of people for which the researcher wishes to know better. Further, Thompson (2010) warned too large a sample may cause difficulties in interpretation of the factor groups due to the demographic information researchers must use to help define the groups. Brown (1980) suggested Q-methodology requires only a sample size large enough to produce distinct factors that can be compared to each other. A general rule of thumb advises that the number of participants should be less than the number of items in the Q-set (Watts & Stenner, 2012). Thompson (2000) suggested that the number of items in a Q-set should be at least twice the number of participants plus two (number of items $\geq 2n + 2$); therefore the number of participants should be no more than half the number of items. After developing the final Q-set consisting of 40 items described in the following section, I estimated a sample of 15-19 participants would be sufficient for this study. The final sample size consisted of 19 participants.

Participants were selected based on the likelihood they would represent an “interesting or pivotal point of view” (Watts & Stenner, 2012, p. 71). I, along with my faculty advisor, who served as the clinic director, reviewed all current clients participating in CCPT at the clinic and selected parents across a variety of demographic characteristics such as gender, race, and economic class. Effort was made to select parents from adoptive families, divorced families, single-parent families, blended families, and families with primary guardians who are non-biological parents (e.g., grandparents, aunts, or uncles, etc.). The length of time the child had participated in counseling was also considered. Every effort was made to select participants who represent a balanced and unbiased group (Watts & Stenner, 2012). Table 3.1 depicts demographic characteristics of parents who participated in the study.

Table 3.1

Demographic Characteristics of Participants (n = 19)

Characteristics	n	%	Characteristics	n	%
<u>Gender</u>			<u>Parent Type</u>		
Male	3	15.8	Biological Parent	14	73.7
Female	16	84.2	Adoptive Parent	2	10.5
			Other Biological Caregiver	3	15.8
<u>Age</u>			<u>Annual Household Income</u>		
< 30 years	3	15.8	<\$15,000	2	10.5
30 – 40 years	11	57.9	\$15,000-20,000	0	0
40 – 50 years	3	15.8	\$20,001-30,000	3	15.8
> 50 years	2	10.5	\$30,001-40,000	3	15.8
			>\$40,001	7	36.8
<u>Race</u>			Unreported	4	21.1
Caucasian	15	78.9			
Hispanic	4	21.1			

Table 3.2 depicts demographic characteristics of the participants’ children who were participating in the play therapy at the time of the study. Ethnicity other than Caucasian was underrepresented due to underrepresentation among the clinic’s clients.

Table 3.2

Demographic Characteristics of Participants' Children Participating in CCPT

Characteristics	<i>N</i>	%	Characteristics	<i>N</i>	%
<u>Gender</u>			<u>Current Primary Household</u>		
Male	10	52.6	Biological Parents	6	31.6
Female	9	47.4	Adoptive Parents	2	10.5
			Single Parent	3	15.8
<u>Age</u>			Parent & Partner/Step-Parent	4	21.1
4 years	3	15.8	Parent & Grandparent	1	5.3
5 years	3	15.8	Other Biological Caregivers	3	15.8
6 years	2	10.5			
7 years	4	21.1	<u>Total CCPT Sessions at Time of Study</u>		
8 years	4	21.1	4-10	6	31.6
9 years	3	15.8	11-20	5	26.3
<u>Ethnicity</u>			20-30	5	26.3
Caucasian	10	52.6	30-40	1	5.3
Hispanic	2	10.5	> 40	2	10.5
African-	1	5.3			
American					
Bi-Racial	6	31.6			

Instruments

Q-Sort Design and Content

The Q-set was developed by first generating an extensive list of potential items. I revised and condensed this initial list in three successive phases.

Phase I

To generate an overly large number of items for consideration in the Q-set, as advised by Watts and Stenner (2012), I began with an extensive review of CCPT literature including text books (Axline, 1974; Cochran et al., 2010; Landreth, 2012; Ray, 2011; VanFleet et al., 2010; Wilson & Ryan, 2005) and peer-reviewed theoretical and empirical journal articles (Bornsheuer & Watts, 2012; Brumfield & Christensen, 2011; Campbell et al., 2000; Cates, Paone, Packman,

& Margolis, 2006; Post et al., 2012). These sources represent every known academic source directly related to how play therapists work with parents in the process of CCPT. I also consulted the Association for Play Therapy's *Play Therapy Best Practices* (2012) and the American Counseling Association's (ACA) *Code of Ethics* (2014) to ensure incorporation of professional and ethical guidelines regarding working with children.

McKeown and Thomas (1988) advised that Q-set items should represent a wide variety of opinions on the subject under investigation. This allows for the most accurate representation of viewpoints among the participants. Watts and Stenner (2012) advised, "It is imperative that all the participants can respond effectively to the research question, in any way that they want, using the items provided. A Q-set must not make them feel limited, restricted, or frustrated by failures of balance and coverage" (p. 58). In order to ensure a wide variety of items, in addition to those specific to CCPT, I consulted general literature regarding guidelines for working with parents in child counseling (Henderson & Thompson, 2010). Table 3.3 lists the initial group of 85 statements I created based on the literature review (see also Appendix A).

Table 3.3

Q-Sample Statements for Consideration in the Q-Set after Phase I

No.	Statement
1	Play therapists should conduct interviews with parents to gain information about the child.
2	Play therapists should conduct interviews with teachers to gain information about the child.
3	Play therapists should obtain information from parents to help assess the child's growth and change.
4	Play therapists should offer parenting suggestions to parents.
5	Parents should meet with a play therapist who doesn't see their child for support and parenting suggestions.
6	Play therapists should provide parenting skills training to teach parents more effective parent skills.
7	Play therapists should refer parents for personal therapy or counseling if appropriate.

(table continues)

Table 3.3 (*continued*).

No.	Statement
8	Play therapists should help parents understand how the child's behaviors in the play therapy room impact changes in their behaviors at home and school.
9	Play therapists should build collaborative relationships with parents.
10	Play therapists should address parents' needs and concerns.
11	Play therapists should consider parents as important to their child's therapy.
12	I want to feel heard and understood by my child's play therapist.
13	Play therapists should explain to parents what play therapy is and how it works.
14	Play therapists should help parents understand why play therapy is used with children.
15	Play therapists should help parents know what to expect during the play therapy process.
16	Play therapists should give parents a tour of the playroom where their child participates in play therapy sessions.
17	Play therapist should teach parents how to respond to their child's defiant behavior in the waiting room (i.e. clinginess, refusal to leave, etc.)
18	Play therapists should teach parents what to say to their children to prepare them for their first session.
19	Play therapists should discuss with parents the physical risks of their children participating in play therapy.
20	Play therapists should discuss with parents the emotional risks of their children participating in play therapy.
21	Play therapists should help parents understand their child's confidentiality regarding what happens in the playroom.
22	Play therapists should allow parents opportunities to observe their child's play therapy sessions.
23	Play therapists should discuss with parents the importance of consistency in attendance to scheduled play therapy sessions.
24	Play therapists should consistently schedule parent consultation sessions with parents.
25	Play therapists should provide opportunities for parents to discuss their child's developmental progress and emotional and behavioral changes.
26	Play therapists should work to understand the unique needs of each family.
27	Play therapists should provide emotional support to parents.
28	Play therapists should provide parents with training in specific parenting skills to help them respond to their child in more positive ways.
29	Play therapists should provide parents with information regarding their child's behavior compared to other children his/her age.
30	Play therapists should conduct parent consultation sessions with all of a child's primary caretakers (i.e. mom, dad, step-parents, custodial grandparents, etc.)
31	Play therapists should help parents know how to respond to things their child creates in the playroom.
32	Play therapists should help parents know how to talk to their child about what he/she does in the playroom.
33	Play therapists should provide parents with opportunities to ask questions and get answers for their concerns.

(*table continues*)

Table 3.3 (*continued*).

No.	Statement
34	Play therapists should provide parents with opportunities to share their feelings, such as guilt, frustration, and angry toward their child.
35	Play therapists should stay updated on each child's medications or any health issues.
36	Play therapists should have their own children and have the experience of being parent themselves.
37	Play therapists should have extensive experience working with children.
38	Play therapists should have received adequate training in play therapy procedures.
39	Play therapists should have expert knowledge regarding children, child behavior, and play therapy.
40	Play therapists should collaborate with other professionals in each child's life, such as pediatricians, teachers, school counselors, etc.
41	Play therapists should be nonjudgmental or evaluative.
42	Play therapists should display warmth and care toward my child.
43	Play therapists should be open-minded and flexible.
44	Play therapists should have a sense of humor.
45	Play therapists should respect a parent's relationships with their child as the most important relationship in their child's life.
46	Play therapists should respect parents' knowledge regarding their child.
47	Play therapists should care about the parents they work with.
48	Play therapists should be patient.
49	Play therapists should seek to understand parents' specific concerns regarding their children.
50	Play therapists should seek to understand parents' expectations regarding the outcomes of play therapy.
51	Play therapists should address children's need holistically.
52	Play therapists should understand a child's previous experiences in counseling/therapy.
53	Play therapists should engage parents as partners in their child's therapy.
54	Play therapists should recognize and address any cultural differences between them and the families they work with.
55	Play therapists should work with parents to understand and establish goals for their child's progress.
56	Play therapists should respect a parent's rights to make decisions for their child.
57	Play therapists should provide parent opportunities to contact them outside regularly scheduled appointments (i.e. by phone, email, or video conferencing).
58	Play therapists should listen carefully to parents and work to understand their needs.
59	Play therapists should have helpful information available to parents in the waiting room.
60	Play therapists use standardized assessments to measure my child's symptoms and progress.
61	When play therapists use standardizes assessments, they clearly explain the results to parents and relate the results to the child's overall progress.
62	Play therapists should provide treatments strongly grounded in a theoretical framework.
63	Play therapists should provide safety for children to freely express themselves.
64	Play therapist should provide treatments sensitive to a child's cultural and familial values.

(*table continues*)

Table 3.3 (*continued*).

No.	Statement
65	Play therapists should collaborate with a child's school as needed.
66	Play therapists should schedule frequent parent consultations meetings.
67	Play therapists should incorporate family members into a child's treatment when appropriate.
68	Play therapists should work collaboratively with parents to define treatment goals.
69	Play therapists should explain the process of play therapy in parent-friendly terms.
70	Play therapists should provide practical parenting advice.
71	Play therapists should explain child's progress in parent-friendly terms.
72	Play therapists should participate in supervision/consultation to ensure high quality treatment.
73	Play therapists should explain assessment results in terms parents can understand.
74	Play therapists should focus on both short- and long-terms goals.
75	Play therapists should convey non-judgmental attitudes toward parent's perspective.
76	Play therapists should allow opportunities for parents to determine agenda of parent consultations.
77	Play therapists should refer children to child psychiatrists when appropriate.
78	Play therapists should incorporate newest editions of assessments into practice.
79	Play therapists should provide treatment in as few sessions as possible.
80	Play therapists should communicate with parent using multiple sources of communication (i.e. phone, email, etc.).
81	Play therapists should utilize treatments deemed "evidenced-based" for working with a child's presenting concerns.
82	Play therapists should respond positively and immediately to special requests made by parents.
83	Play therapists should place primary emphasis on short-term goals.
84	Play therapists should incorporate use of latest technology available into practice.
85	Play therapists should stay knowledgeable on the latest advancements in the field and incorporate new knowledge into practice.

Phase II

A Q-set represents the statements to be sorted by participants during the Q-sort. Watts and Stenner (2012) asserted that there is no one correct way to develop a Q-set; rather, researchers must carefully consider the question they are seeking to answer. Thompson (2000) suggested that the number of items in a Q-set should be at least twice the number of participants plus two (number of items $\geq 2n + 2$). Watts and Stenner (2005) explained successful Q-sorts have been completed with as few as 25 items. The authors further suggested that in certain

situations researchers may need to keep items to a minimum in order to create a Q-set that can be easily completed by participants. For this study, I sought to create a Q-set that parents could easily complete within 30-50 minutes, a typical time their children would be participating in play therapy sessions. I considered both the breadth of the items and the ease at which parents could complete the sort, and I estimated a Q-set of 30-45 items would be sufficient for this study.

After developing the initial list of 85 statements, I consulted with a team of four counselor educator faculty members, including my faculty advisor, each of whom possessed a doctoral degree in counseling or counselor education. Three were experts in practicing and researching play therapy, and three had extensive experience in research design and analysis. Each faculty member independently reviewed the 85 items and provided suggestions regarding rewording items for clarity, combining similar items into single items, deleting redundant or unnecessary items, and creating new items to increase the breadth of topics covered. After receiving feedback from each faculty member, I then consulted with my faculty advisor to review the suggestions and incorporate all of the recommended changes. In addition to condensing the items, we decided to change the format of how the items would be presented to parents. Rather than beginning each statement with “Play therapists should,” we decided to begin each statement with a verb, such as “helps” “teaches” or “discusses.” Our goal in the change was to help parents think about processes they have experienced with their play therapists, rather than ideal behaviors about what play therapists “should” do.

After incorporating feedback from the faculty member consultants, I consulted with four doctoral level play therapists with extensive experience providing CCPT in the university-based counseling clinic in which the study took place. Each play therapist had earned a doctoral degree in counseling, completed at least three graduate level courses in CCPT, provided CCPT in the

clinic, and received weekly supervision for at least three years. I asked the play therapists to offer comments regarding the face validity of the items and any new items they believed should be added. I also asked them to offer suggestions regarding the clarity of the items in order to ensure the items were written in parent-friendly language. I then consulted with my faculty advisor for consensus on incorporating feedback from the play therapists, and I presented the revised set of items to the other faculty member consultants for their final review and approval (see Table 3.4).

Table 3.4

Q-Sample Statements for Consideration in the Q-Set after Phase II

No.	Statement
1	Gathers information about my child's background and current issues at home and school, including behavioral, emotional, academic, and medical information.
2	Recognizes and addresses cultural values or unique needs of our family.
3	Seeks to understand and addresses my specific concerns regarding my child.
4	Gains information from and collaborates with professionals at my child's school, such as teachers, school counselors, or administrators.
5	Refers to and collaborates with medical professionals, such as pediatricians, psychiatrists, and other specialists.
6	Refers me for personal therapy or counseling if appropriate.
7	Offers parenting suggestions and practical advice.
8	Teaches me more effective parenting skills.
9	Teaches me how to respond to my child when he or she is having behavioral problems.
10	Teaches me how to talk to my child about being in play therapy.
11	Helps me respond to my child in more positive ways.
12	Helps me understand my child's behavior and development compared to other children his/her age.
13	Has helpful books, videos, brochures, and other information available to me.
14	Helps me know how to respond to my child following his/her play therapy sessions.
15	Provides me with new disciplinary techniques.
16	Helps me practice new ways to respond to my child.
17	Discusses timeframe for when my child will end therapy.
18	Helps me understand play therapy, how it works, and why it's helpful for my child.
19	Helps me understand how my child's behaviors in the play therapy room impact changes in his or her behaviors at home and school.
20	Discusses possible risks of my child participating in play therapy.
21	Helps me understand my child's confidentiality regarding what happens in the playroom.

(table continues)

Table 3.4 (*continued*).

No.	Statement
22	Helps me see and understand my child's progress in play therapy.
23	Knows about and uses the latest advancements in evidence-based practice.
24	Has experience being a parent themselves.
25	Has extensive experience working with children.
26	Has adequate training and supervision in play therapy.
27	Has expert knowledge regarding children, child behavior, and child development.
28	Provides me with emotional support and addresses my needs and concerns.
29	Builds a collaborative relationship with me.
30	Helps me feel heard and understood.
31	Cares about me.
32	Engages me as a partner in my child's therapy and includes me in decision-making such as setting goals for therapy, planning for parent sessions, and making changes in my child's treatment.
33	Respects me and considers me important to my child's therapy.
34	Uses questionnaires/assessments to measure my child's symptoms and explains the results to help me understand my child's progress.
35	Completes treatment in as few sessions as possible.
36	Provides opportunities to contact him or her outside our regularly scheduled appointments, for example, by phone, email, or webcam.
37	Schedules frequent parent consultation meetings.
38	Includes other family members (such as, step-parents, guardians, grandparents, or other caregivers) into my child's treatment when appropriate.
39	Responds positively and immediately to my special requests.
40	Incorporates use of latest technology such as, online forms and scheduling, computerized record-keeping, or interactive webpage.

Phase III

After creating the final list of 40 items, I randomly numbered each of the items and asked three volunteer parents to review them and provide feedback regarding the wording and clarity (see Appendix B). All three parents were familiar with play therapy, although they did not have children who were participating in play therapy at the time of the study. All three parents reported the items were written clearly and represented important behaviors they would expect from a play therapist. None of the parents requested that new items be added to the list. Table

3.5 lists the 40 statements as they appeared in the Q-Set presented to participants (see also Appendix C).

Table 3.5

Q-Set Administered to Parents

No.	Statement
1	Teaches me how to respond effectively to my child when he or she is having behavioral problems.
2	Incorporates the use of current technology such as online forms and scheduling, computerized record-keeping, or interactive webpage.
3	Recommends personal therapy or counseling for me if appropriate.
4	Knows about and uses effective therapies supported by research.
5	Discusses possible risks of my child participating in play therapy.
6	Helps me practice new ways to respond to my child.
7	Helps me understand play therapy, how it works, and why it's helpful for my child.
8	Respects me and considers me important to my child's therapy.
9	Has expert knowledge regarding children, child behavior, and child development.
10	Completes therapy in as few sessions as possible.
11	Provides me with emotional support and addresses my needs and concerns.
12	Has experience being a parent themselves.
13	Recognizes and addresses cultural values and unique needs of my family.
14	Helps me understand if my child's behavior and development are typical for his or her age.
15	Teaches me how to talk to my child about being in play therapy.
16	Helps me feel heard and understood.
17	Responds positively and immediately to special requests that I might make.
18	Makes referrals to and collaborates with medical professionals such as pediatricians, psychiatrists, and other specialists.
19	Provides opportunities to contact him or her outside our regularly scheduled appointments, for example, by phone, email, or webcam.
20	Schedules frequent and consistent parent consultation meetings.
21	Uses questionnaires or assessments to measure my child's symptoms and explains the results to help me understand my child's progress.
22	Is sensitive to and tries to be accommodating of my financial constraints.
23	Helps me know how to respond to my child following his or her play therapy sessions.
24	Helps me see and understand my child's progress in play therapy.
25	Helps me understand what my child does in the play therapy room and how it impacts changes in his or her behavior at home and school.
26	Teaches me more effective parenting skills.
27	Includes other family members, such as step-parents, guardians, grandparents, or other caregivers, into my child's treatment when appropriate.
28	Provides me with new disciplinary strategies.
29	Helps me respond to my child in more positive ways.

(table continues)

Table 3.5 (*continued*).

No.	Statement
30	Engages me as a partner in my child's therapy and includes me in decision-making such as setting goals for therapy, planning for parent sessions, and making changes in my child's therapy.
31	Helps me understand my child's need for privacy regarding what happens in the playroom.
32	Seeks to understand and addresses my specific concerns regarding my child.
33	Gains information from and collaborates with professionals at my child's school such as teachers, school counselors, or administrators.
34	Gathers information about my child's background and current issues at home and school, including behavioral, emotional, academic, and medical information.
35	Discusses timeframe for when my child will end therapy.
36	Has extensive experience working with children.
37	Offers parenting suggestions and practical advice.
38	Has received training and supervision in play therapy.
39	Has helpful books, videos, brochures, and other information available to me.
40	Cares about me.

Post Q-sort Questionnaire

A post Q-sort questionnaire (Appendix D) was used to collect parents' reactions to completing the Q-sort. Parents were asked to describe the items they placed as "most important" and "least important" and explain what the items meant to them. Parents were also asked questions regarding their satisfaction with the play therapy services their families had received at the clinic.

Child/Adolescent Background Information Form

The Child/Adolescent Background Information Form (Appendix E) was used to gather demographic information about each child, his or her parents, the child's emotional and behavioral concerns, and the home atmosphere. The Child/Adolescent Background Information Forms were completed when the children began play therapy, and copies of the forms were obtained from each child's file at the clinic.

Procedures

Prior to recruiting participants, I gained permission from the University of North Texas Institutional Review Board and the director of the clinic in which the study took place, who also served as my faculty advisor. I met individually with each participant at the clinic to discuss the purpose and procedures of the research project and requested their permission to participate. Participants were asked to participate while they were at the clinic for their children's regularly scheduled play therapy appointments or at another time that was convenient for them. Parents were told their participation would require on average 35-55 minutes of their time. I reviewed the informed consent form with participants, after which they signed and received a copy (Appendix F). I then explained the directions for completing the mediated Q-sort (Thompson, 2010) and gave written copies of the directions to participants. Part of the prompt included, "These cards include some things play therapists might do with parents. Please sort these cards on a continuum from what is *least important* to *most important* to you." A completed copy of the instructions can be found in Appendix G. I gave participants a stack of 2 inch by 3 ½ inch laminated cards each containing a statement from the Q-set (Table 3.4), randomly numbered from one to 40, along with a 3 foot by 1 ½ foot poster of the distribution grid affixed to a large table (Figure 3.1). Participants used the grid to record their responses by placing one card in each of the boxes.

To protect confidentiality and privacy of the participants, all information collected was de-identified using code numbers and kept in a locked cabinet. Access to the cabinet and code numbers was available only to the primary researcher and supervising faculty member. Furthermore, I followed all ethical research and publication responsibilities included in Section G of the ACA's *Code of Ethics* (2014).

Data Analysis

To address the main research question, What processes/services provided by play therapists are valued by parents of children who are participating in child-centered play therapy?, I first calculated and examined descriptive statistics regarding the frequencies with which each Q-sort item was reported by parents in each column, (i.e. -4, -3, -2, -1, 0, +1, +2, +3, and +4). Then, I conducted Q-technique factor analysis in PQMethod statistical software (Schmolck, 2014). I transcribed each Q-sort into PQMethod from recording forms I completed during data collection (see Appendix I). To further ensure accuracy of the data, I compared the recording forms to digital photographs that I took of each participant's completed Q-sort. Additionally, after data was entered, PQMethod automatically performs a function that assesses for missing and duplicate items. I then used the centroid factor analysis function to examine the data and determine the number of factors to retain for further examination. These factors reveal groups of parents that display similar sorting patterns, and therefore values, regarding the Q-sort items.

CHAPTER 4

RESULTS

This chapter contains the results of this study. The results were obtained by calculating descriptive statistics and performing Q-technique factor analysis using PQMethod statistical software (Schmolck, 2014).

To address the research question, What processes/services provided by play therapists are valued by parents of children who are participating in CCPT?, I first calculated descriptive statistics of the frequencies with which parents reported each Q-sort item in the -4, -3, -2, -1, 0, +1, +2, +3, and +4 columns. Items sorted into the -4, -3, -2, and -1 columns represent processes parents reported as being lesser important, while items sorted into the +4, +3, +2, and +1 columns represent processes parents reported as being more important. -4 is least important while +4 is most important. Items sorted into the 0 column represent processes parents reported as being most neutral. The frequencies and percentages can be found in Table 4.1.

Table 4.1

Frequencies and Percentages of Parents' Rankings of each Item by Q-Sort Column

No.	Statement	-4	-3	-2	-1	0	+1	+2	+3	+4	Total
1	Teaches me how to respond effectively to my child when he or she is having behavioral problems.	0 (0%)	0 (0%)	1 (5.3%)	0 (0%)	3 (15.8%)	4 (21.1%)	4 (21.1%)	2 (10.5%)	5 (26.3%)	19 (100%)
2	Incorporates the use of current technology such as online forms and scheduling, computerized record-keeping, or interactive webpage.	7 (36.8%)	5 (26.3%)	2 (10.5%)	3 (15.8%)	0 (0%)	2 (10.5%)	0 (0%)	0 (0%)	0 (0%)	19 (100%)
3	Recommends personal therapy or counseling for me if appropriate.	0 (0%)	2 (10.5%)	3 (15.8%)	4 (21.1%)	3 (15.8%)	3 (15.8%)	4 (21.1%)	0 (0%)	0 (0%)	19 (100%)

(table continues)

Table 4.1 (*continued*).

No.	Statement	-4	-3	-2	-1	0	+1	+2	+3	+4	Total
4	Knows about and uses effective therapies supported by research.	0 (0%)	0 (0%)	0 (0%)	3 (15.8%)	6 (31.6%)	5 (26.3%)	2 (10.5%)	3 (15.8%)	0 (0%)	19 (100%)
5	Discusses possible risks of my child participating in play therapy.	1 (5.3%)	4 (21.1%)	4 (21.1%)	4 (21.1%)	3 (15.8%)	2 (10.5%)	1 (5.3%)	0 (0%)	0 (0%)	19 (100%)
6	Helps me practice new ways to respond to my child.	0 (0%)	1 (5.3%)	1 (5.3%)	0 (0%)	4 (21.1%)	4 (21.1%)	6 (31.6%)	2 (10.5%)	1 (5.3%)	19 (100%)
7	Helps me understand play therapy, how it works, and why it's helpful for my child.	0 (0%)	1 (5.3%)	2 (10.5%)	5 (26.3%)	7 (36.8%)	1 (5.3%)	2 (10.5%)	0 (0%)	1 (5.3%)	19 (100%)
8	Respects me and considers me important to my child's therapy.	0 (0%)	0 (0%)	2 (10.5%)	1 (5.3%)	10 (52.6%)	1 (5.3%)	3 (15.8%)	2 (10.5%)	0 (0%)	19 (100%)
9	Has expert knowledge regarding children, child behavior, and child development.	0 (0%)	0 (0%)	1 (5.3%)	1 (5.3%)	2 (10.5%)	5 (26.3%)	3 (15.8%)	4 (21.1%)	3 (15.8%)	19 (100%)
10	Completes therapy in as few sessions as possible.	9 (47.4%)	6 (31.6%)	2 (10.5%)	2 (10.5%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	19 (100%)
11	Provides me with emotional support and addresses my needs and concerns.	1 (5.3%)	1 (5.3%)	6 (31.6%)	5 (26.3%)	3 (15.8%)	0 (0%)	1 (5.3%)	1 (5.3%)	1 (5.3%)	19 (100%)
12	Has experience being a parent themselves.	6 (31.6%)	3 (15.8%)	5 (26.3%)	3 (15.8%)	2 (10.5%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	19 (100%)
13	Recognizes and addresses cultural values and unique needs of my family.	0 (0%)	6 (31.6%)	6 (31.6%)	5 (26.3%)	0 (0%)	2 (10.5%)	0 (0%)	0 (0%)	0 (0%)	19 (100%)
14	Helps me understand if my child's behavior and development are typical for his or her age.	0 (0%)	0 (0%)	1 (5.3%)	2 (10.5%)	9 (47.4%)	3 (15.8%)	2 (10.5%)	2 (10.5%)	0 (0%)	19 (100%)
15	Teaches me how to talk to my child about being in play therapy.	0 (0%)	0 (0%)	5 (26.3%)	7 (36.8%)	2 (10.5%)	4 (21.1%)	1 (5.3%)	0 (0%)	0 (0%)	19 (100%)
16	Helps me feel heard and understood.	1 (5.3%)	2 (10.5%)	0 (0%)	5 (26.3%)	5 (26.3%)	2 (10.5%)	4 (21.1%)	0 (0%)	0 (0%)	19 (100%)
17	Responds positively and immediately to special requests that I might make.	0 (0%)	2 (10.5%)	4 (21.1%)	5 (26.3%)	4 (21.1%)	4 (21.1%)	0 (0%)	0 (0%)	0 (0%)	19 (100%)

(table continues)

Table 4.1 (*continued*).

No.	Statement	-4	-3	-2	-1	0	+1	+2	+3	+4	Total
18	Makes referrals to and collaborates with medical professionals such as pediatricians, psychiatrists, and other specialists.	0 (0%)	1 (5.3%)	4 (21.1%)	4 (21.1%)	5 (26.3%)	2 (10.5%)	2 (10.5%)	1 (5.3%)	0 (0%)	19 (100%)
19	Provides opportunities to contact him or her outside our regularly scheduled appointments, for example, by phone, email, or webcam.	0 (0%)	4 (21.1%)	4 (21.1%)	5 (26.3%)	4 (21.1%)	1 (5.3%)	0 (0%)	0 (0%)	1 (5.3%)	19 (100%)
20	Schedules frequent and consistent parent consultation meetings.	0 (0%)	0 (0%)	1 (5.3%)	2 (10.5%)	7 (36.8%)	6 (31.6%)	2 (10.5%)	1 (5.3%)	0 (0%)	19 (100%)
21	Uses questionnaires or assessments to measure my child's symptoms and explains the results to help me understand my child's progress.	0 (0%)	0 (0%)	3 (15.8%)	7 (36.8%)	3 (15.8%)	3 (15.8%)	3 (15.8%)	0 (0%)	0 (0%)	19 (100%)
22	Is sensitive to and tries to be accommodating of my financial constraints.	1 (5.3%)	5 (26.3%)	2 (10.5%)	2 (10.5%)	6 (31.6%)	1 (5.3%)	1 (5.3%)	0 (0%)	1 (5.3%)	19 (100%)
23	Helps me know how to respond to my child following his or her play therapy sessions.	0 (0%)	2 (10.5%)	1 (5.3%)	2 (10.5%)	7 (36.8%)	3 (15.8%)	1 (5.3%)	2 (10.5%)	1 (5.3%)	19 (100%)
24	Helps me see and understand my child's progress in play therapy.	0 (0%)	0 (0%)	0 (0%)	1 (5.3%)	5 (26.3%)	3 (15.8%)	7 (36.8%)	3 (15.8%)	0 (0%)	19 (100%)
25	Helps me understand what my child does in the play therapy room and how it impacts changes in his or her behavior at home and school.	0 (0%)	0 (0%)	1 (5.3%)	3 (15.8%)	4 (21.1%)	2 (10.5%)	1 (5.3%)	5 (26.3%)	3 (15.8%)	19 (100%)
26	Teaches me more effective parenting skills.	0 (0%)	0 (0%)	1 (5.3%)	1 (5.3%)	6 (31.6%)	7 (36.8%)	2 (10.5%)	1 (5.3%)	1 (5.3%)	19 (100%)

(table continues)

Table 4.1 (*continued*).

No.	Statement	-4	-3	-2	-1	0	+1	+2	+3	+4	Total
27	Includes other family members, such as step-parents, guardians, grandparents, or other caregivers, into my child's treatment when appropriate.	2 (10.5%)	0 (0%)	8 (42.1%)	3 (15.8%)	4 (21.1%)	1 (5.3%)	1 (5.3%)	0 (0%)	0 (0%)	19 (100%)
28	Provides me with new disciplinary strategies.	0 (0%)	1 (5.3%)	2 (10.5%)	1 (5.3%)	3 (15.8%)	10 (52.6%)	1 (5.3%)	1 (5.3%)	0 (0%)	19 (100%)
29	Helps me respond to my child in more positive ways.	0 (0%)	0 (0%)	0 (0%)	0 (0%)	3 (15.8%)	6 (31.6%)	5 (26.3%)	2 (10.5%)	3 (15.8%)	19 (100%)
30	Engages me as a partner in my child's therapy and includes me in decision-making such as setting goals for therapy, planning for parent sessions, and making changes in my child's therapy.	0 (0%)	0 (0%)	0 (0%)	1 (5.3%)	3 (15.8%)	5 (26.3%)	5 (26.3%)	3 (15.8%)	2 (10.5%)	19 (100%)
31	Helps me understand my child's need for privacy regarding what happens in the playroom.	0 (0%)	3 (15.8%)	5 (26.3%)	8 (42.1%)	2 (10.5%)	0 (0%)	0 (0%)	0 (0%)	1 (5.3%)	19 (100%)
32	Seeks to understand and addresses my specific concerns regarding my child.	0 (0%)	0 (0%)	1 (5.3%)	0 (0%)	4 (21.1%)	4 (21.1%)	4 (21.1%)	3 (15.8%)	3 (15.8%)	19 (100%)
33	Gains information from and collaborates with professionals at my child's school such as teachers, school counselors, or administrators.	0 (0%)	1 (5.3%)	0 (0%)	4 (21.1%)	1 (5.3%)	3 (15.8%)	4 (21.1%)	2 (10.5%)	4 (21.1%)	19 (100%)
34	Gathers information about my child's background and current issues at home and school, including behavioral, emotional, academic, and medical information.	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (5.3%)	2 (10.5%)	5 (26.3%)	9 (47.4%)	2 (10.5%)	19 (100%)
35	Discusses timeframe for when my child will end therapy.	4 (21.1%)	0 (0%)	8 (42.1%)	4 (21.1%)	3 (15.8%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	19 (100%)

(table continues)

Table 4.1 (*continued*).

No.	Statement	-4	-3	-2	-1	0	+1	+2	+3	+4	Total
36	Has extensive experience working with children.	0 (0%)	2 (10.5%)	3 (15.8%)	2 (10.5%)	4 (21.1%)	2 (10.5%)	4 (21.1%)	2 (10.5%)	0 (0%)	19 (100%)
37	Offers parenting suggestions and practical advice.	0 (0%)	0 (0%)	1 (5.3%)	1 (5.3%)	2 (10.5%)	6 (31.6%)	5 (26.3%)	4 (21.1%)	0 (0%)	19 (100%)
38	Has received training and supervision in play therapy.	0 (0%)	0 (0%)	0 (0%)	1 (5.3%)	3 (15.8%)	2 (10.5%)	7 (36.8%)	2 (10.5%)	4 (21.1%)	19 (100%)
39	Has helpful books, videos, brochures, and other information available to me.	1 (5.3%)	3 (15.8%)	3 (15.8%)	4 (21.1%)	5 (26.3%)	1 (5.3%)	2 (10.5%)	0 (0%)	0 (0%)	19 (100%)
40	Cares about me.	5 (26.3%)	2 (10.5%)	2 (10.5%)	3 (15.8%)	4 (21.1%)	2 (10.5%)	0 (0%)	0 (0%)	1 (5.3%)	19 (100%)

Next, I entered the Q-sort data into PQMethod version 2.35 (Schmolck, 2014) to perform centroid factor analysis (Watts & Stenner, 2012). To determine the number of factors for initial extraction, Watts and Stenner (2012) recommended extracting one factor for every six to eight participants; due to the inclusion of 19 participants, I chose to extract three initial factors. Table 4.2 depicts the resulting factor matrix of the centroid factor analysis.

Table 4.2

Unrotated Factor Matrix

Q-sort	Factor1	Factor 2	Factor 3
1	0.66298	0.33518	0.12276
2	0.68241	-0.30322	0.11663
3	0.49528	0.24404	0.05863
4	0.65598	-0.10533	0.01431
5	0.53252	0.22897	0.05077
6	0.58912	-0.25127	0.07774
7	0.79330	0.07256	0.00391
8	0.71223	-0.21307	0.05556
9	0.76468	-0.22214	0.06064
10	0.60883	0.13121	0.01452
11	0.61043	0.19111	0.03388
12	0.71713	-0.16868	0.03502

(table continues)

Table 4.2 (*continued*).

Q-sort	Factor1	Factor 2	Factor 3
13	0.81985	0.17828	0.02958
14	0.86832	-0.13791	0.02452
15	0.54464	0.39128	0.18065
16	0.59976	-0.10829	0.01501
17	0.51990	-0.24038	0.07086
18	0.70191	0.04708	0.00112
19	0.36248	-0.04459	0.00313
Eigenvalue	8.17	.85	0.09
Variance Explained	43.0%	4.5%	0.47%

To determine the number of factors to retain for further analysis, I examined the unrotated factor matrix using multiple approaches. First, I considered the Kaiser-Guttman criterion (Guttman, 1954; Kaiser, 1960, 1970), which recommends retaining factors with eigenvalues greater than or equal to 1.00. Only Factor 1 had an eigenvalue greater than 1.00. These results suggest a single factor solution. However, the Kaiser-Guttman criterion is often considered an unreliable measure as it typically suggests the retention of unnecessary factors or the deletion of factors with eigenvalues less than 1.00 that may in fact be meaningful (Watts & Stenner, 2012).

Brown (1980) suggested retaining factors that have two or more significant factor loadings as depicted on the factor matrix. A significant factor loading can be calculated using the equation: $2.58 \times (1/\sqrt{\# \text{ of items in the Q-set}})$ (Watts & Stenner, 2012). This equation determines significant factor loadings for $p < .01$ significance level. I calculated the significant factor loading as follows: $2.58 \times (1/\sqrt{40}) = 0.41$. Only Factor 1 contained two or more significant factor loadings greater than 0.41, thus supporting a one factor solution.

Humphrey's rule is an additional method for determining the number of factors to retain (Brown, 1980). Humphrey's rule states, "a factor is significant if the cross-product of its two

highest loadings (ignoring the sign) exceeds twice the standard error” (Brown, 1980, p.223).

Standard error can be calculated using the equation: $1 / (\sqrt{\# \text{ of items in the Q-set}})$ (Watts & Stenner, 2012). I calculated the standard error as follows: $1 / (\sqrt{40}) = 0.16$. I then calculated the cross-products of the two highest loadings for each factor: Factor 1 = .71, Factor 2 = .13, and Factor 3 = .02. Only Factor 1 had a cross-product greater than 2×0.16 (0.32), further suggesting a one factor solution.

Cattell’s (1966) scree plot analysis is a graphical representation of eigenvalues computed during principal component analysis (PCA). Although PCA is not recommended in Q-methodology, it is recommended that Q-methodologists use PCA for the purposes of developing a scree plot and conducting parallel analysis. Although the eigenvalues computed during PCA are different than eigenvalues computed during centroid factor analysis, the scree plot is considered helpful in determining the number of factors to retain. The point at which the line changes slope and flattens out signals the number of factors to extract. Figure 4.1 represents the scree plot of eigenvalues computed during PCA. The scree plot suggests the retention of one factor.

Figure 4.1. Scree plot of eigenvalues from principal component analysis.

Parallel analysis (Horn, 1965) is frequently regarded as a more sound method of selecting the number of factors to retain (Watts & Stenner, 2012). In parallel analysis, eigenvalues are generated from random data sets that resemble the data of a given study. Parallel analysis generates eigenvalues that show how big eigenvalues derived from the data might be if no factors are present in the data. I utilized SPSS to generate the results of the parallel analysis (O'Connor, 2000). The eigenvalues obtained from PCA are compared to eigenvalues obtained in parallel analysis using 1,000 random data sets. If the observed eigenvalue exceeds the parallel analysis eigenvalue, there is a less than 5% chance that the observed value could have occurred when in fact no factor actually existed in the data. Table 4.3 depicts the observed eigenvalues derived from PCA and eigenvalues from parallel analysis. The results of the parallel analysis suggest the retention of one factor.

Table 4.3

Eigenvalues from PCA and Parallel Analysis

Factor	Observed Eigenvalues	95 th Percentile Eigenvalues for 1000 Random Data Sets
1	8.680	2.478
2	1.677	2.143
3	1.392	1.900
4	1.243	1.700
5	1.034	1.523

Based on the results of these analyses, the data represent a single factor solution. Because only one factor was identified as significant, factor rotation was not necessary. PQMethod software requires the retention of at least two factors in order to perform a rotation of the data for further statistical analysis (Schmolck, 2012).

Eighteen of the 19 participants were represented by Factor 1, each with significant loadings greater than 0.41. This means that 18 of the 19 parents who participated in the study reported similar patterns in sorting their responses. Further, Factor 1 accounted for 43% of the variance among all the Q-sorts. Sound solutions in factor analysis typically represent at least 35-40% of the total variance (Kline, 1994).

To more closely examine the reported beliefs of the factor group, frequency percentages were calculated for each Q-sort to reflect the number of times parents placed each statement into columns -4 and -3 (indicating lowest importance) and columns +4 and +3 (indicating highest importance). Participant 19 is excluded from the following analysis due to having an insignificant factor loading (less than .41). Table 4.4 illustrates the four items which were placed in columns -4 and -3 (indicating lowest importance) by more than 33% of participants. Items 10 and 2 (“Completes therapy in as few sessions as possible” and “Incorporating the use of current

technology such as online forms and scheduling, computerized record-keeping, or interactive webpage”) were as placed in columns -4 and -3 by more participants than any other item.

Table 4.4

Frequency Percentage Table for Items Identified as Least Important

No.	Statement	Frequency (%)
10	Completes therapy in as few sessions as possible.	14 (77.9%)
2	Incorporates the use of current technology such as online forms and scheduling, computerized record-keeping, or interactive webpage.	12 (66.7%)
12	Has experience being a parent themselves.	8 (44.4%)
40	Cares about me.	7 (38.9%)

Note: All items placed in -3 and -4 columns by more than 33% of participants

Table 4.5 illustrates the six items which were placed in columns +4 and +3 (indicating highest importance) by more than 33% of the participants. Item 34 (“Gathers information about my child’s background and current issues at home and school, including behavioral, emotional, academic, and medical information”) was placed in columns +4 and +3 by more participants than any other item.

Table 4.5

Frequency Percentage Table for Items Identified as Most Important

No.	Statement	Frequency (%)
34	Gathers information about my child’s background and current issues at home and school, including behavioral, emotional, academic, and medical information.	11 (61.1%)
25	Helps me understand what my child does in the play therapy room and how it impacts changes in his or her behavior at home and school.	8 (44.4%)
1	Teaches me how to respond effectively to my child when he or she is having behavioral problems.	7 (38.9%)
9	Has expert knowledge regarding children, child behavior, and child development.	7 (38.9%)
32	Seeks to understand and addresses my specific concerns regarding my child.	6 (33.3%)
38	Has received training and supervision in play therapy.	6 (33.3%)

Note: All items placed in +3 and +4 columns by more than 33% of participants

Examining the Q-sort data, along with additional information gained from the post Q-sort questionnaire (Appendix D) and the Child/Adolescent Background Information form (Appendix E), I developed a qualitative description of the parent group (Thompson, 2000). Overall, Factor 1 represented parents that tend to value the process of play therapists understanding the unique background and needs of their children. They valued play therapists' expert knowledge about children and play therapy training and supervision. Additionally, they valued the process of play therapists helping them understand how the specific behaviors their children exhibit in the play room can lead to improved behavior and functioning outside of play therapy. These parents placed lesser importance on play therapists using advanced technology in their practice and being parents themselves. Moreover, the vast majority placed the least amount of importance on their children completing therapy as quickly as possible. Regarding demographics, 10 of the 18 parents were Caucasian biological mothers between the ages of 30 and 40 years old. Two biological fathers were represented, along with five adoptive parents and other biological caregivers. Seven of the parents reported household incomes less than \$40,000 per year, seven reported incomes greater than \$40,000, and four parents did not disclose their income. Seventeen of the parents reported being satisfied or highly satisfied with the play therapy services they received at the clinic, while one reported being neither satisfied nor dissatisfied.

CHAPTER 5

DISCUSSION

The purpose of this study was to investigate the values parents hold regarding the processes involved and services received in child-centered play therapy (CCPT). Q-methodology was utilized, and the results revealed a one factor solution consisting of 18 of the 19 participants. These 18 parents reported similar beliefs regarding the processes they considered most and least important to their experience in working with child-centered play therapists. This chapter includes a discussion of the results presented in the previous chapter followed by limitations and implications for practice of CCPT, training of play therapists, and future research.

Parent Values in CCPT Processes and Services

During the Q-sorting procedures, many parents reported feeling the task was difficult, particularly when ranking values that were more important to them. Parents appeared to have an easier time identifying the least important items versus those they believed to be most important. This is reflected in the greater percentage of agreement on items placed in columns -3 and -4, versus the items placed in +3 and +4. Although parents more easily identified items of least importance, it should be noted that these items do not necessarily signify them as being unimportant to parents; rather, these items represent the least important of the 40 items in the Q-set.

Length of Therapy

Fourteen parents (77.9%) placed Item 10 “Completes therapy in as few sessions as possible,” in columns -3 and -4, assigning this process the least amount of importance. In a particularly striking amount of agreement, participants agreed on the placement of this item more than any other item included in Q-set. Although CCPT is not necessarily a long-term treatment

approach, play therapists are encouraged not to “impose predetermined solutions on the child in order to hurry up the process of growth” (Landreth, 2012, p. 365). CCPT is specifically designed to rely on a child’s natural development toward growth and healing, and this process should be respected in order for CCPT to be effective (Landreth, 2012). These results indicate that parents participating in this study seemed to align with this philosophy. When completing the post Q-sort questionnaire, several parents reported believing that therapy for children should not be a “quick fix.” One parent explained, “I just want him to feel better. It doesn’t matter how long it takes.” Another parent said, “Quickness isn’t important to me. She should be allowed to go at her own pace,” while another said, “I trust the process.” It is unclear whether these parents were more likely to seek CCPT as a treatment modality that aligned with their beliefs, or if interactions with their play therapists over time influenced their beliefs. Either way, these particular parents seemed to strongly value the importance of accommodating their children’s natural pace of healing.

Mental health professionals are facing increasing pressure from managed care companies to treat clients as quickly and efficiently as possible, and this has prompted the development of multiple short-term play therapy approaches (Kaduson & Schaefer, 2006). In fact, CCPT has been found to be effective in as few as four sessions (Post, 1999). Additionally, Ray (2008) assessed archival data for over 200 children who participated in CCPT and found significant results beginning at 11-18 sessions, or approximately three to four months of weekly sessions. However, short-term therapy is not appropriate for all children (Landreth, 2012). Results of meta-analyses conducted by LeBlanc and Ritchie (2001) and Bratton et al. (2005) found optimal treatment effects when children participated in 30-40 play therapy sessions. At times, managed care companies seem to be at odds with practices that play therapists know to be effective;

therefore, Landreth (2012) encouraged play therapists “to be diligent in educating managed care providers and agency administrators about the emotional and developmental needs of children and the efficiency of the play therapy process” (p. 365). The clinic in which this study took place did not accept payments from third-party payers, hence, parents participating in this study paid out-of-pocket for their children’s services, perhaps demonstrating the value they placed on CCPT and respecting their children’s developmental needs. It is possible these parents were more supportive of a larger number of sessions because they were receiving services on a reduced fee sliding scale basis, whereas parents paying standard fees in private practice settings may have reported more importance on short-term therapy. However, the majority of parents in this study rated Item 22, “Is sensitive to and tries to be accommodating of my financial constraints,” as being neutral or of lesser importance, suggesting they placed greater importance on meeting the child’s needs over their financial concerns. However, many families across the United States do not have access to a low-cost community counseling clinic nor are they able to afford standard fees charged by play therapists in private practice. Therefore, these results support the importance of play therapists advocating on behalf of children and families and the profession of play therapy for decreased restrictions regarding treatment length.

Role of Technology

Twelve parents (66.7%) placed Item 2 “Incorporates the use of current technology such as online forms and scheduling, computerized record-keeping, or interactive webpage,” in the -3 and -4 columns, assigning this process the least amount of importance. The percentage of agreement regarding this item was second only to the length of treatment. Again, this is a striking finding given the role that technology currently plays in society, particularly in regard to the internet, smart phones, and social media. The newest revision of the American Counseling

Association's (ACA) *Code of Ethics* (2014) includes an expanded section regarding guidelines for counselors' use of social media and technology in counseling. For the first time, counselors are now ethically mandated to be knowledgeable of the evolving role of technology in counseling and understand how these resources may be used to strengthen the services provided to clients.

Furthermore, the Association for Play Therapy's (APT) *Best Practices* (2012) includes regulations regarding the role of technology in play therapy, specifically related to online communication, social media, web sites, and the use of technology in session. In "The iPad Playroom," Snow and colleagues discussed the increasing frequency in which technology is being represented in play therapy sessions, and they discussed their utilization of iPad applications as therapeutic techniques for children (Snow, Winburn, Crumrine, Jackson, & Killian, September, 2012). Parents in this study reported placing little importance on the role of technology. When asked why they sorted the incorporation of technology in the least important column, several parents simply stated, "I don't care about that." One parent explained, "The clinical part is more important," while another said, "The personal part is more important to me." One parent was a bit more supportive of technology but explained, "Technology is great, but it doesn't make [play therapy] better." Although the increasing role of technology is relatively new, it is rapidly evolving, and play therapists must be prepared to decide the extent to which they embrace its integration into their practice.

Play Therapists as Parents

Eight parents (44.4%) placed Item 12 "Has experience being a parent themselves," in columns -3 and -4, assigning this item the least amount of importance. CCPT scholars have not supported the idea that all play therapists should be parents themselves. However, this item was

included in the Q-set due to consultation with expert faculty members and practitioners regarding their experiences in working with parents. Consultation resulted in consensus that parents appear to assign greater credibility to play therapists who are also parents. Yet, this consensus was not supported by findings in this study. This is a surprising finding, given that play therapists, particularly those who appear young, frequently report that they are asked if they have children.

The parents who participated in this study placed little value on the importance of play therapists being parents themselves. One parent shared, “Play therapists can be competent without being parents. Some parents are bad parents. Training and experience matter more.” Another parent said, “I could care less about this. You don’t need to be a parent to understand kids and be a good therapist,” while another shared, “Not being a parent can help you be more objective, and I think experience as a play therapist is more important.” It is unclear if parents felt this way prior to beginning play therapy or if this belief was developed over time through building trusting relationships with their play therapists. Regardless, these explanations as to why parents ranked this item as least important appears to be connected with the higher value they place on play therapists’ training and experience, which is discussed in further detail in the following section.

Play Therapists’ Expert Knowledge, Training, and Supervision

Seven parents (38.9%) placed Item 9 “Has expert knowledge regarding children, child behavior, and child development,” in columns +3 and +4, while six parents (33.3%) placed Item 38 “Has received training and supervision in play therapy,” in columns +3 and +4. This indicates, in general, parents who participated in this study valued play therapists’ expert knowledge, training, and supervision experiences. These results are not surprising considering parents typically want the best available services for their children. The parents who participated

in this study specifically sought services from a clinic specializing in children and families, trusting that the counselors were well trained and supervised.

These findings support the ACA's *Code of Ethics* (2014), which mandates, "Counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience" (C.2.b). Additionally, APT (2014) has established guidelines for certification as a Registered Play Therapist (RPT). Requirements include licensure as a mental health professional along with 150 hours of play therapy specific instruction and 500 hours of supervised clinical experience practicing play therapy. Specific to CCPT, Ray (2011) asserted, "Facilitation of CCPT requires extensive training for the play therapist providing services to children" (p. 301). Ray recommended all mental health professionals who practice CCPT should, at a minimum, complete a 3-credit-hour graduate level course focused on the principles of child-centered philosophy and a supervised clinical experience in which students practice CCPT skills. Ray considered this a minimal standard presumably because much more training and experience is needed for play therapists to develop the expert knowledge regarding children, child behavior, and child development.

Although play therapy is a growing field, graduate courses and supervised clinical experiences in play therapy are not standard in most graduate mental health training programs across the United States. APT maintains a database of universities offering graduate courses in play therapy (www.a4pt.org). As of September 2014, 183 graduate mental health programs in the United States reported offering at least one play therapy course. However, only 77 of these programs reported having a RPT or RPT-Supervisor (RPT-S) among their faculty and offering supervised clinical experiences practicing play therapy in addition to coursework. Further, previous research has indicated many mental health professionals lack training or practice play

therapy without obtaining adequate training (Cerio, Taggart, & Costa, 1999; Ray, Armstrong, Warren, & Balkin, 2005; Ryan, Gomory, & Lacasse, 2002).

In light of results of this study, it seems parents align with professional standards and support training for play therapists. As one parent shared her opinion, mental health professionals, “shouldn’t be doing play therapy without training,” while another parent said, “You should be trained in play therapy if you’re practicing play therapy.” These results send a valuable message to practitioners. In order for play therapists to maintain professional standards, it is important that the field work to expand the amount of high quality play therapy training that is available to mental health professionals across the country.

Gathering Background Information

Eleven parents (61.1%) placed Item 34 “Gathers information about my child’s background and current issues at home and school, including behavioral, emotional, academic, and medical information,” in columns +3 and +4, while six parents (33.3%) placed Item 32 “Seeks to understand and addresses my specific concerns regarding my child” in columns +3 and +4. These results indicate parents seem to value the process of play therapists gathering a wide variety of information sufficient enough to understand the specific needs of each individual child client. One parent explained, “Every kid is different. Play therapists need to understand their uniqueness to determine what’s normal given their background.” Another parent explained why she placed Item 32 as most important by saying, “You need to understand my child and her needs. That’s why we’re here.”

This process has been covered extensively by CCPT scholars (Cochran et al., 2010; Landreth, 2012; Ray, 2011; VanFleet et al., 2010; Wilson & Ryan, 2005) who have recommended gathering extensive information during a first meeting with a parent. Further, Ray

(2011) created a detailed developmental history questionnaire to help guide play therapists in clarifying parents' concerns and further conceptualizing individual children. Given the importance parents placed on these processes, it seems play therapy training could be strengthened by allotting adequate time to helping students develop intake and assessment skills, not only for the first session, but throughout their therapeutic relationships with parents.

Typically play therapy training focuses on skills utilized in the playroom with children. In the spirit of Ray's (2011) developmental history questionnaire, play therapists may benefit from more time devoted to the topic of working with parents and helping students learn how to effectively gather sufficient information to understand and respond to each parent's concerns.

Conceptualizing Play Therapy and Teaching Parenting Skills

Eight parents (44.4%) placed Item 25 "Helps me understand what my child does in the play therapy room and how it impacts changes in his or her behavior at home and school," in columns +3 and +4, while seven parents (38.9%) placed Item 1 "Teaches me how to respond effectively to my child when he or she is having behavioral problems," in columns +3 and +4, assigning these processes high importance. Given the results described in the previous section, parents highly value play therapists who understand the unique and individual needs of their children. As an extension to that notion, it seems parents also value play therapists who can help them understand their child's unique progress in play therapy. One parent explained, "I appreciate when [my child's play therapist] helps me understand how to respond to my child in a helpful way based on their sessions. [My child's play therapist] helps me understand the world from [my child's] perspective." Several parents mirrored the importance of play therapists helping them understand what happens in play therapy sessions to help them see the world from their children's perspectives. One parent shared why it is important for her that her play

therapist helps her understand the impact of her child's behavior in the playroom, "If I don't understand why it's helping, I won't come back."

As discussed previously it is important for play therapists to be well-trained in play therapy and knowledgeable regarding children, child behavior, and child development. This knowledge and training is necessary to help strengthen a play therapist's ability to conceptualize a child's behavior in session and translate for a parent how that behavior impacts the child outside of play therapy. Moreover, the stronger a play therapist's conceptualization ability, the better equipped she may be to teach a parent how to respond to his child's unique behavioral issues. CCPT scholars (Landreth, 2012; Ray, 2011; VanFleet et al., 2010) have recommended play therapists use part of their consultation meetings with parents to teach specific skills that help parents respond to their children more effectively, and parents in this study placed high value on this process. One parent shared, "I want to know what I can do for [my child] to be helpful to her." Another parent described this process as helping her to have "tools in my toolbox." Again, it seems play therapy training could be strengthened by devoting adequate time to helping play therapists develop skills outside of what happens in the play therapy room. Play therapists benefit from strong conceptualization skills and an ability to share their clinical insights with parents in a helpful and meaningful way. Additionally, play therapists can share their insights with parents by teaching skills they can utilize at home to further promote their children's healing and encourage improvement in social and emotional functioning.

Therapeutic Relationship

Seven parents (38.9%) placed Item 40 "Cares about me," in columns -3 and -4, assigning this item little importance. One parent explained, "The focus should be on my child, not me. I could get my own counselor to talk about issues not related to parenting." This is somewhat

surprising given that CCPT scholars have discussed the importance of developing positive relationships with parents in more depth than any other issue related to working with parents (Cochran et al., 2010; Landreth, 2012; Ray, 2011; VanFleet et al., 2010; Wilson & Ryan, 2005). However, it should be noted that parents did not report feeling as if their relationships with their play therapists were unimportant. Rather, they ranked Item 40 lower in importance than most other items. Other items related to relationships between parents and play therapists (e.g. Item 8 “Respects me and considers me important to my child’s therapy,” Item 11 “Provides me with emotional support and addresses my needs and concerns,” Item 16 “Helps me feel heard and understood,” and Item 30 “Engages me as a partner in my child’s therapy and includes me in decision-making such as setting goals for therapy, planning for parent sessions, and making changes in my child’s therapy”) were more highly ranked by parents. Several parents reported that feeling cared about was important to them but not as important as play therapists caring about their children. Several parents shared that play therapy should be “more about my child.” One parent explained, “We’re not here for me. But if it’s in my child’s best interest, I know I might have to talk about difficult things.” Furthermore, it seems feeling cared about may have been important to parents, but only to the extent to which play therapists were able to communicate understanding of the parents and their concerns about their children. Given the rankings of all the items related to the quality of relationships between parents and play therapists, it seems parents tended to more highly value the aspects of the relationships that directly impacted their children. Perhaps these findings could best be summarized by a parent who said, “I don’t need to be cared about. We just need to be able to work together and care about my kids.” Landreth (2012) suggested that developing a trusting working alliance with a parent should be placed above all other goals in facilitating a parent’s involvement in CCPT.

Results of this study suggest a successful working alliance could perhaps be best established by play therapists who are able to demonstrate and utilize their expertise and knowledge of child development in a way that demonstrates an empathic understanding of a parent's concerns and the child's individual needs.

Limitations

This study was the first to investigate parents' values regarding the services they have received in CCPT, and the results provide valuable information for practicing play therapists and supervisors. However, a few limitations regarding the results of this study should be acknowledged. First, because all participants in this study were parents of children currently receiving CCPT in the university-based counseling clinic in which this study took place, the views of parents of children receiving other types of play therapy and those receiving play therapy in other types of settings like private practice were not assessed. Additionally, the views of parents who received CCPT services and terminated prematurely were not assessed. Parents of children who have elected to receive other types of mental health services, those in other types of settings, and those who have been dissatisfied with their experiences with play therapy may represent views quite different than those of the parents who participated in this study. Therefore, although results obtained from this study will be helpful in informing the practice of play therapists who provide CCPT; this study is limited in its impact to inform the practice of other types of play therapy or counseling with children and play therapy facilitated in other types of settings.

Furthermore, in Q-methodology studies, researchers attempt to investigate similarities and differences among distinct participant groups identified using factor analysis. However, the data collected in this study revealed a single factor solution indicating there was general

consensus of values among 18 of the 19 parents. Noted Q-methodologist, Steven Brown (2010), suggested that overwhelming consensus could represent a conscious or subconscious ideal ordering of values rather than participants' true beliefs. Because all the parents in this study were receiving services from play therapists practicing CCPT, and none of the parents reported being dissatisfied with those services, it is possible their reported values could have been influenced by their interactions with the play therapists. Their values may have been different at the initiation of therapy but have since been shaped by their participation in CCPT. For example, during parent consultations, play therapists would have explained play therapy in a manner consistent with CCPT philosophy, and over time, these interactions could have shaped the parents' beliefs to more closely align with CCPT philosophy. When and how parents developed these beliefs is unclear, but their reported satisfaction and continue commitment to therapy further demonstrates their support of CCPT.

Regarding the Q-sort items, it is possible the items failed to represent an accurate breadth of values held by parents. Participants in all Q-methodology studies are constrained by the limited items they are given to sort. If additional or alternate items had been included in the Q-set, this could have altered what parents reported as being most and least important. After completing the Q-sort, all participants were asked, "As you sorted the cards, did you feel that anything was missing? If so, what?" (see Appendix D). In response to this question, none of the parents reported additional values that they would have sorted as being most important to them.

An additional limitation regarding the participants involved the selection of a small, convenience sample of parents. Q-methodology, by its nature, involves an in-depth analysis of a small group of participants. The intent in conducting Q-methodology is not to generalize findings to a larger population; rather the intent is to inform practice (Watts & Stenner, 2012).

Because all the parents in this study were recruited at the same university-based counseling clinic, the findings are specific to this clinic's clientele, and therefore the results of this study can directly inform the practice and procedures of this clinic. However, these results can also be used to guide future research endeavors with a larger goal of impacting the practice of CCPT with all children and their parents in all types of settings.

Implications for Practice

Despite the limited generalizability, the results of this study provide important implications for the practice of CCPT. The one factor solution representing 18 of the 19 participants seems to indicate that parents, despite the diversity of their backgrounds and experiences, are in consensus on CCPT processes and services generally regarded by CCPT scholars as being standard practice, at least in this setting. The practice of CCPT may be strengthened by play therapists who understand and respect these commonalities when working with parents.

Additionally, the completion of this study represents a first step toward developing best practice standards for working with parents in CCPT. Other than recommendations of CCPT scholars, no empirically supported guidelines exist regarding the facilitation of parent consultations in CCPT. Ray (2011) developed a manual describing the attitudinal qualities and therapeutic skills play therapists should demonstrate to successfully conduct CCPT sessions, and the effectiveness of these standards have been supported by the manual's use in multiple research studies (e.g. Bratton et al., 2013; Ray, Stulmaker, Lee, & Silverman, 2013; Swan & Ray, 2014). By following guidelines provided in the manual, play therapists are provided a structure for specific behaviors they should demonstrate in the playroom in order to increase the effectiveness of CCPT. On the other hand, no such uniform set of guidelines exists for how parent

consultations should be structured. Currently, play therapists implement parent consultations based on their own interpretations of recommendations from various CCPT scholars. The results provided by this study offer empirical support for some of these recommendations, including the use of didactic instruction to teach new parenting skills and assessment and information gathering techniques to gain an understanding of the unique background and needs of the child. Play therapists may benefit from considering these findings when working with parents.

However, more research is needed to continue the development of specific guidelines and to empirically test their effectiveness. For example, future studies could investigate the attitudinal qualities and therapeutic skills play therapists should demonstrate in parent consultation sessions and the impact these may have on the therapeutic effectiveness of CCPT. Furthermore, the extent to which these attitudinal qualities and skills reflect person-centered theory should be explored to ensure the development of guidelines and standards that are theoretically consistent with the philosophy of CCPT.

Implications for Training

The results of this study offer important implications for the training of future child-centered play therapists. Given the importance parents placed on play therapists' skills such as didactic instruction and information gathering and assessment, it seems important that sufficient attention should be paid to developing these skills when training play therapists. As previously discussed, the availability of play therapy courses is limited across the United States, and those courses that are available tend to focus primarily on teaching students therapeutic skills to utilize with children, rather than parents. Because parents typically serve as gatekeepers for children accessing play therapy services, it seems parent consultation skills are just as important to the overall success of therapy as therapeutic skills with children. Hence, students may benefit from

play therapy courses in which more time is devoted to the topic of parent consultations. Furthermore, play therapy students may benefit even more so by an entire course devoted to working with parents and developing attitudinal qualities and skills to utilize in parent consultations.

Implications for Future Research

Because this study represents one of the first attempts to explore the role of parents in CCPT, much more research is needed. Perhaps most importantly, a more generalizable research methodology, such as a national survey targeting play therapists across the United States, should be used to further investigate parents' perceptions and needs on a much larger scale. Taking the results of this study into account, larger samples of parents should be investigated to more specifically determine parents' opinions regarding length of treatment, use of technology, and characteristics of successful working alliances between parents and play therapists. A larger sample of parents would allow for greater insight into the diversity of needs that may exist among parents across gender, race, age, ethnic background, and socioeconomic status. Additionally, to further investigate the limitations of the setting in which this study took place, this study could be replicated with parents in a different type of setting, such as a private practice.

Another area worthy of investigation includes the needs of parents who received CCPT services and terminated prematurely. The participants in this study represented parents who were satisfied with the services they received. The needs of parents who accessed CCPT services and did not complete treatment have not been thoroughly investigated. More information is needed as to why parents terminate prematurely in order to understand the role

play therapists play in increasing treatment completion rates and providing the most effective services to all families who seek CCPT services.

Conclusion

In this study Q-methodology was utilized to investigate the values of parents regarding the services they received from child-centered play therapists at a university-based counseling clinic. The results revealed a single factor solution representing general agreement among 18 of 19 participants. Parents were selected across a variety of demographic characteristics representative of the clinic's clientele, and despite the diversity of the sample, results revealed a consensus of beliefs. In general, parents' beliefs aligned with CCPT philosophy, particularly in regards to respecting children's natural pace of development and healing. Furthermore, parents shared preferences for play therapists who demonstrated expert knowledge and training and who understood the individual needs of their children. In spite of limitations, the results of this study offered several implications regarding the practice of CCPT and training of future play therapists. However, because this study was the first to explore parents' needs in CCPT, further research is warranted to develop standards of best practice for involving parents in CCPT.

APPENDIX A

Q-SAMPLE STATEMENTS FOR CONSIDERATION IN Q-SET

No.	Statement
1	Play therapists should conduct interviews with parents to gain information about the child.
2	Play therapists should conduct interviews with teachers to gain information about the child.
3	Play therapists should obtain information from parents to help assess the child's growth and change.
4	Play therapists should offer parenting suggestions to parents.
5	Parents should meet with a play therapist who doesn't see their child for support and parenting suggestions.
6	Play therapists should provide parenting skills training to teach parents more effective parent skills.
7	Play therapists should refer parents for personal therapy or counseling if appropriate.
8	Play therapists should help parents understand how the child's behaviors in the play therapy room impact changes in their behaviors at home and school.
9	Play therapists should build collaborative relationships with parents.
10	Play therapists should address parents' needs and concerns.
11	Play therapists should consider parents as important to their child's therapy.
12	I want to feel heard and understood by my child's play therapist.
13	Play therapists should explain to parents what play therapy is and how it works.
14	Play therapists should help parents understand why play therapy is used with children.
15	Play therapists should help parents know what to expect during the play therapy process.
16	Play therapists should give parents a tour of the playroom where their child participates in play therapy sessions.
17	Play therapist should teach parents how to respond to their child's defiant behavior in the waiting room (i.e. clinginess, refusal to leave, etc.)
18	Play therapists should teach parents what to say to their children to prepare them for their first session.
19	Play therapists should discuss with parents the physical risks of their children participating in play therapy.
20	Play therapists should discuss with parents the emotional risks of their children participating in play therapy.
21	Play therapists should help parents understand their child's confidentiality regarding what happens in the playroom.
22	Play therapists should allow parents opportunities to observe their child's play therapy sessions.
23	Play therapists should discuss with parents the importance of consistency in attendance to scheduled play therapy sessions.
24	Play therapists should consistently schedule parent consultation sessions with parents.
25	Play therapists should provide opportunities for parents to discuss their child's developmental progress and emotional and behavioral changes.
26	Play therapists should work to understand the unique needs of each family.
27	Play therapists should provide emotional support to parents.

- 28 Play therapists should provide parents with training in specific parenting skills to help them respond to their child in more positive ways.
- 29 Play therapists should provide parents with information regarding their child's behavior compared to other children his/her age.
- 30 Play therapists should conduct parent consultation sessions with all of a child's primary caretakers (i.e. mom, dad, step-parents, custodial grandparents, etc.)
- 31 Play therapists should help parents know how to respond to things their child creates in the playroom.
- 32 Play therapists should help parents know how to talk to their child about what he/she does in the playroom.
- 33 Play therapists should provide parents with opportunities to ask questions and get answers for their concerns.
- 34 Play therapists should provide parents with opportunities to share their feelings, such as guilt, frustration, and angry toward their child.
- 35 Play therapists should stay updated on each child's medications or any health issues.
- 36 Play therapists should have their own children and have the experience of being parent themselves.
- 37 Play therapists should have extensive experience working with children.
- 38 Play therapists should have received adequate training in play therapy procedures.
- 39 Play therapists should have expert knowledge regarding children, child behavior, and play therapy.
- 40 Play therapists should collaborate with other professionals in each child's life, such as pediatricians, teachers, school counselors, etc.
- 41 Play therapists should be nonjudgmental or evaluative.
- 42 Play therapists should display warmth and care toward my child.
- 43 Play therapists should be open-minded and flexible.
- 44 Play therapists should have a sense of humor.
- 45 Play therapists should respect a parent's relationships with their child as the most important relationship in their child's life.
- 46 Play therapists should respect parents' knowledge regarding their child.
- 47 Play therapists should care about the parents they work with.
- 48 Play therapists should be patient.
- 49 Play therapists should seek to understand parents' specific concerns regarding their children.
- 50 Play therapists should seek to understand parents' expectations regarding the outcomes of play therapy.
- 51 Play therapists should address children's need holistically.
- 52 Play therapists should understand a child's previous experiences in counseling/therapy.
- 53 Play therapists should engage parents as partners in their child's therapy.
- 54 Play therapists should recognize and address any cultural differences between them and the families they work with.
- 55 Play therapists should work with parents to understand and establish goals for their child's progress.
- 56 Play therapists should respect a parent's rights to make decisions for their child.
- 57 Play therapists should provide parent opportunities to contact them outside regularly scheduled appointments (i.e. by phone, email, or video conferencing).

- 58 Play therapists should listen carefully to parents and work to understand their needs.
59 Play therapists should have helpful information available to parents in the waiting room.
60 Play therapists use standardized assessments to measure my child's symptoms and progress.
61 When play therapists use standardizes assessments, they clearly explain the results to parents and relate the results to the child's overall progress.
62 Play therapists should provide treatments strongly grounded in a theoretical framework.
63 Play therapists should provide safety for children to freely express themselves.
64 Play therapist should provide treatments sensitive to a child's cultural and familial values.
65 Play therapists should collaborate with a child's school as needed.
66 Play therapists should schedule frequent parent consultations meetings.
67 Play therapists should incorporate family members into a child's treatment when appropriate.
68 Play therapists should work collaboratively with parents to define treatment goals.
69 Play therapists should explain the process of play therapy in parent-friendly terms.
70 Play therapists should provide practical parenting advice.
71 Play therapists should explain child's progress in parent-friendly terms.
72 Play therapists should participate in supervision/consultation to ensure high quality treatment.
73 Play therapists should explain assessment results in terms parents can understand.
74 Play therapists should focus on both short- and long-terms goals.
75 Play therapists should convey non-judgmental attitudes toward parent's perspective.
76 Play therapists should allow opportunities for parents to determine agenda of parent consultations.
77 Play therapists should refer children to child psychiatrists when appropriate.
78 Play therapists should incorporate newest editions of assessments into practice.
79 Play therapists should provide treatment in as few sessions as possible.
80 Play therapists should communicate with parent using multiple sources of communication (i.e. phone, email, etc.).
81 Play therapists should utilize treatments deemed "evidenced-based" for working with a child's presenting concerns.
82 Play therapists should respond positively and immediately to special requests made by parents.
83 Play therapists should place primary emphasis on short-term goals.
84 Play therapists should incorporate use of latest technology available into practice.
85 Play therapists should stay knowledgeable on the latest advancements in the field and incorporate new knowledge into practice.
-

APPENDIX B
REQUEST FOR PARENT FEEDBACK ON FINAL Q-SET

Dear Parent,

Thank you for your time! I am in the process of developing a questionnaire to assess parents' values regarding the services they receive from play therapists, and I need your help with creating statements to include on the questionnaire.

I want to know what is most important to parents when they meet with their child's play therapist. Below are some statements of things play therapists might do with parents. I would like your feedback on these statements.

- * Do these statements seem to represent things you might value if your child was participating in play therapy?
- * Are any of the words or phrases confusing or unclear?
- * Is there something missing that I didn't include that would be important to you if your child was participating in play therapy?

Any and all feedback is welcomed and appreciated. Thank you for time and honesty!

No.	Statement
1	Teaches me how to respond effectively to my child when he or she is having behavioral problems.
2	Incorporates use of latest technology such as online forms and scheduling, computerized record-keeping, or interactive webpage.
3	Refers me for personal therapy or counseling if appropriate.
4	Knows about and uses effective interventions supported by research.
5	Discusses possible risks of my child participating in play therapy.
6	Helps me practice new ways to respond to my child.
7	Helps me understand play therapy, how it works, and why it's helpful for my child.
8	Respects me and considers me important to my child's therapy.
9	Has expert knowledge regarding children, child behavior, and child development.
10	Completes treatment in as few sessions as possible.
11	Provides me with emotional support and addresses my needs and concerns.
12	Has experience being a parent themselves.
13	Recognizes and addresses cultural values or unique needs of our family.
14	Helps me understand if my child's behavior and development is typical for his or her age.
15	Teaches me how to talk to my child about being in play therapy.
16	Helps me feel heard and understood.
17	Responds positively and immediately to my attempts to contact him or her and special requests that I might make.
18	Refers to and collaborates with medical professionals such as pediatricians, psychiatrists, and other specialists.
19	Provides opportunities to contact him or her outside our regularly scheduled appointments, for example, by phone, email, or webcam.
20	Schedules frequent and consistent parent consultation meetings.
21	Uses questionnaires/assessments to measure my child's symptoms and explains the results to help me understand my child's progress.
22	Is sensitive to and tries to be accommodating of my financial constraints.

23	Helps me know how to respond to my child following his or her play therapy sessions.
24	Helps me see and understand my child's progress in play therapy.
25	Helps me understand how what my child does in the play therapy room impacts changes in his or her behavior at home and school.
26	Teaches me more effective parenting skills.
27	Includes other family members, such as step-parents, guardians, grandparents, or other caregivers, into my child's treatment when appropriate.
28	Provides me with new disciplinary strategies.
29	Helps me respond to my child in more positive ways.
30	Engages me as a partner in my child's therapy and includes me in decision-making such as setting goals for therapy, planning for parent sessions, and making changes in my child's treatment.
31	Helps me understand my child's confidentiality regarding what happens in the playroom.
32	Seeks to understand and addresses my specific concerns regarding my child.
33	Gains information from and collaborates with professionals at my child's school such as teachers, school counselors, or administrators.
34	Gathers information about my child's background and current issues at home and school, including behavioral, emotional, academic, and medical information.
35	Discusses timeframe for when my child will end therapy.
36	Has extensive experience working with children.
37	Offers parenting suggestions and practical advice.
38	Has good training and supervision in play therapy.
39	Has helpful books, videos, brochures, and other information available to me.
40	Cares about me.

APPENDIX C

FINAL Q-SET

No.	Statement
1	Teaches me how to respond effectively to my child when he or she is having behavioral problems.
2	Incorporates the use of current technology such as online forms and scheduling, computerized record-keeping, or interactive webpage.
3	Recommends personal therapy or counseling for me if appropriate.
4	Knows about and uses effective therapies supported by research.
5	Discusses possible risks of my child participating in play therapy.
6	Helps me practice new ways to respond to my child.
7	Helps me understand play therapy, how it works, and why it's helpful for my child.
8	Respects me and considers me important to my child's therapy.
9	Has expert knowledge regarding children, child behavior, and child development.
10	Completes therapy in as few sessions as possible.
11	Provides me with emotional support and addresses my needs and concerns.
12	Has experience being a parent themselves.
13	Recognizes and addresses cultural values and unique needs of my family.
14	Helps me understand if my child's behavior and development are typical for his or her age.
15	Teaches me how to talk to my child about being in play therapy.
16	Helps me feel heard and understood.
17	Responds positively and immediately to special requests that I might make.
18	Makes referrals to and collaborates with medical professionals such as pediatricians, psychiatrists, and other specialists.
19	Provides opportunities to contact him or her outside our regularly scheduled appointments, for example, by phone, email, or webcam.
20	Schedules frequent and consistent parent consultation meetings.
21	Uses questionnaires or assessments to measure my child's symptoms and explains the results to help me understand my child's progress.
22	Is sensitive to and tries to be accommodating of my financial constraints.
23	Helps me know how to respond to my child following his or her play therapy sessions.
24	Helps me see and understand my child's progress in play therapy.
25	Helps me understand what my child does in the play therapy room and how it impacts changes in his or her behavior at home and school.
26	Teaches me more effective parenting skills.
27	Includes other family members, such as step-parents, guardians, grandparents, or other caregivers, into my child's treatment when appropriate.
28	Provides me with new disciplinary strategies.
29	Helps me respond to my child in more positive ways.
30	Engages me as a partner in my child's therapy and includes me in decision-making such as setting goals for therapy, planning for parent sessions, and making changes in my child's therapy.
31	Helps me understand my child's need for privacy regarding what happens in the playroom.
32	Seeks to understand and addresses my specific concerns regarding my child.
33	Gains information from and collaborates with professionals at my child's school such as teachers, school counselors, or administrators.
34	Gathers information about my child's background and current issues at home and school, including behavioral, emotional, academic, and medical information.

- 35 Discusses timeframe for when my child will end therapy.
 - 36 Has extensive experience working with children.
 - 37 Offers parenting suggestions and practical advice.
 - 38 Has received training and supervision in play therapy.
 - 39 Has helpful books, videos, brochures, and other information available to me.
 - 40 Cares about me.
-

APPENDIX D:
POST Q-SORT QUESTIONNAIRE

****Q-SORT INFORMATION****

1. Refer to the statements you placed in the “Most Important” column. What do these statements mean to you?

2. Refer to the statements you placed in the “Least Important” column. What do these statements mean to you?

3. As you sorted the cards, did you feel that anything was missing? If so, what? Where would you place the card and why?

****PLAY THERAPY INFORMATION****

1. What is the primary reason your child is currently receiving play therapy?

2. How satisfied are you with the play therapy services you have received at the Child and Family Resource Clinic?

Highly Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Highly Dissatisfied
5	4	3	2	1

3. What could the clinic or your play therapist do to help you feel more satisfied?

APPENDIX E
CHILD/ADOLESCENT BACKGROUND INFORMATION FORM

CFRC _____
CHDC _____

University of North Texas
Department of Counseling and Higher Education
Counseling Program Clinical Services

Child/Adolescent Background Information (use for all minors)

Welcome to the Child and Family Resource Clinic. Please answer all information as completely as possible. If applicable, both mother and father should complete together. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. Your child's counselor will discuss your responses with you after he/she has reviewed the form.

Child's Name: _____ Date of First Visit: _____
Last First MI

Completed by: _____ Relationship to Child: _____

Cell Phone: _____ (May call? Yes No May Leave Message? Yes No)

Home Phone: _____ (May call? Yes No May Leave Message? Yes No)

Work Phone: _____ (May call? Yes No May Leave Message? Yes No)

Best Time and Place to call: _____

Child's Address: _____
Street City State Zip

(12) Child's Gender: Male _____ Female _____ (13) Age _____ (14) Date of Birth ____/____/____

(15) Child's Ethnicity:

African American _____ Bi-racial _____ Hispanic/Latin _____
 Asian _____ Caucasian _____ Native American _____ Other _____

Child's primary language: English _____ Spanish _____ Other _____

Language spoken at home (parent's language): _____

Child's Legal Guardian (Managing Conservator): _____

(If the child is not living with both natural parents, both adoptive parents, or only living parent, the clinic requires a photocopy of the legal document stating custody arrangements, consisting of the cover page, page specifying conservator(s), and signature page). (The photocopy should be stapled to this form.)

In case of emergency, contact: _____
Name: Last, First Relationship Phone

Is your child presently receiving counseling elsewhere? Yes No

(If yes, do not complete this form until you have talked with your counselor)

Family members receiving services at this clinic? Yes No (Name/Dates of service) _____

Is your child currently on probation? Yes No School Child attends: _____

Current School Address & Phone: _____

Grade Level (now): _____ Has your child ever been retained? Yes No If yes, what grade? _____

Current Teacher(s): 1) _____ 2) _____ 3) _____

Current School Counselor: _____

(16) Is your child receiving special education or other services? Yes No

(explain) _____

Has your child ever seen a mental health professional (psychiatrist, psychologist, or a counselor)? Yes No (If so, we will need your permission in order to communicate with that individual or agency)

Previous Mental Health Professional/Agency: _____
Name Address

Phone: _____ Dates of Service: _____ (beginning - ending)

Has your child been hospitalized for mental health concerns? Yes No

If yes: When _____ Where _____

How were you referred to our clinic? (Check those that apply):

Counselor/Psychologist/Psychiatrist _____		School personnel _____
Court _____	Minister _____	Self _____
DPRS _____	Newspaper Ad _____	UNT Community _____
Flyer _____	Physician _____	Yellow Pages _____
Friend or Co-Worker _____	Relative _____	Other _____

Are you seeking services because your child is a victim of a crime? Yes No

Did it result in legal action? Yes No (If Yes, explain) _____

Person responsible for financial arrangements with our clinic: _____
Name: Last, First

Are you applying for sliding scale payments? Yes No

(17) Gross Household Annual Income (including Child Support Payments)

Less than \$15,000 _____ 15,000 – 20,000 _____ 20,001 – 30,000 _____ 30,001 – 40,000 _____ 40,001+ _____

(18) How many family members currently reside in your home? _____

*** INFORMATION ON CHILD'S MOTHER ***

Mother's Name: _____

(19) I am: _____
Last First MI
_____ biological mother _____ stepmother _____ adoptive mother other _____

Address: _____

Street City State Zip

Home Phone: _____ Work Phone: _____
(May call: Yes No Leave Message: Yes No) (May call: Yes No Leave Message: Yes No)

Date of Birth: _____	Occupation: _____
Employer: _____	How Long: _____

(20) Education Level of Mother:

8th grade or below _____	Trade School/Some College _____	Undergraduate Degree _____
High School _____	GED _____	Graduate Degree _____

History of learning, emotional, or behavioral problems: Yes No

(If yes, please explain) _____

History of alcohol/drug/substance abuse: Yes No

(If yes, please explain) _____

History of family violence: Yes No

(If yes please explain) _____

History of criminal activity: Yes No

(If yes, please explain) _____

(21) *Current living arrangements:*

Family of origin____ Single____ Spouse/Partner ____ Roommate____ Other____

(22) *Marital Status (indicate all that apply and duration of each, ex. 1965-1985):*

Never married____ Currently married____ Divorced____ Widowed____ Deceased____

(23) *Marital History*

Number of Marriages____ Number of Divorces____

*** INFORMATION ON CHILD'S FATHER ***

Father's Name: _____

(24) I am _____ *Last* _____ *First* _____ *M.* _____
_____ biological father _____ stepfather _____ adoptive father _____ other _____

Address: _____

Home Phone: _____ *Street* _____ *City* _____ *State* _____ *Zip* _____
(May call: Yes No Leave Message: Yes No) (May call: Yes No Leave Message: Yes No)

Date of Birth: _____	Occupation: _____
Employer: _____	How long: _____

(25) *Education Level of Father*

8th grade or below _____ Trade School/Some College _____ Undergraduate Degree _____
High School _____ GED _____ Graduate Degree _____

History of learning, emotional, or behavioral problems: Yes No

(If yes, please explain) _____

History of alcohol/drug/substance abuse: Yes No

(If yes, please explain) _____

History of family violence: Yes No

(If yes please explain) _____

History of criminal activity: Yes No

(If yes, please explain) _____

(26) *Current living arrangements:*

Family of origin____ Single____ Spouse/Partner ____ Roommate____ Other____

(27) *Marital Status (indicate all that apply and duration of each, ex. 1965-1985):*

Never married____ Currently married____ Divorced____ Widowed____ Deceased____

(28) *Marital History*

Number of Marriages____ Number of Divorces____

*** GENERAL INFORMATION ***

(29) *Child's current household:*

Adoptive parents _____

Father only _____

Foster family _____

Institution _____

Mother only _____

Biological Father and Stepmother _____

Biological Mother and Stepfather _____

Biological Parents _____

Relatives (specify) _____

Grandparents _____

List by Household your child's current family, beginning with the oldest member and include the child:

Primary Household (anyone who currently lives with child)

How long in this current living situation: _____

Name	Age	Gender	Relationship to you (include step, half, etc.)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Child lives in: House _____ Apartment _____ Duplex _____ Other _____

Second Household (non-custodial or extended family - if applicable)

Name	Age	Gender	Relationship to you (include step, half, etc.)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Currently involved in a custody dispute: No Yes (If yes, explain) _____

If divorced, circle the number which best describes your relationship with your ex-spouse.

Hostile		Frustrating		Friendly
1	2	3	4	5

How often does client see non-custodial parent? _____

*** CHILD'S HEALTH ***

Child's Primary Care Physician: _____

Name

Phone

Address

Has your child ever seen a psychiatrist? Yes No

Is child currently seeing a psychiatrist? Yes No (If yes, list name, address and phone):

Name

Phone

Address

Date of LAST complete physical: _____
Physical Disability: Yes No (If yes, explain) _____
Chronic Illness: Yes No (If yes, explain) _____
Terminal Illness: Yes No (If yes, explain) _____

Check the following items for a diagnosis or medication that your child is now receiving or has received:

Diagnosis	Current (list dates)	Past (list dates)	Physician's Name	Name of medication	Dosage
Depression	_____	_____	_____	_____	_____
ADHD	_____	_____	_____	_____	_____
Conduct Disorder	_____	_____	_____	_____	_____
Anxiety/ Nervousness	_____	_____	_____	_____	_____
Manic-Depression (Bipolar)	_____	_____	_____	_____	_____
Schizophrenia	_____	_____	_____	_____	_____
Oppositional Defiant Disorder	_____	_____	_____	_____	_____
Mood/Anger	_____	_____	_____	_____	_____
Tics	_____	_____	_____	_____	_____
Insomnia/ Sleeplessness	_____	_____	_____	_____	_____
Obsessive/ Compulsive	_____	_____	_____	_____	_____
Addictions	_____	_____	_____	_____	_____
Seizures	_____	_____	_____	_____	_____
Post-Traumatic Stress Disorder	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

(If you do not know the name and dosage of current medication, please bring the medication to your next session)

What other medication is your child currently taking?

Medication	Dosage	Taken for what reason?
_____	_____	_____
_____	_____	_____
_____	_____	_____

*** CURRENT CONCERNS ***

(30) Circle the item that you see as the most significant issue for your child. Underline any additional concerns.

Problems Related to Abuse

Current or past physical abuse
Current or past sexual abuse
Current or past emotional abuse
Current or past neglect
History of abandonment
Suspected sexual abuse
History of family domestic violence

Academic/School Problems

Learning difficulties
Problems with peers
Problems with teachers
Speech Problem

Mood-related Concerns

Disturbing memories
Difficulty going to sleep/staying asleep
Nightmares/night terrors
Suicidal ideation
Sadness
Depression
Feelings of guilt and shame
Excessive worrying
Anger/Irritable

Family Relationship Concerns

Difficulty adjusting to family changes
Discipline concerns
Parent-child relationship problems
Sibling concerns
Divorce/Separation
Religious/Spiritual Concerns

Rule-Breaking/Behavior Problems

Aggression toward others
Drug/alcohol use
Truancy
Gang involvement
Running away
Stealing
Intentionally hurting animals
Fire-setting

Other Behavioral Concerns

Sexual identity concerns
Inappropriate sexual behavior
Overeating/refusal to eat
Bedwetting or soiling
Hyperactive/Inattentive

Other Unusual Behaviors

(Please specify) _____

****Remember to circle the most significant issue.***

When did you first become concerned about the main/most significant issue? _____

How have you attempted before now to deal with this issue? _____

Other treatment your child has received to address any of the concerns indicated above: None____

Couples Counseling____

Group counseling____

Individual counseling____

Family counseling____

Hospitalization____

Other _____

*** HISTORY OF TRAUMA/STRESSORS RELATAED TO THE CHILD ***

(For each of the following items that apply, write in your child's approximate age at the time it occurred):

Chronic illness of family member____ Death of significant person____ Domestic Violence____
 Family member absent (explain) _____
 Family member's disability/major accident/illness____
 Family member emotional problems (explain) _____
 Family member suicide (explain) _____
 Parents divorced____
 Child separated from parent (how long and when) _____
 Death of a pet____ Difficult medical treatments____ Natural Disaster____
 Sexual Assault____ Victim of trauma (unusual, terrifying experience)____
 Other_____

History of your child having learning, emotional, behavioral problems: Yes No

(If yes, please explain) _____

History of your child having alcohol/drug/substance abuse: Yes No

(If yes, please explain) _____

History of family violence: Yes No

(If yes, please explain) _____

History of criminal activity in the family: Yes No

(If yes, please explain) _____

Has your child been abused (check all that apply): Physically____ Emotionally____ Sexually____

Has your child been neglected (check all that apply): Physically____ Emotionally____

School Problems (check all that apply):

Academic problems____ Discipline problems____ Social Problems____ Other ____

Early Language/Speech Problems (explain) _____

History of health/physical problems includes: (check all that apply):

Asthma____	Disability____	Nervous stomach ____
Bedwetting____	Dizziness ____	Neurological problems/exam____
Bone/joint/muscle ____	Severe Headaches ____	Severe PMS ____
Chest pain ____	Heart Palpitations____	Serious overeating/under-eating____
Chronic illness____	Hospitalization____	Shortness of breath without exertion ____
Developmental delay(s) ____	Major accident____	Sleep problems____
Chronic Diarrhea ____	Major illness____	Surgeries____ Other_____

*** HOME ATMOSPHERE ***

Your child's current use of Computer, VCR, and Television (circle the number of hours that best describes use):

Computer (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

TV/VCR (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

What do you enjoy most about this child? _____

What do you find most difficult about this child? _____

Anything else you think we need to know? _____

What is the one thing I need to know to help your child today? _____

APPENDIX F

INSTITUTIONAL REVIEW BOARD INFORMED CONSENT FORM

University of North Texas Institutional Review Board

Informed Consent Form

Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the purpose, benefits and risks of the study and how it will be conducted.

Title of Study: Examining Parents' Values in Child-Centered Play Therapy Parent Consultations: A Q-Methodological Investigation

Student Investigator: Kasie Lee, a doctoral candidate at the University of North Texas (UNT) Department of Counseling and Higher Education.

Supervising Investigator: Dr. Dee Ray, a professor in the University of North Texas (UNT) Department of Counseling and Higher Education.

Purpose of the Study: You are being asked to participate in a research study which involves investigation of your values and beliefs regarding the services provided to you by your child's play therapist. The information gathered through this study may be used to enhance the services provided to parents by play therapists and to inform the training of future play therapists.

Study Procedures: You will be asked to sort your values regarding the play therapy services provided to you by your child's play therapist on a continuum of *most important to least important*. You will also be asked to answer background questions about you and your child, such as age, race, gender, marital status, occupation, and educational background. This should take about 30-50 minutes of your time. Your consent also allows me to review the background form located in your child's counseling file that you completed when your child entered play therapy.

Foreseeable Risks: There are no significant foreseeable risks to any participant, but the possibility exists that participants may experience discomfort due to the length of time that may be required for their participation. Any instruments completed by you are considered confidential, meaning that the researchers will not reveal anything that is said or written during the administration process. However, if you disclose child abuse, neglect, exploitation or intent to harm another person, the therapist is required by law to report to the appropriate authority.

Benefits to the Subjects or Others: Although this study may not be of any direct benefit to you, this study is expected to benefit others by providing information to assist the researcher in training future play therapists and by improving play therapy services provided to parents.

Compensation for Participants: You will be compensated \$10.00 for your participation.

Procedures for Maintaining Confidentiality of Research Records: This researcher will take all necessary precautions to protect your confidentiality by coding your signed consent form, your demographic information, and your responses, and maintaining them in separate locations.

When the results of this study are presented, only general demographic information will be disclosed, and therefore, your confidentiality will be maintained. The confidentiality of your individual information will be maintained in any publications or presentations regarding this study.

Questions about the Study: If you have any questions about the study, you may contact Kasie Lee at 940-565-2066 or Kasie.Lee@unt.edu or Dr. Dee Ray, UNT Department of Counseling Development and Higher Education, at 940-565-2066 or Dee.Ray@unt.edu.

Review for the Protection of Participants: This research study has been reviewed and approved by the UNT Institutional Review Board (IRB). The UNT IRB can be contacted at (940) 565-3940 with any questions regarding the rights of research subjects.

Research Participants' Rights: Your signature below indicates that you have read or have had read to you all of the above and that you confirm all of the following:

- Ms. Lee has explained the study to you and answered all of your questions. You have been told the possible benefits and the potential risks and/or discomforts of the study.
- You understand that you do not have to take part in this study, and your refusal to participate or your decision to withdraw will involve no penalty or loss of rights or benefits. The study personnel may choose to stop your participation at any time.
- Your decision whether to participate or to withdraw from the study will have no effect on services provided to you or your child.
- You understand why the study is being conducted and how it will be performed.
- You understand your rights as a research participant and you voluntarily consent to participate in this study.
- You have been told you will receive a copy of this form.

Printed Name of Participant

Signature of Participant

Date

For the Student Investigator: I certify that I have reviewed the contents of this form with the subject signing above. I have explained the possible benefits and the potential risks and/or discomforts of the study. It is my opinion that the participant understood the explanation.

Signature of Student Investigator

Date

APPENDIX G
Q-SORT INSTRUCTIONS

Play therapists provide a number of services in their work with parents. We want to know what is most important to you when you meet with your child's play therapist. These cards include some things play therapists might do with parents. Please sort these cards on a continuum from what is *least important* to *most important* to you. You might feel that all of these cards are important. If you place a card under least important, it does not necessarily mean that the card is unimportant to you.

1. On the table, notice the grid. Within each square on the grid you will place one of the statement cards.

2. Please read through all 40 statement cards to become familiar with the statements.
3. Please read through the statements for a second time. As you read through the statements again, please organize them into three piles:
 - On the left, place the cards with the statements you believe are **least important**.
 - On the right, place the cards with the statements you believe are **most important**.
 - In the middle, place the cards that you feel undecided about (**neutral**).
4. Beginning with the pile on the left (least important), place the 2 cards that you most strongly believe are least important in the far left column under -4.
5. Next, turning to your right side (most important), place the 2 cards that you most strongly believe are most important with in the far right column under +4.
6. Return to the pile on the left, following this pattern as you work your way to the center.
7. You are free to change your mind during the sorting process and switch items around as long as you maintain the requested number of items under each number.
 - You should have 2 cards under markers -4 and +4.
 - You should have 3 cards under markers -3 and +3.
 - You should have 5 cards under markers -2 and +2.
 - You should have 6 cards under markers -1 and +1.
 - You should have 8 cards under marker 0.
8. After you have sorted the cards into 9 columns, please sort each column, from top to bottom, from most important to least important.
9. After you are satisfied with the placement of the cards, please leave them neatly on the grid, and we will complete the post-sort questionnaire.

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APPENDIX H

RECEIPT OF COMPENSATION FOR PARTICIPATION FORM

Receipt of Compensation

This is to acknowledge that I _____ (*printed name*) received \$10.00 as compensation for my participation in the research study titled “Examining Parents’ Values in Child-Centered Play Therapy Parent Consultations: A Q-Methodological Investigation.”

Participant Signature

Date

Investigator Signature

APPENDIX I
RECORDING FORM FOR Q-SORT RESPONSES

Q-Sort Responses

Parent's Name: _____ Date/Time: _____

[illegible]

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