EXPLORING FACTORS IMPACTING SOCIAL JUSTICE ADVOCACY ATTITUDES AMONG PLAY THERAPISTS

by

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ABSTRACT

LAUREN REBECCA CHASE. Exploring factors impacting social justice advocacy attitudes among play therapists. (Under the direction of DR. PHYLLIS POST)

Overall, the United States' population is becoming more diverse, and children in minority groups have many disadvantages due to circumstances beyond their control. They experience more poverty (US Census Bureau, 2017), unequal educational opportunities (US Census Bureau, 2019), discriminatory practices (Pascoe & Smart Richman, 2009), trauma (Sacks & Murphey, 2018), mental health diagnoses, and inadequate mental health services. Mental health professionals who work with children, specifically play therapists, are called to be more responsive to the increase in diversity of the growing population of children. To support diverse children and support therapists in offering responsive services and advocate on behalf of children, researchers need to explore factors that may influence their social justice advocacy attitudes. Therefore, a standard multiple regression was utilized to examine the impact of play therapists' (N=409) adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility with regard to their social justice advocacy attitudes. Results indicated that attitudes related to trauma-informed care and cultural humility contributed significantly to the prediction of social justice advocacy attitudes, accounting for 11% of the variance. Implications, limitations, and recommendations for future research are discussed.

DEDICATION

This dissertation is dedicated to my thoughtful, kind, and supportive parents, Arnold and Cheryl Chase. You instilled in me a work ethic that got me to this point. You always believed in me even when I did not believe in myself.

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CHAPTER I: INTRODUCTION

Overall, the United States' population is becoming more diverse. In the general population, approximately 60.1% are White; 18.5 % are Hispanic or Latino; 13.4 % are Black or African Americans; 5.9% are Asians; and 6.2% belong to other racial and cultural backgrounds (US Census Bureau, 2018). Currently, children make up 22.6 % of the American population ("Child Trends," 2019), and this population is increasing in diversity, as well. For the first time in 2018, the total nonwhite population, including people who identify as Black, Hispanic, Asian, multiracial, and other races, were the dominant share of the under 15-year-old population. By 2050, researchers have projected that 39% of all children ages 0-17 will be White; 31% will be Hispanic; 14% will be Black; 7% will be Asian; and 9% will be all other races (US Census Bureau, 2019).

From 2010 to 2018, the population of White children 0 to 11 years old decreased by 2-4% (US Census Bureau, 2019). The population of children enrolled in schools shifted as well. Between 2000 and 2017, the percentage of school-age children who were White decreased from 62% to 51% (National Center for Education Statistics, 2019). In contrast, the percentages of students from other racial/ethnic groups increased from 2000 to 2017: Hispanic children, from 16% to 25%; Asian children, from 3% to 5%; and multiracial children, from 2% to 4%. Generally, racial diversity is increasing across age groups in the United States.

Furthermore, diversity is increasing, and overall, children in minority groups have many disadvantages due to circumstances beyond their control. They experience more poverty (US Census Bureau, 2017), unequal educational opportunities (US Census Bureau, 2019), discriminatory practices (Pascoe & Smart Richman, 2009), trauma (Sacks & Murphey, 2018), mental health diagnoses, and inadequate mental health services. These children are not receiving

satisfactory services because of a shortage of mental health professionals, low funding, and inadequate training (Mellin, 2009). Furthermore, children of different races and ethnicities do not experience trauma equally (Sacks & Murphey, 2018). Nationwide, 61% of Black children and 51% of Hispanic children have experienced at least one adverse childhood experience compared to 40% of White children and only 23% of Asian children. Adverse childhood experiences are traumatic events with possible negative long-term consequences on well-being, such as maltreatment, abuse, and living in an environment that is harmful to children's development (Boullier & Blair, 2018; Cronholm et al., 2015; Felitti et al., 1998). In every region of the United States, the frequency of adverse childhood experiences is lowest among Asian children and is highest among Black children (Sacks & Murphey, 2018). Because of the unequal experiences of trauma and adverse childhood experiences among racial groups, mental health professionals need to adopt a trauma-informed care approach. Mental health professionals who work with children, specifically play therapists, are called to be more responsive to the increase in diversity of the growing population of children.

Unfortunately, while the population of children in the United States is racially diversifying, the professionals who practice play therapy are not racially diverse. Currently, no studies have addressed play therapists' cultural humility, but two studies have addressed their multicultural competency attitudes (Penn & Post, 2012; Ritter & Chang, 2002). However, Ritter and Chang (2002) did not address participants' race, and Penn and Post (2012) had an 87.5% Caucasian sample. This dramatic increase in the multicultural population and lack of diversity among play therapists confirms the need for professionals and students in helping professions to examine factors related to social justice advocacy attitudes. Though professionals in the play therapy field have cited that more multicultural training is needed (Ceballos et al., 2012;

Hinman, 2003; Penn & Post, 2012; Ritter & Chang, 2002), participants in these studies have responded that they have not received adequate training in multicultural areas.

Researchers need to explore factors that can influence play therapists' social justice advocacy attitudes to prepare them to provide effective services and advocate on behalf of children. Responding to this need, the purpose of this study is to examine how adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility are related to social justice advocacy attitudes among play therapists. Researchers' further understanding of these relationships will assist in the development of innovative interventions and effective training programs that prepare play therapists to become stronger social justice advocates.

Overview

The following section will outline the major variables of interest in this study. This section will describe social justice advocacy attitudes and explore factors that researchers have investigated concerning social justice advocacy. Additionally, the author will provide the rationale for examining how adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility impact social justice advocacy attitudes.

Social Justice Advocacy Attitudes

While social justice is defined as a belief that in a just world all benefits are fairly distributed with all people holding equal opportunities within society (Chang et al., 2014), the concept of advocacy focuses on systemic changes needed to create social justice advocacy for all (Fouad et al., 2006). Mental health professionals' role of social justice includes advocating on behalf of minorities and marginalized groups to have a voice, receive benefits, and access resources (Chang et al., 2014). While social justice advocacy is essential in mental health work, it is especially important with vulnerable populations, such as diverse children (Ackerman, 2017;

Baggerly, 2006; Ceballos & Bratton, 2010; O'Connor, 2005; Sheely-Moore & Bratton, 2010), but has been minimally addressed in the literature and needs to be explored further.

Research on social justice advocacy attitudes among play therapists needs to be expanded upon because only two articles in the literature discuss play therapists' social justice advocacy attitudes (Ceballos et al., 2012; Parikh et al., 2013). Ceballos et al. (2012) examined factors that impact play therapists' social justice attitudes and found that social justice attitudes were positively correlated with the number of continuing education credits, percentage of time both receiving and providing supervision with a multicultural focus, quality of supervision provided, and years spent as a play therapist. Additionally, Parikh et al. (2013) explored the impact of belief in a just world and political ideology on play therapists' social justice advocacy and found that belief in a just world and political ideology were related to social justice advocacy. Researchers have minimally explored play therapists' social justice advocacy attitudes and have not explored the impact of adverse childhood experiences, cultural humility, and attitudes related to trauma-informed care on social justice advocacy attitudes among play therapists.

Furthermore, researchers have found cultural humility and social justice advocacy to be related constructs (Shriberg & Clinton, 2016). Social justice advocacy is an additional and more active method to serve the diverse population of children, and it distinguishes advocacy related to issues of power and privilege from professional or vocational advocacy (Smith et al., 2009; Toporek et al., 2009). Overall, social justice advocacy has the main goal of ending oppression, privilege, and inequality (Lee & Hipolito-Delgado, 2007). Social justice advocates strive to attain these goals by offering availability of resources, increasing involvement in governmental policies and laws, and promoting positive relationships among populations (Crethar et al., 2008; Crethar & Winterowd, 2012). Shriberg and Clinton (2016) found cultural humility and social

justice to be related constructs because many social injustices happen within the context of cultural diversity, such as systemic forces that decrease fair access to resources for marginalized people. Whereas social justice is conceptualized as a framework encouraging equitable, respectful, and culturally responsive services and advocacy for social change (Shriberg & Clinton, 2016), cultural humility is conceptualized as a way of being (Foronda et al., 2016). Cultural humility allows play therapists to become more aware of social injustices and to actively engage in social justice advocacy. Furthermore, cultural humility encourages play therapists to be active social justice advocates within their systems and institutions by promoting open discourse about culture, diversity, and oppression; challenging policies and procedures that maintain inequality; and committing to partnering with community leaders to ensure culturally responsive services (Fisher-Borne et al., 2015). Connecting cultural humility with social justice advocacy is needed in the literature to go beyond theory to examine if play therapists' cultural humility influences their social justice advocacy attitudes.

Adverse Childhood Experiences

A factor that may influence social justice advocacy attitudes is adverse childhood experiences. Professionals began discussing adverse childhood experiences when Felitti et al. (1998) mailed an adverse childhood experience (ACE) questionnaire to adults at a large health management organization. Researchers asked participants whether they had experienced specific traumatic events before their 18th birthdays. The events were in one of two categories: childhood abuse and household dysfunction. Childhood abuse questions assessed for psychological abuse, physical abuse, and contact sexual abuse. Household dysfunction questions assessed for substance abuse within the household, exposure to a mentally ill family member, domestic violence against a female caregiver, and criminal behavior within the household (Felitti et al.,

1998). Of 9,508 respondents, more than half reported at least one traumatic experience from their childhood, while 25% reported at least two. Presently, adverse childhood experiences are so pervasive, scholars have called adverse childhood experiences a public health epidemic (Women and Trauma, 2013). Felitti et al. (1998) surveyed adults about their adverse childhood experiences, but current researchers have examined the impact of adverse childhood experiences on children. Children who experience adverse childhood experiences are at risk to experience future violence and victimization, chronic health conditions, cognitive impairments, decreased life potential, difficulties with executive functioning, impulse control, emotion regulation, low self-esteem, and even premature death (Alim et al., 2006; Brown et al., 2009; Copeland et al., 2007; Felitti et al., 1998; Giaconia et al., 1995; Gilbert et al., 2015; Metzler et al., 2017). For mental health providers to fully address adverse childhood experiences, they need to implement trauma-informed approaches.

Attitudes Related to Trauma-Informed Care

Because children in diverse racial groups experience higher rates of trauma, it is critical to understand how attitudes related to trauma-informed care are related to social justice advocacy attitudes. Trauma-informed care is a term created in the 1990s to describe an approach to comprehensive care that understands the impacts that adverse childhood experiences and trauma have on the people who experience them (Harris & Fallot, 2001; Jennings, 2007; SAMHSA, 2014). Since the 1990s, professionals in diverse systems have been called to implement trauma-informed care (Burch et al., 2010; Jennings, 2007; Ko et al., 2008; Women and Trauma, 2013). Trauma-informed care is an approach that: (a) realizes trauma's impact and recognizes possible recovery paths, (b) recognizes the signs of trauma, (c) integrates data about trauma into governmental policies, and (d) aims to prevent re-traumatization (Cavanaugh, 2016).

Furthermore, core principles of trauma-informed care include integrating trauma theory into descriptions of stress, psychopathology, and coping; creating core standards of safety, trustworthiness, choice, cooperation, and empowerment; avoiding approaches that are against the values of trauma-informed care; and approaching education or services that enable the construction of skills (e.g., emotional regulation) and the connection with supplementary services (e.g., protected housing) (Harris & Fallot, 2001). The approach has been applied in federal agencies, universities, managed care organizations, public schools, hospitals, social services, child advocacy centers, and veterans' centers (Conners-Burrows et al., 2013; Fratto, 2016; Hall et al., 2016; Martin et al., 2017) but has been minimally addressed (Post et al., 2019, 2020) in the mental health and play therapy literature. Many initiatives were made to support people who have experienced trauma by encouraging them to adopt this approach; however, researchers have lacked the clarity of what trauma-informed care is and how to measure the concept. To close the gaps specified, researchers have explored attitudes of staff working with people who have experienced trauma to increase their awareness of the impact their attitudes have on their clients. Addressing clinicians' attitudes about trauma-informed care can impact the ability of clinicians to meet the diverse needs of clients as they become more aware of the attitudes they hold towards trauma-informed care approaches.

Cultural Humility

Cultural humility is defined as a sense of respect and a lack of superiority towards the culture of others (Hook et al., 2013). Mental health professionals who are culturally humble are willing to admit their limitations and recognize their potential to make mistakes (Fouad & Arredondo, 2007). Furthermore, cultural humility occurs when mental health professionals engage in self-reflection, learn their biases, open themselves to diverse cultures, and commit to

partnering authentically and redressing imbalances of power (Minkler, 2012). Cultural humility seeks to address shortcomings of cultural competency by placing less emphasis on knowledge, highlighting the importance of relationships (Juarez et al., 2006; Ortega & Faller, 2011), and responding to the intersectionality of cultural identities (Davis, 2008). The concept shifts from the multicultural competency paradigm focusing on knowledge to emphasizing the continual need to learn (Fisher-Borne et al., 2015; Fouad & Arredondo, 2007; Juarez et al., 2006).

While mental health professionals desire to have cultural humility, many factors impede professionals' cultural humility, including a false sense of security in their training, lack of flexibility in their point of view, and isolated increases in their cultural knowledge without changes in attitudes or behaviors (Tervalon & Murray Garcia, 1998). Additionally, the diverse clientele who play therapists serve have a variety of needs. Due to these various needs, play therapists need to comprehend the conceptual framework of social justice advocacy, including definitions and concepts related to this construct. While researchers have conducted studies in the social science fields, few researchers have conducted empirical research within the field of play therapy. The population of children is continuing to diversify, and mental health providers are challenged to examine their cultural humility in order to respond with social justice-oriented attitudes. Researchers have shown that trained professionals in play therapy *who* meet diverse children's needs were limited (Ceballos et al., 2012; Chang et al., 2005; Parikh et al., 2013; VanderGast et al., 2010). This study aims to bridge the gap and explore how play therapists can better meet the needs of diverse clients.

Issues of meeting diverse children's needs mean more than just one professional training and cite a need for more extensive measures of preparation for play therapists. In an article by O'Connor (2005), the author outlined existing diversity issues, such as the disparity between

some of the expectations of most play therapy models and the beliefs of specific cultural groups. O'Connor proposed that play therapists went through Pederson's (1988) awareness, skills, and knowledge (ASK) model in their multicultural competency journey. Play therapists gained self-awareness surrounding their culture, and then they gained skills of dynamic sizing and scientific mindedness (Sue, 1998). *Dynamic sizing* refers to play therapists' skills in generalizing and individualizing culture-specific knowledge to a client. In addition to developing skills, play therapists need the knowledge to meet their clients' diverse cultural needs, including cultural variations of children's play behavior, toys used in children's culture, and specific interventions most appropriate for children's culture. Play therapy researchers have addressed multicultural competency but have not addressed cultural humility. Cultural humility in play therapy requires mental health professionals to constantly evaluate their views, beliefs, and feelings about the children they serve.

Conclusion

The researchers cited have focused on the importance of exploring factors related to the social justice advocacy attitudes of play therapists to best serve the increasing diversity of children in the United States. The literature indicates there is little known about how play therapists' adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility relative to their social justice advocacy attitudes. Specifically, this study aims to fill a gap in the literature.

Significance of the Study

Researchers have documented the importance of adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility, but research on the impact of these concepts on social justice advocacy attitudes is lacking. As play therapy is increasingly

acknowledged as a distinct specialty area for working with children, discussions about the development and dimensions of play therapists' social justice advocacy attitudes are essential. Mental health professionals who practice play therapy have a duty to provide social justice-oriented services to diverse families and children. This idea of social justice-oriented services is a challenge when most of the play therapists are White and are serving a multicultural population. Children of different races and ethnicities do not experience trauma equally. Clinicians, school counselors, counselor educators, and students who practice play therapy will all benefit from the outcome of this study. Additionally, counselor educators and supervisors who supervise and teach play therapy will also benefit from the outcome of this study to better serve their students, become more trauma-informed, and prepare students to become social justice advocates and work in this diverse and multicultural society.

Purpose of the study

The purpose of the study is to examine how adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility impact social justice advocacy attitudes among play therapists.

Research question

The overarching question guiding this research is: How do adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility impact social justice advocacy attitudes among play therapists in the United States?

Assumptions

The assumptions made in the study are:

- Participants will complete all surveys and scales voluntarily.
- Participants will answer all surveys and scales truthfully.

- The sample is representative of the population.
- The instruments used are valid and reliable measures.

Delimitations

The factors the researcher can control in this study are:

- This purposive, convenience, homogenous population sample will be obtained from self-identified play therapists across the United States.
- Play therapists are defined as professional counselors, social workers, psychologists, or school counselors with at least a master's degree who has conducted, supervised, or conducted research about play therapy.
- Data will be collected online via SurveyShare.

Limitations

The following limitations, those factors outside the researcher's control, are true of this study:

- The study's purposive sample of play therapists limits the ability to generalize the results to all mental health professionals and all play therapists.
- A limitation is social desirability bias, which is the likelihood of participants in the study responding to survey questions in a way they believe could be viewed as positive by others (Walzenbach, 2019).
- Due to the correlational research design, no causal inferences can be made.

Threats to Internal Validity

Internal validity in quantitative research shows that changes in the dependent variable can be credited to the effect of the independent variable and not to unrelated variables (Johnson & Christensen, 2004). This non-experimental survey research design in this study will have several

measures in place to ensure internal validity. Threats to internal validity in this study include instrumentation and social desirability. This study used only instruments that have been sufficiently evaluated in prior studies and have been regarded as reliable and valid. With the promise of being anonymous, the researcher assumes participants will be more likely to provide truthful responses, and this may reduce social desirability bias (McMillian, 2008).

Threats to External Validity

External validity in quantitative research shows researchers can generalize study results to the population to increase the study's social relevance (Johnson & Christensen, 2004). Several factors can obstruct a researcher's capacity to generalize about their study's findings. The researcher will handle threats to external validity as outlined. In this study, the researcher will use a convenience sample, and play therapists who respond to this study will be investigated. However, the researcher expects the results to be generalizable only to other play therapists with similar demographics and experience.

Operational Definitions

Play Therapists

Play therapists are professional counselors, social workers, psychologists, or school counselors with at least a master's degree who have conducted, supervised, or conducted research about play therapy.

Play Therapy

Play therapy is defined as a modality that uses the therapeutic powers of play in clinical work with children.

Social Justice Advocacy Attitudes

Social justice advocacy is defined as actions individuals take to support and to speak up on behalf of other individuals or groups to get them what they deserve in terms of rights and benefits (Chang et al., 2014). Social justice advocacy attitudes will be measured by the Social Issues Advocacy Scale (SIAS; Nilsson et al., 2011), which is a 21-item instrument measuring social justice-oriented behaviors and attitudes on a 5-point Likert scale. In this study, the overall total score on the SIAS will be defined as participants' social justice advocacy attitudes.

Adverse Childhood Experiences

Adverse childhood experiences are traumatic events that have occurred in children's lives including physical and emotional abuse and neglect, sexual abuse, and household dysfunction such as divorce, living with an adult experiencing mental illness or substance abuse, witnessing violence in the home, or the incarceration of a family member (Felitti et al., 1998). For the purpose of this study, adverse childhood experiences will be measured by the participants' total score on the 10-item ACE questionnaire (Felitti et al., 1998).

Attitudes Related to Trauma-Informed Care

Trauma-informed care is service delivery that combines participants' understanding of the extensive biological, psychological, and social consequences of adverse childhood experiences and trauma to ameliorate rather than exacerbate their effects (Harris & Fallot, 2001; Jennings, 2007; SAMHSA, 2014). Attitudes related to trauma-informed care will be measured by the Attitudes Related to Trauma-Informed Care Scale (ARTIC; Baker et al., 2016) which is a 35-item instrument measuring favorable or less-favorable attitudes towards trauma-informed care on a 7-point Likert scale. For the aim of this study, attitudes related to trauma-informed care will be measured by the participants' total score on the ARTIC scale.

Cultural Humility

Cultural humility is the ability to maintain an interpersonal stance that is other-oriented in relation to aspects of cultural identity that are most important to the person (Hook et al., 2013). Cultural humility will be measured by the Multidimensional Cultural Humility Scale (MCHS; Gonzalez et al., 2020), which is a 15-item instrument measuring culturally humble attitudes on a 6-point Likert scale. For the aim of the study, cultural humility will be measured by participants' total score on the MCHS scale.

Summary

The mental health field will benefit from an exploration of how adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility are related to social justice advocacy attitudes among play therapists. This chapter briefly overviewed the variables of social justice advocacy attitudes, adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility, followed by the purpose of the study. Assumptions, delimitations, limitations, and threats to validity were acknowledged, followed by the operational definitions of every variable.

Organization of the Study

This dissertation includes five chapters. The first chapter presents a rationale and overview of factors that may contribute to play therapists' social justice advocacy attitudes by describing the purpose, significance of the research problem, research question, and variables of inquiry. Further details are given highlighting the author's assumptions, delimitations, and operational definitions. The second chapter is a review of the literature outlining current evidence-based and conceptual research on adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility and the impact that they may have on play therapists' social justice advocacy attitudes. The third chapter outlines the methodology used in

the study including the participants, instrumentation, design, procedures, data collection process, and data analysis. The fourth chapter provides a review of the results of the study including information about results for each outcome variable (adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility) based on the research question. Finally, chapter five includes a discussion of the results found, limitations of the study, implications of the findings, and recommendations for future research.

CHAPTER II: REVIEW OF THE LITERATURE

The purpose of this study is to examine how adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility are related to social justice advocacy attitudes among play therapists. This chapter will comprehensively review relevant literature to establish the need for this research study. The literature review will begin with a discussion of the theoretical framework, Multicultural and Social Justice Counseling Competencies, and the population of interest, play therapists. The next section will provide an overview of the outcome variable, social justice advocacy attitudes, followed by a literature review focusing on how the predictor variables, adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility are related to social justice advocacy attitudes. The final section will present a summary of the chapter and the conclusions drawn from the review of the literature.

Theoretical Framework

Multicultural and Social Justice Counseling Competencies

The demographics are changing rapidly in the United States because of lower white birth rates and increased immigration over the last 30 years (US Census Bureau, 2018). This increase in diversity has contributed to changes in the demographics and socioeconomic climate of the country. Cultural diversity has significantly impacted many aspects of mental health, ranging from how mental health is perceived, help-seeking behavior, and attitudes of clients as well as mental health professionals and systems who serve diverse clients (Gopalakrishnan, 2018). Counseling professionals, including play therapists, should respond to diverse children's needs who are exhibiting mental health problems. Multicultural counseling competence aims to ensure equitable and sufficient mental health treatment among diverse children. When serving diverse

populations, play therapists need to be culturally responsive social justice advocates in their work.

Based on the changing demographics and needs of diverse children, it is appropriate that this study's theoretical framework is the *Multicultural and Social Justice Counseling Competencies* (MSJCC; Ratts et al., 2016). Researchers' and scholars' emerging interests and new views on social justice advocacy, transformed the *Multicultural Counseling Competencies* (MCC; Sue et al., 1992) into *Multicultural and Social Justice Counseling Competencies* (MSJCC; Ratts et al., 2016). Scholars updated the *Multicultural and Social Justice Counseling Competencies* for two reasons: (a) to explain culture and diversity broadly and inclusively and (b) to thoroughly address expanding professional counselors' responsibilities to incorporate individual counseling and social justice advocacy. Scholars added the term, *social justice*, to the revised competencies to reflect changes in the profession to have a stronger social justice focus (Ratts et al., 2016). For this reason, this study will examine factors related to social justice advocacy attitudes among play therapists.

Furthermore, this change in the MSJCC reflects an increasing awareness of interactions between various cultural identities. Sue et al.'s (1992) original competencies focused on majority 'White' counselors working with minority clients, and Ratts et al.'s (2016) new competencies aimed to respond to a range of diversity in counseling, including minority counselors working with majority clients. Earlier researchers had explored intersections of racial, gender, ethnic, sexual, age, socioeconomic, religious, spiritual, and disability identities, termed *intersectionality*, and concluded these identities influence mental health outcomes and health disparities (Conron et al., 2010; Hankivsky et al., 2010; Institute of Medicine, 2011).

A concept that responds to the intersectionality of cultural identities, cultural humility, addresses shortcomings of cultural competency by placing less emphasis on knowledge and highlighting the importance of relationships (Davis, 2008; Ortega & Faller, 2011). Intersectionality is an important component of cultural humility because cultural competency measures tend to focus on one aspect of culture, such as race, while ignoring other aspects, such as religion, gender, and sexual orientation. While cultural competency is more singularly focused, cultural humility places clients as experts of their cultural view encouraging professionals to engage with clients from a "not-knowing" perspective (Tervalon & Murray-Garcia, 1998). Similar to practicing cultural humility, developing multicultural and social justice competence is a lifelong process (Hook et al., 2013). Furthermore, because the MSJCC aims to explain culture and diversity broadly and inclusively, cultural humility is a concept that may impact social justice advocacy attitudes.

Interactions between these cultural identities in the counseling relationship fit into one of four quadrants: (a) Privileged Counselor–Marginalized Client, (b) Privileged Counselor–Privileged Client, (c) Marginalized Counselor–Privileged Client, and (d) Marginalized Counselor–Marginalized Client (Ratts et al., 2016; see figure 1). When play therapists allow clients to be experts of their culture, they can understand how cultural factors interact to create clients' identities and experiences. Furthermore, professionals need to be aware of their own intersecting identities. Intersectionality considers multiple parts of the play therapists' identity. For example, they may be privileged in parts of their identity (e.g. White or educated) and marginalized in other parts of their identity (e.g. experiencing poverty). Intersectionality, a component of cultural humility, is a social justice-oriented way to view play therapists' identities.

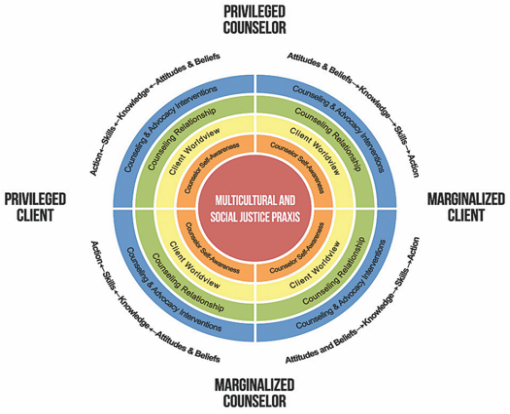

Figure 1: The MSJCC conceptual framework (Ratts et al., 2016)

Within each quadrant, the MSJCC model portrays four developmental domains, shown by concentric circles in each quadrant, each proposing a linear progression, which mental health professionals, including play therapists, are encouraged to follow to provide multiculturally competent counseling services: (a) counselor self-awareness, (b) client worldview, (c) counseling relationship, and (d) counseling and advocacy interventions (Ratts et al., 2016). Culturally responsive play therapists are proactive in learning about their assumptions, beliefs, values, biases, cultures, and social group identities and seek opportunities to learn how power, privilege, and oppression influence their experiences. Responsive play therapists are curious and desire to learn about worldviews and experiences of privileged and marginalized clients. Furthermore, they are aware of appropriate advocacy interventions. When play therapists are perceptive to clients' worldviews and cultural experiences, they understand unique ways that power and oppression mold the counseling relationship and can consider the appropriate multicultural and social justice approaches and interventions. When play therapists integrate cultural responsiveness with social justice advocacy, they are better equipped to handle diverse clients' mental health issues. Ultimately, play therapists need to understand what multicultural and social

justice interventions and strategies clients need to address individual and community-wide change.

Within each domain, the MSJCC is further organized into four additional competencies: (a) attitudes and beliefs, (b) knowledge, (c) skills, and (d) action. Scholars, who retained attitudes and beliefs, knowledge, and skills from the original *Multicultural Counseling Competencies* (Sue et al., 1982), now added the fourth competency, action, to operationalize the Sue et al. (1982) model. Furthermore, MSJCC authors not only connected multiculturalism with social justice, but they also called for researchers to further bridge the gap in multicultural and social justice scholarship (Ratts et al., 2016). This study aims to bridge this gap in scholarship by exploring factors that impact play therapists' *attitudes towards action* or social justice advocacy attitudes.

In addressing issues of marginalized children, play therapists should advocate within the individual, group, and systemic levels (Lewis et al., 2011). Play therapists advocate on behalf of clients on an individual level when they empower clients to speak up and have a voice. At the group level, play therapists can encourage groups to have access to resources and create equal opportunities. Finally, on a systemic level, play therapists can help shape policy reform to create equality for all. Thus, the multilevel framework outlined in this model can influence a discussion to determine if individual counseling or social justice advocacy would be most appropriate (Ratts et al., 2016). Because one of the reasons for the updated MSJCC is to thoroughly address expanding professional counselors' responsibilities to incorporate individual counseling and social justice advocacy, this study will focus on factors related to social justice advocacy. If play therapists hold more positive social justice advocacy attitudes, they may be more likely to be open to social justice advocacy with clients. If they hold negative social justice advocacy

attitudes, play therapists might miss opportunities to be responsive to the children they work with.

The increasing diversity within the United States has created the need for a theoretical framework that comprehends and reflects the diverse identities of both clients and mental health professionals. Scholars call play therapists to respond to diverse children's needs by engaging in advocacy at the individual, group, and community levels. Researchers can begin the process by examining factors that impact social justice advocacy attitudes. Ultimately, these researchers' findings can influence trainings that help play therapists improve their social justice advocacy attitudes.

Play Therapists

Play therapists are trained mental health professionals from various disciplines, including mental health counselors, school counselors, social workers, psychologists, and marriage and family therapists who have completed additional training in play therapy. Scholars began discussing play therapy in the early 18th century when philosopher Jean Jacques Rousseau promoted learning about children through their play and was one of the first to note that children were not tiny adults (Landreth, 2012). Following in the early 19th century, Sigmund Freud published the first therapeutic use of play with "Little Hans," a five-year-old boy who had phobia symptoms. In the 1930s, Sigmund Freud's student, Melanie Klein used play in therapy, allowing children under six to free associate. Other significant contributions to play therapy at the time were Levy's release play therapy and Taft and Allen's relationship play therapy, focusing on the curative power of the emotional relationship built between therapists and clients. Later in the 1940s, Sigmund Freud's daughter, Anna Freud, used play in person-centered therapy to build relationships with children. Melanie Klein's and Anna Freud's clinical and research work further

contributed to the expansion of play therapy in Europe. In the United States, Virginia Axline used Carl Rogers' person-centered therapy to expand non-directive play therapy, enabling children to play freely with no attempt to control or change them. Axline's approach was crucial to play therapy's development in the United States (Landreth, 2012).

In 1982, play therapy's increasing popularity and continual evolution in the United States led professionals to create the Association for Play Therapy (APT), an organization that endorses the value of play, play therapy, and credentialed play therapists (Landreth, 2012). The APT encourages play therapists to support children in resolving psychological issues, grow, and develop to become more fully functioning individuals (Association for Play Therapy [APT], 2019). Presently, play therapy professionals, including those in APT, offer education through courses, training, and supervision to prepare them to work with children (Landreth, 2012). The APT (2020) website reports 154 universities in the United States that offer play therapy training, but the current number is unknown because professors must inform the organization about their university's training to be included (C. Vega, personal communication, August 7, 2020).

Because play therapists build strong therapeutic relationships with children, they have a duty to advocate on behalf of the children with whom they work (Kolos, 2009). The population of children in the United States is becoming more racially diverse (US Census Bureau, 2019), and there are unequal experiences of trauma and adverse childhood experiences among racial groups (Sacks & Murphey, 2018). Additionally, because children cannot control their oppressive experiences, the opportunity to achieve self-actualization is not without struggle (Axline, 1950). Play therapists, who are predominantly White women, need to create therapeutic relationships based on empathy and acceptance for children to feel safe and heard (Landreth, 2002; O'Connor, 2005). Furthermore, play therapists can gain empathy when they understand the emotional

impact that oppression has on marginalized children. For these reasons, it is important to understand play therapists' attitudes towards social justice advocacy in their work. A review of the literature about factors related to social justice advocacy attitudes included adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility. This is the rationale for these variables to be explored among play therapists.

At an organizational level, APT addresses diversity and multicultural competence in its mission statement and Registered Play Therapist and Registered Play Therapist Supervisor (RPT/RPT-S) credentialing guidelines, but the documents do not specifically address cultural humility and social justice advocacy. Recent historical events, specifically the acquittal of Trayvon Martin's murderer in 2013, prompted the emergence of the Black Lives Matter movement (Black Lives Matter, n.d.). The movement aims to eliminate White supremacy and build local power to intervene in violence inflicted on Black communities by the police and vigilantes. Black Lives Matter has called for professional organizations to reassess how they view factors that impact social justice advocacy. Professionals at APT recently created an Inclusion, Diversity, and Equity Awareness (IDEA) team, which aims to support play therapists of color and educate therapists on issues faced by children and families of color (APT, 2020). Though the recently created IDEA team is a start, up to now, few researchers have conducted empirical studies on factors impacting play therapists' social justice advocacy attitudes. Researchers have found belief in a just world (Parikh et al., 2013), political ideology, number of CEUs (Ceballos et al., 2012), percentage of time receiving supervision with a multicultural focus, quality of supervision provided, and years as a play therapist to be predictors of social justice advocacy attitudes, but researchers have not examined other factors that may be important to the development of social justice advocacy attitudes, such as play therapists' adverse

childhood experiences, attitudes related to trauma-informed care, and cultural humility. Because social justice advocacy is important to empower children and create change, recent historical events prompted organizations to become aware of their deficits and strongly focus on social justice advocacy at this time. Both of these issues, at an individual and organizational level, cite the need for play therapists to expand their understanding of factors related to social justice advocacy attitudes for children. Therefore, this study will contribute to that effort.

Social Justice Advocacy

Counseling scholars and researchers have evolved the concept of social justice over time. Frank Parsons and Carl Rogers ignited advocacy in counseling when they strived to change social policy interventions at the individual and societal levels (McWhirtner, 1997). Additionally, Parsons collaborated with local social groups to employ boys in poverty in Boston, Massachusetts, showing the mental health profession benefits of connecting with the community. (Fouad et al., 2006).

Following, in the 1940s and 1950s, counseling psychologists provided social justice work when they helped World War II veterans adjust to civilian life. Protests against war and social discrimination in the 1960s and 1970s prompted an increased social justice advocacy focus in counseling (Lee, 1998). Additionally, counseling psychologists promoted prison and higher education reform, including veterans' education benefits (Fouad et al., 2006). The 1987 position paper from the American Association for Counseling and Development was another notable call for counselors to become social justice advocates**.** In addition to the 1987 position papers, Lofaro (1982) suggested counselors assert themselves on behalf of people who have disabilities, and Kurpuis and Rozecki (1992) posited that counselors need to possess advocacy characteristics.

Scholars in multiple disciplines influenced and highlighted the importance of social justice advocacy in counseling.

In addition to scholars, new technology, the HIV/AIDS epidemic, and an economic recession altered social action in the 1990s. Counseling psychologists focused their advocacy efforts on their employment rather than advocating for clients (Fouad et al., 2006). Currently, social justice demands counselors to work on a global level, citing social responsibility as imperative to reach one's full potential (Lee, 1998). Counselors are socially responsible when they comprehend the impact of oppression on their clients' lives.

Scholars have defined social justice as professional practice, research, and scholarship that acknowledges and challenges social procedures and practices that negatively impact marginalized individual's mental health (Chung & Bemak, 2012; Ratts & Hutchins, 2009; Steele, 2008). Counselors are social justice advocates when they: (a) comprehend the importance of systemic work when helping others, (b) partner with their clients to create systematic change by educating clients on how to implement change, and (c) recognize how to systematically create change (Lee, 1998). Social justice allows for equality where everyone, including children, in society has equal rights, prospects, and access to resources through advocacy (Chang et al., 2014; Fouad et al., 2006; Ratts, 2009). Counselors seek to lessen the marginalization and disparity of individuals through social justice advocacy when they offer resources, increase commitment to governmental policies and laws, and promote positive relationships among populations (Crethar et al., 2008; Crethar & Winterowd, 2012). Social justice advocacy approaches focus on the underlying causes and systemic challenges that impact the lives of marginalized populations (Ratts et al., 2016; Ratts & Hutchins, 2009). Furthermore, these approaches encourage mental health professionals to go beyond individual counseling and engage in wider advocacy efforts.

Regarding social justice advocacy with children, play therapists have an essential role to eliminate barriers and advocate for social justice, allowing children in marginalized groups to obtain equal opportunities (Chang et al., 2014). Furthermore, play therapists advocate on behalf of children at three levels: (a) individual, (b) community-wide, and (c) public. Individually, therapists can help empower clients to gain self-awareness through education, to recognize client strengths, and to teach clients the value of positive self-talk. At the community level, they collaborate within communities to create change, and publicly, they can collaborate with groups to amend governmental policies.

Social Justice Advocacy among Counselors

Researchers have explored social justice advocacy attitudes among counseling leaders (Myers & Sweeney, 2004), counseling psychology trainees (Beer et al., 2012; Miller & Sendrowitz, 2011), counselor trainees (Decker, 2013; Inman et al., 2015), mental health practitioners (Bradley et al., 2012), ACA members (Steele et al., 2014), and school counselors (Crook et al., 2015; Feldwisch & Whiston, 2016; Parikh et al., 2011). Together, these scholars' research studies support the need for increasing awareness of adverse childhood experiences, attitudes towards trauma-informed care, and cultural humility by promoting social justice advocacy attitudes among professionals.

Myers and Sweeney (2004) surveyed 71 counseling leaders for their advocacy efforts, resources, and needs and found that more than half of the professional organizations that the leaders represented had statements requiring advocacy activities. Researchers included the following categories of questions: (a) demographic information, (b) structure of advocacy efforts of participants' organizations, (c) nature and success of advocacy efforts by the organization, (d) participants' perceptions of current advocacy needs for the profession, (e) resources needed by

the organization for advocacy efforts, (f) existence of interprofessional alliances for advocacy and perceptions of the need for such alliances, (g) obstacles to effective advocacy, and (h) perceptions of the importance of advocacy for the future of the counseling profession. Researchers found remarkable results that 96% of the counseling leaders surveyed considered advocacy to be a moderately needed professional activity. Advocacy efforts seemed to be effective because participants considered their advocacy efforts to be moderately to highly successful (81%). Though leaders have viewed efforts to be successful and advocacy to be vital to the profession, the researchers found that the lack of an organized effort among counseling organizations appears to be a more substantial barrier to success than the lack of any of the available resources. Overall, counseling leaders deemed advocacy to be important in the profession, and they engaged in social justice advocacy regularly. The results have implications for counselor educators to encourage counseling students' social justice advocacy by preparing them with the skills and knowledge needed to become effective advocates for the profession and their clients.

With a different population, social justice researchers Miller and Sendrowitz (2011) examined the external validity of Miller et al.'s (2009) social-cognitive model of social justice interest and commitment among 229 counseling psychology trainees. The researchers also aimed to discover the extent to which perceived social justice program training environment and personal moral imperative related to participants' development of social justice interest and commitment. They discovered trainees with higher levels of interest in social justice may be more likely to commit to social justice advocacy in the future. Additionally, the program training environment and personal moral imperative were related to social justice interest and commitment. Researchers also discovered that participants were encouraged to implement social

justice advocacy, though they were not given enough time, resources, and support needed for social justice advocacy.

With similar participants, who were also counseling psychology graduate students (*n*=260), Beer et al. (2012) examined their commitment to social justice advocacy in a mixed-methods study. For the quantitative portion, participants completed an online survey assessing their commitments to social justice and relevant personal and training variables. Participants' commitment to social justice advocacy was predicted less by their individual activist orientations, but more so by their overall commitment to advocacy of their training program. In the qualitative portion, researchers used phenomenology to expand upon their quantitative results. Researchers interviewed seven trainees who identified as strong social justice activists and four categories emerged: (a) nature of social justice, (b) motivation for activism, (c) role of training, and (d) personal and professional integration. Researchers' results encourage graduate student training to integrate more social justice advocacy to support more systemic commitment to social justice in the profession. Regardless of participants' multicultural counseling and advocacy personal values and strengths, their programs' social justice advocacy stance was the strongest impact on participants' social justice advocacy.

Inman et al. (2015) examined 274 graduate counselor trainees' direct and indirect relationships between belief in a just world, belief in an unjust world, social justice social supports, social justice training supports, and counseling trainees' social justice self-efficacy, interest, and commitment from an established social cognitive social justice model (Miller & Sendrowitz, 2011). Researchers used structural equation modeling and found that social justice self-efficacy had direct and indirect effects on social justice commitment by bolstering social justice interest highlighting the role of self-efficacy in social justice advocacy (Inman et al.,

2015). Overall, the researchers' results support the impact of social justice interest support and a strong social justice training environment has in influencing trainees' social justice advocacy commitment.

Similarly, Decker (2013) explored advocacy among 112 counselor educators and mental health professionals in training. She investigated relationships between social justice advocacy training, counselor competence in social justice advocacy, and likelihood to advocate among counselor educators and counselor trainees. Furthermore, the researcher discovered a significant relationship between social justice advocacy training and ratings of social justice advocacy competence. Additionally, the researcher found that advocacy training led to an increased likelihood to advocate, particularly at community and societal levels. Accordingly, counselor trainees who reported higher advocacy competence might be more likely to engage in social justice advocacy activities. Decker's (2013) findings supported including social justice advocacy training in counselor education. Overall, researchers (Beer et al., 2012; Decker, 2013; Inman et al., 2015; Miller & Sendrowitz, 2011) have explored counselors-in-trainings' social justice advocacy attitudes.

Bradley et al. (2012) qualitatively explored barriers to social justice advocacy involvement of rural mental health counselors in two Mid-Atlantic states. Bradley and colleagues interviewed eight counselors about benefits and challenges to rural practice, experiences with social justice advocacy, and their social justice advocacy perspectives in relation to their counseling profession. Participants found the benefits of working in a rural area to be building relationships with other professionals/agencies, knowing people and clients in the community, having a high demand of services and shortage of providers, and possessing characteristics of rural living. Challenges of working in a rural area included balancing multiple relationships,

having a lack of anonymity, having a lack of resources, seeing clients in poverty, obtaining transportation, and knowing clients in the community. Ultimately, Bradley and colleagues found that most participants did not involve themselves in community advocacy because of the higher likelihood of conflict when advocacy steps from a smaller level involving the individual client to a macro-level approach involving social justice advocacy. Participants held the general assumption of the mental health counseling profession that community advocacy is more expected from social workers.

Additionally, Steele et al. (2014) explored perceptions of social justice advocacy among 214 liberal, moderate, and conservative ACA members. They measured perceptions of social justice advocacy with the Advocacy Characteristics Scales, consisting of five separate self-report measures of advocacy attributes, attitudes, behaviors, skills, and knowledge, as well as three measures that assess participants' perspectives on the importance of advocacy, their actual advocacy practices, and levels at which they advocate. For political ideology, researchers had participants rate themselves as extremely liberal, liberal, slightly liberal, moderate, slightly conservative, conservative, extremely conservative, or have not thought about this much. To measure political involvement, participants responded with yes or no to seven different types of political activity. Steele and colleagues found conservative participants held somewhat less favorable perceptions of social justice advocacy, but overall were not statistically different from liberal and moderate participants. However, statistically significant differences were discovered among extremely liberal participants. Extremely liberal participants had significantly higher perceptions of social justice advocacy attitudes, behaviors, and skills in comparison to the perceptions of participants with less liberal, moderate, or conservative views. Overall, participants supported ACA resource use for social activism.

Also exploring political ideology, researchers explored belief in a just world in relation to school counselors' social justice advocacy attitudes (Parikh et al., 2011). Researchers examined how the predictor variables, belief in a just world, political ideology, religious ideology, socioeconomic status of origin, and race are related to the outcome variable, social justice advocacy attitudes, among 298 school counselors. Researchers found political ideology and belief in a just world to be statistically significant predictors of social justice advocacy attitudes. Race and socioeconomic status were not statistically significant predictors, but this may be because of the lack of variability in the sample, i.e. mostly White middle-class participants. Parikh et al. (2011) found that school counselors who have a lower belief in a just world were more likely to have higher and more positive attitudes toward social justice advocacy. Additionally, the authors found that political ideology was the only factor that significantly related to school counselor's social justice advocacy attitudes, accounting for 11% of the variance in the model. Overall, the study supports the importance of exploring how school counselors' personal beliefs influence their social justice advocacy attitudes.

In a similar study, Crook et al. (2015) explored 255 school counselors' perceptions of their social justice advocacy competence and how demographic variables, participation in social justice advocacy-related associations and activities, social justice advocacy training, and type of advocacy training predicted social justice advocacy competence. Overall, researchers found that school counselors perceived themselves as at least moderately competent in regards to social justice advocacy. Furthermore, researchers found work settings and training to impact school counselors' self-perceived social justice advocacy. For example, participants who worked in an urban school setting and received advocacy training had higher levels of perceived social justice advocacy competence overall. Additionally, female school counselors scored higher on the client

empowerment subscale indicating they may be more likely to advocate for students in marginalized backgrounds (Crook et al., 2015). This finding is significant because a majority of participants in play therapy research are women.

In another study surveying school counselors, Feldwisch and Whiston (2016) examined 171 school counselors' commitment to social justice advocacy, with a mostly female (85.7%) and White (93.8%) population. The researchers utilized the Advocacy Competencies Self-Assessment (ACSA) and the Social Issues Advocacy Scale (SIAS) to measure social justice advocacy attitudes. Furthermore, the researchers examined whether school counselors' self-reports of social justice work related to their scores on social justice advocacy measures. Participants responded to the question "To what extent do you engage in social justice advocacy through your work as a counselor?" relative to their overall mean scores on the ACSA and SIAS. School counselors reported moderate to high social justice advocacy attitudes and beliefs, similar to the findings of Crook et al. (2015). Additionally, researchers found school counselors who reported implementing social justice advocacy also scored higher on social justice advocacy measures. Therefore, researchers' results indicated participants demonstrated a commitment to social justice advocacy. Furthermore, this sample is similar in demographics to many play therapy research studies and may suggest play therapists will report moderate to high social justice advocacy attitudes.

Overall, researchers have explored social justice advocacy attitudes among counseling leaders (Myers & Sweeney, 2004), counseling psychology trainees (Miller & Sendrowitz, 2011), counselor trainees (Decker, 2013; Inman et al., 20515), mental health practitioners (Bradley et al., 2012), ACA members (Steele et al., 2014), and school counselors (Crook et al., 2015; Feldwisch & Whiston, 2016; Parikh et al., 2011). Furthermore, researchers have connected social

justice advocacy attitudes to concepts, such as political ideology (Parikh et al., 2011; Steele et al., 2014), social support (Inman et al., 2015), social justice advocacy training (Decker, 2013), belief in a just world (Parikh et al., 2011), work setting (Crook et al., 2015), and social justice advocacy implementation (Feldwisch & Whiston, 2016). Researchers have demonstrated the importance of exploring social justice advocacy attitudes, and this further encourages researchers to continue to explore the topic among diverse mental health professionals and trainees.

Social Justice Advocacy among Play Therapists

Play therapists are in a distinctive place of power related to social justice advocacy efforts. In relation to working with children, social justice advocacy is a process in which advocates know how an oppressive environment impacts a child's mental health and address the environment in the counseling relationship; this process goes beyond including and accepting cultural diversity to action promoting broader social change (Ackerman, 2017; Lewis et al., 2011; Presseau et al., 2019). Social justice advocacy is essential in mental health work with diverse children (Ackerman, 2017; Baggerly, 2006; Ceballos & Bratton, 2010; O'Connor, 2005; Sheely-Moore & Bratton, 2010), but there is a dearth of play therapy research that has addressed social justice advocacy (Ceballos et al., 2012; Parikh et al., 2013).

In the literature, researchers have suggested several ways to advocate for social justice with children. Researchers have advocated for play therapists to be more active through social justice advocacy by going to clients' environments, such as their schools and neighborhoods (Ceballos & Bratton, 2010; Sheely-Moore & Bratton, 2010); increasing their self-awareness of their work with oppressed children (Baggerly, 2006); and being aware of oppression when looking at their clients' emotions (O'Connor, 2005). Overall, researchers have demonstrated the need for culturally responsive services (Ceballos & Bratton, 2010; Sheely-Moore & Bratton,

2010) and multicultural education and supervision (Chang et al., 2005; Donald et al., 2015; VanderGast et al., 2010) in the play therapy field. The gap in the literature is how researchers are exploring play therapists' social justice advocacy attitudes.

Only two empirical research studies in the play therapy literature have directly addressed play therapists' social justice advocacy attitudes (Ceballos et al., 2012; Parikh et al., 2013). Because comprehending social justice attitudes help diverse clients reach their full potential (Chang et al., 2010; Ratts, 2009) and long-term mental health (Crethar et al. 2008), Ceballos et al. (2012) and Parikh et al. (2013) explored factors related to play therapists' social justice advocacy attitudes, particularly members of the APT. Both studies used a sample of 450 participants, mostly female (416; 92.9%) and White (379; 84.6%).

Ceballos et al. (2012) used the following predictor variables: (a) number of continuing education units earned, (b) quality of multicultural supervision received and provided, (c) percentage of time addressing multicultural issues in supervision received and provided, (d) percentage of minority clients, and (e) number of years practicing play therapy. They found that the number of continuing education units earned, the quality of supervision provided, years practicing play therapy, and the amount of time receiving supervision with focusing on multicultural issues were related to social justice advocacy attitudes. Furthermore, this study suggested the need for effective multicultural supervision, continuing education opportunities, and multicultural training to promote social justice advocacy among play therapists.

Parikh et al. (2013) used the predictor variables: (a) belief in a just world, (b) political ideology, (c) socioeconomic status (SES) of family of origin, and (d) race. The researchers found that political views were related to social justice advocacy attitudes, specifically participants who identified as being liberal or more liberal were more likely to hold stronger social justice

advocacy attitudes. Furthermore, they also found that belief in a just world was negatively correlated to social justice advocacy attitudes. Researchers also found that socioeconomic status of family of origin and race were not related to social justice advocacy attitudes (Parikh et al., 2013). Both the insignificant results regarding socioeconomic status of family of origin and significant results regarding political ideology were consistent with findings in Parikh et al.'s (2011) study among school counselors. Additionally, researchers' results suggest play therapists may need social justice-oriented education and supervision to address oppressive factors in their clients' lives (Parikh et al., 2013). Overall, this study informs school counselors and counselor educators on specific training play therapists may need to increase their social justice advocacy attitudes.

Researchers have explored play therapists' social justice advocacy attitudes, but more researchers need to explore additional factors impacting social justice advocacy attitudes and how to improve mental health treatment of children of diverse backgrounds. Both Ceballos et al.'s (2012) and Parikh et al.'s (2013) significant results showed various factors influence social justice advocacy attitudes among play therapists, and this merits further exploration. In addition to the factors previously explored that are related to social justice advocacy attitudes, there is a gap in the exploration of how personal experiences and values impact social justice advocacy attitudes, including adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility. Understanding how these experiences and values are related to social justice advocacy attitudes can add to the literature that can help play therapy researchers and educators promote social justice advocacy to support children.

Summary

Professional mandates and codes call play therapists to advocate for children on various levels (CACREP, 2009; Lewis et al., 2011; O'Connor, 2005), and empirical studies in the literature demonstrate the range of variables examined that impact social justice advocacy attitudes among diverse mental health professionals (Beer et al., 2012; Bradley et al., 2012; Crook et al., 2015; Decker 2013; Feldwisch & Whiston, 2016; Inman et al., 2015; Miller & Sendrowitz, 2011; Myers & Sweeney, 2004; Parikh et al., 2011; Steele et al., 2014); however, only two studies have explored factors related to play therapists' social justice advocacy (Ceballos et al., 2012; Parikh et al., 2013). There is a gap in the exploration of how play therapists' personal experiences and values impact social justice advocacy attitudes, including adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility. The next section will explore how these factors relate to social justice advocacy attitudes.

Adverse Childhood Experiences

Childhood trauma refers not only to children who are exposed to traumatic events but also dysfunctional family relations that impact their attachment and development (NCTSN, 2018). Early theorists assumed children were not impacted by trauma until the age of 5, but recent researchers have found that children can be impacted by trauma as young as 7 months old (Gaensbauer, 2002; Masten, 2014). Adverse childhood experiences are potentially traumatic events that can have negative long-term consequences on an individual's overall health and well-being, including maltreatment, abuse, living with an adult who experiences mental illness or substance abuse, incarceration of a family member, or living in an environment that is harmful to one's development (Boullier & Blair, 2018; Cronholm et al., 2015; Felitti et al., 1998).

Professionals began discussing the concept of adverse childhood experiences when Felitti et al. (1998) mailed an Adverse Childhood Experience (ACE) questionnaire to 13,494 adults

after they responded to a standard, medical evaluation at a large HMO; 9,508 responded. Researchers asked participants if, before their 18th birthday, they had experienced specific, traumatic events, which were divided into one of two categories: (a) childhood abuse and (b) household dysfunction. Childhood abuse questions assessed for participants' experiences of psychological abuse, physical abuse, and contact sexual abuse. Household dysfunction questions assessed for participants' experiences of substance abuse within the household, exposure to a mentally ill family member, domestic violence against a female caregiver, and criminal behavior within the household (Felitti et al., 1998). Researchers measured childhood adversities on a scale from zero to ten, with ten indicating full exposure, and zero indicating no exposure.

Felitti et al.'s (1998) research created surprising results; of 9,508 respondents, more than 50% reported experiencing at least one traumatic experience during their childhood, 25% reported at least two, and 6.2% reported four or more. However, a major limitation of Felitti et al.'s (1998) research was their sample of participants who were mostly White (75%), high school graduates (93%), with private health insurance (100%) (Felitti, et al., 1998). Though the sample was not diverse, this was one of the first studies to examine how multiple traumas affect participants' health. Furthermore, Felitti et al.'s (1998) participants are similar, regarding their race and private health insurance, to those in many play therapy studies, indicating they may have experienced more adverse childhood experiences.

Furthermore, researchers found a relationship between adverse childhood experiences and health-risk behaviors, such as smoking, alcoholism, suicidality, shortened lifespan, heart diseases, and drug use, which seem to be consciously or unconsciously to cope with these stressful experiences (CDC, 2010; Felitti et al., 1998; Layne et al., 2014; van der Kolk et al., 2005). Researchers found a "strong dose-response relationship" (Felitti, et al., 1998, p. 250)

between the number of adverse childhood experiences and negative physical and mental health consequences. Results also showed that, as ones' adverse childhood experiences score increases, the likelihood of experiencing health or social problems also increases (Sciaraffa et al., 2018).

For example, researchers found individuals who scored a four on their ACEs questionnaire are twice as likely to become smokers and seven times more likely to become alcoholics. Furthermore, these individuals are 1200% more likely to attempt or commit suicide (CDC, 2019). However, individuals who scored a six or more on their ACEs questionnaire are more likely to experience shortened lifespans by about 20 years (Felitti et al., 1998). Compared to those who did not experience any childhood trauma, an individual with four or more adverse childhood experiences is more than twice as likely to develop heart disease, almost twice as likely to develop cancer, almost four times as likely to develop chronic bronchitis or emphysema, more than twice as likely to be a smoker, over ten times as likely to have used intravenous drugs, and over seven times as likely to consider themselves an alcoholic (Felitti et al., 1998). While Felitti et al. (1998) originally intended to conceptualize relationships between trauma and physical health, they have, instead, shown connections between trauma and mental health, which researchers cannot ignore. Figure 3 illustrates the conceptual framework for the adverse childhood experiences study used by Felitti et al. (1998).

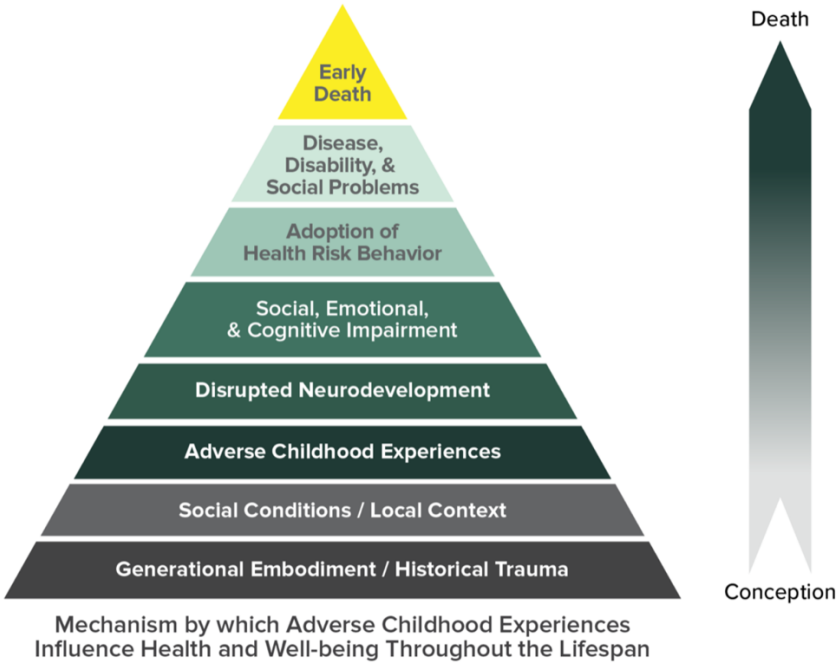

Figure 3: ACEs Pyramid represents the conceptual framework for the ACEs Study (NCIPC-DVP (CDC), 2019).

Currently, adverse childhood experiences are so common that it has been named a public health epidemic (Women and Trauma, 2013). In the United States, almost 61% of children experience or observe violence, often numerous times, and as many as 15% experience six or more occurrences (Finkelhor et al., 2015). About 45% of children in the United States have at least one adverse childhood experience, and that percentage is significantly higher in certain states. Notably, states with higher adverse childhood experience scores also had higher poverty rates (Sacks & Murphey, 2018), with children in poverty often experiencing trauma, loss, and violence (Wade et al., 2014). However, children in minority cultures are at an even greater risk of experiencing both adverse childhood experiences and poverty (Alim et al., 2006; Lipschitz et al., 1999; Sochting et al., 2007). One in ten children have experienced three or more adverse childhood experiences, with children in poverty experiencing trauma more often than their more socioeconomically privileged counterparts (Steele et al., 2016). For this reason, this study will

focus on the impact of adverse childhood experiences on social justice advocacy attitudes among play therapists.

Consequences of experiencing adverse childhood experiences are directly related to long-term impacts on physical and mental health, i.e. future instances of violence and victimization, chronic health conditions, cognitive impairments, decreased life potential, challenges with executive functioning, impulse control, emotion regulation, low self-esteem, and even premature death (Alim et al., 2006; Brown et al., 2009; Copeland et al., 2007; Felitti et al., 1998; Giaconia et al., 1995; Gilbert et al., 2015; Metzler et al., 2017). While researchers have found that experiencing even one adverse childhood experience creates an increased risk for individuals to experience other traumas in the future, there is evidence to suggest that this risk becomes higher with every additional adverse childhood experience faced (Hughes et al., 2017; Lamers-Winkelman et al., 2012; Liming & Grube, 2018). Though researchers have used diverse forms of the ACEs questionnaire to retrospectively measure childhood trauma, few researchers have explored the impact of adverse childhood experiences on those delivering services to others. The following researchers will explore personal adverse childhood experiences among helping professionals, mental health professionals, and child mental health professionals.

Adverse childhood experiences among helping professionals

Researchers have explored adverse childhood experiences among diverse helping professionals, including teachers and student health practitioners. Few researchers have explored these topics, and most have focused on clients rather than helping professionals themselves. Together, these studies support researchers further investigating helping professionals' adverse childhood experiences.

Exploring teachers' adverse childhood experiences, Lepore (2017) examined how early childhood teacher attachment and trauma histories may impact their stress in teacher-parent relationships, and how reflective supervision may impact this stress. Thirty-seven teachers participated in the quantitative component and 20 teachers in the qualitative portion. Lepore found teachers who received reflective supervision for more than two years (M = 4.09 years) had less frustration with parents during the school year compared to teachers who received reflective supervision for only a year. Also, she found teachers experienced between zero and seven ACEs, and more than half of the teachers reported one or more ACEs (M = 1.81). Additionally, teachers who reported more adverse childhood experiences also reported borderline or clinical levels of stress. Lepore's results demonstrated that teachers who experienced more adverse childhood experiences reported increased frustration with parents, discussed their personal history more frequently and connected these experiences to students and families more often than participants with fewer adverse childhood experiences.

Investigating students' personal trauma histories using the ACEs questionnaire (Felitti et al., 1998) and the impact on their desire to address both their own and their clients' adverse childhood experiences, Strait and Bolman (2016) conducted a quantitative research study with 967 students in health professions. Of the students who participated in the trauma-informed course created for their research, 267 responded to a pre-course survey, 422 responded to the post-course survey, and a total of 169 students completed both surveys. Researchers found that participants who were more aware of the lasting, damaging impact of trauma were more likely to address their own trauma and responded more favorably to trauma-informed care practices. Additionally, researchers explored the responses of those who had completed only the post-curricular survey and found that when one assessed their own ACE score, there was an increase

in their comprehension of and familiarity with adverse childhood experiences and trauma-informed care.

Exploring 146 teachers' adverse childhood experiences, Grybush (2020) examined how adverse childhood experiences, professional development, and professional quality of life (compassion satisfaction, burnout, and secondary traumatic stress) were related to their attitudes related to trauma-informed care. The average ACE score was 3.55, and 46 participants (31.5%) reported four or more adverse childhood experiences. Conducting a three-step hierarchal regression, Grybush found that adverse childhood experiences did not account for any of the variance in participants' attitudes toward trauma-informed care. Though participants experienced adverse childhood experiences, the researcher did not find a significant relationship between adverse childhood experiences and attitudes toward trauma-informed care.

Considering the negative outcomes related to adverse childhood experiences, researchers need to explore adverse childhood experiences among helping professionals. Researchers have explored adverse childhood experiences among teachers and students in health professions. Furthermore, researchers have connected adverse childhood experiences among helping professionals to stress, trauma knowledge, and trauma-informed attitudes. Significant results in these studies support researchers exploring adverse childhood experiences among mental health professionals, specifically play therapists.

Adverse childhood experiences among mental health professionals

Professionals have broadly acknowledged that the mental health field is challenging, particularly working in children's mental health (Thomas, 2016). Mental health professionals, particularly play therapists, frequently see children and families who experience oppression, poverty, injustice, and violence and provide services to people who experience trauma,

marginalization, and are suffering. They often negotiate complex situations concerning numerous stakeholders with conflicting needs, and they work in systems with inadequate resources. Play therapists, who experience adverse childhood experiences, may be at a higher risk for problems with wellness and employment instability. These challenges cite the need to explore adverse childhood experiences among play therapists. Scholars have explored adverse childhood experiences among social workers (Michalopoulos & Aparicio, 2012; Steen, 2017; Thomas, 2016), mental health professionals (MacQuarrie, 2019; Mott & Martin, 2019), direct support professionals (Keesler, 2018), and child service providers (Esaki, & Larkin, 2013).

Steen (2017) used a mixed-methods approach to explore adverse childhood experiences among 444 licensed social workers, all of whom reported life-long problems with alcohol, drugs, and their relationship with career success. Participants were not only more likely to report experiencing adverse childhood experiences than the general population, but researchers also found that substance-use treatment helped mediate the relationship between adverse childhood experiences and career success. When comparing these results of those respondents with fewer adverse childhood experiences, those with more adverse childhood experiences were not only more likely to have accessed substance-use treatment, but those who have accessed substance-use treatment were more likely to report higher levels of career success than respondents who did not access treatment.

Also exploring adverse childhood experiences among social workers, Thomas (2016) explored the frequency and significance of early trauma among 79 masters of social work students. He found that 79% experienced at least one adverse childhood experience, 38% experienced one to three, 42% experienced four or more, and 25% experienced six or more. Participants' most commonly cited adverse childhood experience was parental

divorce/separation (48.6%), followed by physical abuse (43%), and then emotional neglect and substance abuse (both at 40.5%). More than one-third of participants reported mental illness in their families (36.7%), and 35.4% experienced emotional abuse. Younger students under the age of 34 had lower ACEs scores than older students, and students who had minor children had higher ACEs scores than students who did not. Participants experienced more adverse childhood experiences than participants in the original study (Felitti et al., 1998), and several other studies. Results of the study are significant because 82.3% of the participants were female, similar to many play therapy studies.

In another study using social workers, Michalopoulos and Aparicio (2012) explored the role of personal trauma history, social support, and experience level in the development of vicarious trauma among 160 Maryland licensed social workers. Among participants, 33% (*n*=52) reported a history of trauma. Researchers using a linear multiple regression found that an increase in social support and experience levels of social workers predicted less severe vicarious trauma. Participants' trauma history did not have a main effect in predicting vicarious trauma. Additionally, researchers found a correlation between trauma history and social support, which was significant in indicating that, while more social support might help social workers without a trauma history, it may not be as helpful to those with a trauma history against experiencing vicarious trauma.

Furthermore, MacQuarrie (2019) explored humor as a mediating factor for post-traumatic growth among 409 mental health professionals who have experienced adverse childhood experiences. The researcher discovered three key factors: (a) adaptive humor can help mediate the ability to achieve post-traumatic growth; (b) adaptive humor and presence of adverse childhood experiences predict the ability to achieve post-traumatic growth; and (c) there is a

positive correlation between adverse childhood experiences and post-traumatic growth in mental health professionals. Most participants identified as Caucasian, female, and had a master's degree-level education, similar to most play therapy study participants. Overall, this study demonstrates a relationship between adverse childhood experiences and post-traumatic growth, with results encouraging further exploration into the adverse childhood experiences among mental health professionals.

Also exploring mental health providers, Mott and Martin (2019) examined how self-care moderates various self-compassion outcomes among 371 mental health providers (88.4% White and 94.1% women). Researchers surveyed participants on their self-care, adverse childhood experiences, burnout, secondary traumatic stress, and compassion satisfaction. Using an independent samples t-test, researchers found participants who had adverse childhood experiences (82.5%) endorsed stronger negative compassion outcomes than those who did not experience adverse childhood experiences. Using three hierarchal multiple regressions, researchers found that participants' endorsement of self-care activities significantly predicted their compassion satisfaction and burnout. Self-care moderated between adverse childhood experiences and burnout. Overall, researchers found that self-care is an essential component to decrease negative compassion outcomes among mental health professionals who experienced childhood trauma.

Additionally, Keesler (2018) explored the prevalence of both adverse childhood experiences categories and scores among 386 direct support professionals (DSPs) who work with clients who had intellectual and developmental disabilities. Results showed that 75% of DSPs experienced at least one adverse childhood experience, while 30% had an ACE score of four or more. Participants, who were female and in their position for less than a year, had significantly

higher ACE scores than males, as well as those who had been in their position longer, respectively. Compared to other adverse childhood experience studies, the four most common adverse childhood experiences categories among DSPs, e.g. divorce, emotional abuse, mental illness, and substance abuse, remained the same; however, DSPs in the current study had higher overall ACE scores and was almost double the percentage of those participants who had an ACE score of four or more. An overwhelming majority of the respondents were females (87%) citing they may experience more adverse childhood experiences than the general population. Similar to Steen's (2016) and Thomas' (2016) results, these participants were more likely to have higher ACE scores than the general population.

Among 134 substance-use disorder clinicians, Jordan-Cox (2018) quantitatively examined experiences of childhood trauma to determine whether it was more prevalent among substance use clinicians than in the general population and the relationship between perceptions of organizational trauma-informed care performance and severity of childhood trauma experienced. Using the original 10-item ACE questionnaire, the average ACEs score was 3.45, and 48.1% reported an ACEs score of four or more, significantly higher than the original ACEs study, where researchers found only 12.5% of participants recounted four or more adverse childhood experiences (Felitti, 1998). Jordan-Cox found the most common adverse childhood experience was emotional abuse and household drug or alcohol use (50%). Furthermore, Jordan-Cox (2018) found no significant relationship between substance use clinicians' adverse childhood experiences and attitudes related to trauma-informed care, meaning participants who have experienced four or more adverse childhood experiences were likely to have a similarly positive outlook on their workplace as those who have experienced fewer adverse childhood experiences.

Finally, Esaki and Larkin (2013) investigated the prevalence of adverse childhood experiences among 94 child service providers, most of whom were female (*n*= 72, 79.1%) and White (*n*= 60, 65.9%), which is similar to most play therapy studies. Results showed that almost 75% of participants reported at least one ACE category, 53.8% reported at least two, and 15.9% reported at least four. Though most participants experienced at least one adverse childhood experience category, their overall ACE scores were not differentiated in terms of demographics. Additionally, this study confirms similar results found by Steen (2016), Thomas (2016), and Keesler (2018), i.e. participants in the mental health field have higher ACE scores than the general population.

Considering the negative outcomes associated with the experiences of adverse childhood experiences, it is important to explore the relationship between adverse childhood experiences and other variables, such as social justice advocacy attitudes, among mental health professionals. Researchers have explored adverse childhood experiences among social workers (Steen, 2017; Thomas, 2016; Michalopoulos & Aparicio, 2012), mental health professionals (MacQuarrie, 2019), direct support professionals (Keesler, 2018), substance use clinicians (Jordan-Cox, 2018), and child service providers (Esaki, & Larkin, 2013). Furthermore, researchers have connected adverse childhood experiences among mental health professionals to alcohol and drug use (Steen, 2017), social support and vicarious trauma (Michalopoulos & Aparicio, 2012), attitudes related to trauma-informed care (Jordan-Cox, 2018), self-care (Mott & Martin, 2019), and humor and posttraumatic growth (MacQuarrie, 2019). The significant results found in most of these studies have demonstrated the need for researchers to explore adverse childhood experiences among play therapists. Overall, this study will explore adverse childhood experiences among a new population, play therapists.

Adverse childhood experiences and social justice advocacy attitudes among helping professionals

Counseling organizations have recently focused on the expanding roles of counselors to provide social justice advocacy to marginalized populations (Ratts et al., 2016). Adverse childhood experiences are experiences that can potentially be marginalizing. Though scholars have discussed expanding counselors' social justice advocacy roles and counselors may serve clients who are experiencing or have experienced adverse childhood experiences, no researchers have directly explored the relationship between adverse childhood experiences and social justice advocacy attitudes among mental health professionals, including play therapists. However, researchers have explored legislators' perspectives about barriers and opportunities to create policies on the prevention of adverse childhood experiences (Srivastav et al., 2020), the need for advocacy for social workers who have experienced adverse childhood experiences (Thomas, 2016), the relationship between parents breaking the intergenerational trauma cycle and social justice advocacy (Wang, 2019), and how doctors screening for adverse childhood experiences are related to social justice advocacy (Finkelhor et al., 2015).

Since social justice advocates need to advocate for their clients at multiple levels, Srivastav et al. (2020) qualitatively interviewed 24 state legislators about barriers and opportunities to create policies that could prevent adverse childhood experiences in South Carolina. Researchers selected participants who did not have prior experience with child health policy issues. Participants identified several components that could influence legislation on adverse childhood experiences: (a) awareness of adverse childhood experiences; (b) gaps in understanding about what they could do about adverse childhood experiences; (c) the use of data and stories that contextualize the problem of adverse childhood experiences; (d) capitalizing on

the bipartisanship of children's issues; and (e) linking to current adverse childhood experience-related issues on the policy agenda, such as school safety and violence prevention and the opioid epidemic. Researchers identified themes that can inform specific social justice advocacy policies to prevent adverse childhood experiences and mediate the consequences.

As mentioned previously, Thomas (2016) focused on exploring adverse childhood experiences among 79 social work students. Thomas (2016) found that adverse childhood experiences related to social justice advocacy, particularly in social work, can be complicated because schools have complex gatekeeping practices that compete with the need to promote social justice for social work educators. Professional social work training programs struggle to serve students, particularly those who have had challenging experiences before beginning their training.

Additionally, Wang (2019) used a mixed-methods design to identify the pathways from parents' adverse childhood experiences to their children's behavioral problems and functions and to explore families' lived experiences of trauma transmission and behavioral health interventions that can counteract trauma transmission. He qualitatively interviewed 12 parents regarding their families' lived experiences and perceptions to discover helpful and unhelpful strategies related to breaking the cycle of intergenerational trauma. Wang (2019) also surveyed 202 parents about pathways of intergenerational trauma transmission. By studying how to interrupt generational trauma cycles, one can argue that intergenerational trauma is directly related to social justice. Parents' trauma diminishes life opportunities across generations and deters social mobility, which has a distinct impact on families, especially when among diverse racial/ethnic groups and those of lower socioeconomic status (Metzler et al., 2017). Wang's (2019) results demonstrated that parents' adverse childhood experiences were, directly and indirectly, related to behavioral

problems in childhood and functioned according to two important mediators: parental emotion regulation and mentalization. Parental mentalization is parents' ability to understand their children's behavior by their children's mental state. He also discovered that parents' trauma resulted in emotional regulation difficulties, leading to coercive parent-child interactions; trauma-affected mentalization, on the other hand, resulted in challenged parent-child bonding. Furthermore, parents' distorted sense of self, lack of awareness, and insufficient self-care skills added to the likelihood of trauma transmission.

Finkelhor et al. (2015) aimed to expand the ACE Scale and analyzed the National Survey of Children's Exposure to Violence 2014, a telephone survey conducted from August 2013 through April 2014. The sample was 1,949 children and adolescents ages 10 to 17 and their caregivers who were asked about adverse childhood experiences, physical health ailments, and mental health symptoms. Researchers added measures of peer victimization, peer isolation/rejection, and community violence exposure, and these measures added significantly to the prediction of mental health symptoms. The measure of low socioeconomic status added significantly to the prediction of physical health problems. Researchers discussed how adverse childhood experiences research has been used as an advocacy tool, demonstrating what policies need to be created to prevent and respond to adverse childhood experiences. The present research shows that the social justice policy advocates need to broaden their focus in regards to peer relationships, poverty, and neighborhood violence. This information provides mental health professionals, specifically, play therapists, on what factors may predict social justice advocacy attitudes.

Szilagyi et al. (2016) explored 302 pediatricians about their beliefs about childhood stressors, their role in supporting parents, and whether they asked parents about adverse

childhood experiences. Most participants (61%) did not ask about parents' adverse childhood experiences. Participants who believed that their advice influenced positive parenting skills inquired about more parents' adverse childhood experiences. Few participants asked about parents' adverse childhood experiences though they recognized the impact of these experiences on parents' behaviors and children's development. Researchers' findings have implications for social justice advocacy because pediatricians have a role in advocacy for effective screening and interventions regarding adverse childhood experiences to improve child health outcomes.

Purtle et al. (2019) described 475 state legislators' opinions about adverse childhood experiences as risk factors for adult mental health problems and identified how opinions vary between legislators with different demographic characteristics. Dependent variables were how much legislators felt that four adverse childhood experiences (sexual abuse, physical abuse, witnessing domestic violence, and childhood neglect) increased the risk of adult mental health problems. Independent variables were legislator demographic characteristics. Researchers conducted four separate logistic regression models to estimate adjusted associations between legislator characteristics and identification of each adverse childhood experience as a major risk factor. They also conducted Rao-Scott chi-square tests to examine differences by legislator characteristics, accounting for clustering by state. Researchers found that 77% identified childhood sexual abuse as a major risk factor for adult behavioral health conditions, 59% identified childhood physical abuse, 39% identified witnessing domestic violence as a child, and 38% identified childhood neglect. The proportion of participants who identified each adverse childhood experience as a major risk factor for adult behavioral health conditions were significantly higher among Democrats than Republicans, among liberals than conservatives, and among women than men. Overall, many state legislators were not aware of the research about

how adverse childhood experiences influence the risk of adult behavioral health conditions. The researchers' findings are essential when exploring the relationship between adverse childhood experiences and social justice advocacy because participants in this study are people who are creating policies that impact those who have experienced trauma and professionals who treat those who have experienced trauma.

Overall, researchers have mentioned that there is a potential relationship between adverse childhood experiences and social justice advocacy, mainly regarding how adverse childhood experiences can potentially be addressed through social justice advocacy, specifically policy work (Finkelhor et al., 2015; Purtle et al., 2019; Srivastav et al., 2020; Szilagyi et al., 2016; Thomas, 2016; Wang, 2019). However, researchers have not directly connected the two concepts within the empirical literature. When scholars have discussed these topics, participants have often been parents, direct support professionals, mental health professionals, social work students, and/or child service providers. Examining the impact of adverse childhood experiences on play therapists' social justice advocacy attitudes can help inform social policy to support people who have experienced trauma. This study will be the first to examine the relationship between adverse childhood experiences and social justice advocacy attitudes among play therapists. Furthermore, the impact of adverse childhood experiences has been so powerful in diverse professions, professionals have created trauma-informed care to serve people who have experienced trauma.

Trauma

To comprehend trauma-informed care, professionals need to understand trauma and how it impacts development. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) defined trauma as a health problem caused by violence, abuse, neglect, loss,

disaster, war, and other emotionally harmful experiences. Furthermore, authors of the DSM-5 defined trauma as when a person is "exposed to actual or threatened death, serious injury, or sexual violence" (American Psychiatric Association [APA], 2013, p. 271), but the psychological definition of trauma has been expanded past the diagnostic definition to include community, historical, and intergenerational trauma. The word *trauma* originated from the Greek word, "trōma," which means "wound" (Wilkin & Hillcock, 2014, p. 185) and was originally named by Sigmund Freud. He predominantly used the term "hysteria," though the diagnosis was inaccurate because most of the women he treated had experienced sexual abuse as children. Conversely, Freud disregarded the women's account of childhood abuse and presumed hysteria was an indication of their sexual fantasies (Wilkin & Hillcock, 2014).

Professionals began discussing trauma again in World Wars I and II using the term *shell shock* to describe soldiers who were involuntarily trembling, tearful, fearful and had persistent intrusions of memory (Wilkin & Hillcock, 2014). During World War I and II, the definition of trauma was re-directed from women to men. Though professionals termed traumatic stress shell shock as a traumatic stress response, they saw it as a character flaw. In the mid-1970s, professionals began recognizing psychological trauma when they added the diagnosis, post-traumatic stress disorder (PTSD), to the DSM-III (American Psychiatric Association, 1980). Though past researchers focused on women and soldiers, present researchers have shifted and found trauma impacts a wider range of people. Additionally, researchers have found trauma contributes significantly to morbidity and mortality (Felitti et al., 1998; SAMHSA, 2014).

Traumatization happens when both internal and external resources cannot cope with an external threat (van der Kolk, 1989). The experience itself does not do the damage, but the individual's body and mind reaction is the most traumatic (Bloom, 1999). Trauma impacts the

whole person, including thoughts, behaviors, learnings, memory, and self-image. When discussing trauma reactions, it is important to discuss the fight or flight response, also named the acute stress response. This physiological response, first described in the 1920s, is part of our complex evolution as humans that allows us to assess and respond to a perceived harmful event, attack, or threat to survival (Bloom, 1999). When the fight or flight response occurs, two responses, the autonomic nervous system (ANS) and hypothalamic-pituitary axis (HPA), are activated (Leitch, 2017; Sciaraffa et al., 2018).

The body reacts to threats quickly when the ANS releases two hormones, epinephrine and norepinephrine. Responses include increased heart rate, increased blood flow to the heart and brain, reduced blood flow to the skin and stomach, and released glucose to receive extra energy. The HPA releases cortisol, a stress hormone, impacting the brain in areas, such as memory, attention, thought management, and emotions. Increased and sustained levels of cortisol, i.e. long-term stressors such as traumatic experiences, impairs cognition and cardiovascular physiological systems (Leitch, 2017; Sciaraffa et al., 2018). When stressors are prolonged and persistent, the brain becomes overwhelmed and the results are toxic or traumatic stress (Shonkoff et al., 2012).

Furthermore, researchers moved from medical conceptualizations of trauma, discussed above, to more comprehensive conceptualizations including community, historical, and generational trauma. Community trauma covers a broad range of trauma impacting community safety, including schools, neighborhoods, and reservations. Historical trauma refers to multifaceted and shared trauma experienced over time and across generations by a group of people who share an identity, connection, or event (Brave Heart & DeBruyn, 1998; Crawford, 2013; Evans-Campbell, 2008; Gone, 2013). Generational trauma, also called intergenerational or

transgenerational trauma, is defined as a form of secondary trauma that is an effect of the transmission of trauma from parents to children (Davidson & Mellor, 2001; Motta et al., 1997). McKenzie-Mohr (2004) suggested professionals broaden the lens of trauma to include strengths and resilience, group and community experiences, experiences across diverse cultures, formerly marginalized voices, and the connection between trauma and oppression. Furthermore, McKenzie-Mohr posits the lens of trauma needs to be expanded because of the Western dominance in trauma research, and those researchers have failed to acknowledge how racism and oppression impact culturally diverse populations. Additionally, this conceptualization is especially important in play therapists' work because they are mainly White women working with a more multicultural population.

This expanded conceptualization of trauma enables professionals to consider the context of individuals when exploring ways to combat the effects of their trauma. People who experience trauma do not do so in a vacuum, but their environment or *system* in which they grow and develop impacts how they respond. To entirely address the damaging impact of trauma, systems must be *informed* of the signs, effects, and long-term impact of trauma and how to be responsive to individuals in ways that can reestablish their original developmental trajectories.

Trauma-informed care

Trauma-informed care was named in the 1990s to describe an approach to comprehensive care that understands the impacts that adverse childhood experiences and trauma have on the people who experience them (Harris & Fallot, 2001; Jennings, 2007; SAMHSA, 2014). Since the 1990s, professionals in diverse systems have implemented trauma-informed care (Burch et al., 2010; Jennings, 2007; Ko et al., 2008; Women and Trauma, 2013). Federal agencies, philanthropies, universities, managed care organizations, and media outlets have focused on how

adverse childhood experiences and trauma impact people across the life span and call for trauma-informed services.

The Substance Abuse and Mental Health Services (SAMHSA, 2014) defines an organization as trauma-informed when it: (a) *realizes* the impact of trauma and recognizes possible paths for recovery, (b) *recognizes* the signs of trauma, (c) *respond*s in ways that actively incorporate the knowledge of trauma, and (d) prevents *re-traumatization*. Additionally, trauma-informed care cites six key principles: (a) safety, (b) trustworthiness and transparency, (c) peer support, (d) collaboration and mutuality, (e) empowerment, voice and choice, and (f) cultural, historical, and gender issues (SAMHSA, 2014). The Substance Abuse and Mental Health Services Administration's definition aims to distinguish between a system that has a trauma-informed approach and their use of interventions that aim to address the effects of trauma. Furthermore, professionals have distinguished differences between modalities designed for people who have experienced trauma and trauma-informed modalities.

Furthermore, the National Child Traumatic Stress Network (NCTSN) provides a comprehensive definition of trauma-informed care. The NSTSN (n.d.) defines trauma-informed care as a system that: (a) screens regularly for trauma exposure and symptoms; (b) utilizes evidence-based, culturally responsive assessment and treatment for mental health symptoms; (c) provides resources to children, families, and professionals on trauma exposure, effects of trauma, and trauma treatment; (d) strengthens the resilience and protective factors of children and family impacted by trauma; (e) discusses parent and caregiver trauma and the impact on the family; (f) emphasizes the continuity of care and collaboration; and (g) creates a supportive environment for staff addressing secondary traumatic stress and increases staff's wellness. Similar to the SAMHSA (2015) definition, this definition of trauma-informed care moves beyond a specific

treatment modality implemented with one client to a multifaceted approach forming a sensitive environment responsive to clients who have experienced trauma.

Keeping the principles in mind, trauma-informed workers' goals are to (a) normalize and validate clients' feelings and experiences, (b) assist clients in comprehending how their past affects them in the present, (c) encourage and empower clients to lead strong lives, and (d) help clients understand the connection between their current struggles and past trauma (Knight, 2015). Other goals include combining information about the biopsychosocial effects of trauma into policy work that creates stronger and more responsive services (Brown et al., 2012; Lang et al., 2016; Levenson, 2017).

Researchers have discussed benefits from trauma-informed care including greater reduction of symptoms, less time in treatment, higher discharge rates to a lower level of care, improved mental health and substance abuse outcomes, increased feelings of safety, and gained developmental trajectories (Greenwald et al., 2012; Hodgdon et al., 2013; Morrissey et al., 2005; SAMHSA, 2014). Professionals have implemented trauma-informed care in a diverse range of settings, such as schools, hospitals, child welfare systems, child advocacy centers, and veteran service centers, and professionals may implement trauma-informed care in more settings as they learn more about the approach. Researchers have addressed trauma-informed care among health professionals and child mental health professionals.

Trauma-informed Care among Health Professionals

The psychological and physiological impact of trauma encourages the implementation of trauma-informed approaches in systems that serve people who have experienced trauma. Researchers (Berkhout, 2018; Bruce et al., 2018; Hall et al., 2016; Jacobowitz et al., 2015; Niimura et al., 2019; Truesdale et al., 2019) have quantitatively and qualitatively explored

trauma-informed care among diverse health professionals. Together, their research supports the need for increasing awareness of trauma-informed attitudes among health professionals.

Exploring how traumatic events, resilience, confidence, and compassion fatigue were related to PTSD symptoms among 172 psychiatric hospital staff, Jacobowitz et al. (2015) assessed participants who were mostly registered nurses (RNs) and Psychiatric Aides (73%) and female (67%). Most were married, lived with a partner or their family (86%), and last attended a trauma-informed care meeting within the previous six months (83%). Researchers conducted a hierarchical linear regression and found two variables that were predictors of PTSS (post-traumatic stress symptoms): (a) trauma-informed care meeting attendance and (b) burnout symptoms. The positive Beta values indicated that PTSS increased as the length of time between attending trauma-informed care meetings increased and as signs of burnout increased. Severe traumatic events, age, and compassion satisfaction also contributed to the model. This study provides researchers with more knowledge about factors that can reduce PTSD symptoms among staff.

Examining the experiences of emergency department nurses learning about trauma-informed care, Hall et al. (2016) conducted a mixed-methods study. Researchers collected quantitative data using an 18-item pre-education and post-education questionnaire and qualitative data among members of two focus groups after the participants received trauma-informed care education. Participants were 34 emergency department nurses who participated in trauma-informed care education and 14 emergency department nurses in the focus groups. The quantitative results indicated significant changes in nine of the 18-items after trauma-informed care education. Concerning the qualitative results, researchers found themes based on the perceived effectiveness of trauma-informed care education and the subsequent changes in

clinical practice in the period after trauma-informed care education. Overall, the quantitative and qualitative results showed the effectiveness of trauma-informed care for emergency department nurses.

Bruce et al. (2018) explored 147 trauma providers' perspectives on trauma-informed care. Providers who worked in trauma resuscitation, trauma critical care, and trauma care units, including nurses, physicians, physical therapists, occupational therapists, and respiratory therapists, were included. Researchers examined potential relationships among demographic variables and survey items using chi-square analyses or logistic regression. Researchers found that 75% of participants answered the knowledge items accurately and 89% held favorable opinions about trauma-informed care. In the multiple logistic regression, researchers found that knowledge and opinions of trauma-informed care were not related to any reported trauma-informed care practices. Conversely, self-rated competence was related to all trauma-informed care practices. In the qualitative portion, participants acknowledged significant barriers to providing basic trauma-informed care to be: (a) time constraints, (b) need for training, (c) confusing information about trauma-informed care, and (d) concern about retraumatizing patients. Participants were knowledgeable and held favorable views toward trauma-informed care.

Using a different population, Berkhout (2018) quantitatively examined how personal trauma history impacted attitudes related to trauma-informed care among 21 direct-care staff at youth residential facilities. The results were not statistically significant, but researchers uncovered that direct-care staff who experienced more personal trauma held generally less favorable attitudes toward trauma-informed care. Overall, direct-care staff experienced more personal trauma than the general population. Specifically, results showed participants who

experienced physical neglect, physical abuse, and racial or ethnic discrimination held less favorable attitudes toward trauma-informed care. Furthermore, though direct-care staffs' attitudes were more favorable after training in trauma-informed care, participants' responses to clients were not affected. The researcher's findings show that personal trauma may impact professionals' trauma-informed attitudes.

In contrast, Truesdale et al. (2019) qualitatively explored the perspectives and experiences of 25 practitioners in the United Kingdom who worked with adults with intellectual disabilities who experienced trauma. Participants included clinical psychologists, psychiatrists, nurses, allied health professionals, and social workers. Researchers found seven themes: (a) unmasked trauma, (b) trauma-informed care, (c) person-centered care and support, (d) multi-disciplinary working, (e) reasonable adjustments, (f) barriers to treatment, and (g) awareness, training and education. The study supported the importance of practitioners to know trauma-informed care practices when they work with adults with intellectual disabilities who have experienced trauma.

Niimura et al. (2019) explored the impact of a one-day trauma-informed training on attitudes related to trauma-informed care among 65 psychiatric hospital professionals in Japan. Most participants were female registered nurses with a mean of almost eight years of experience. Results indicated that the training had a significant effect on attitudes more favorable to trauma-informed care. Three months later, over half of the participants indicated they had applied trauma-informed care into their work. The contradictory findings of these studies cite the need for additional exploration of trauma-informed care.

Overall, researchers in diverse health professions (Berkhout, 2018; Bruce et al., 2018; Hall et al., 2016; Jacobowitz et al., 2015; Niimura et al., 2019; Truesdale et al., 2019) have

explored trauma-informed care among psychiatric hospital staff, nurses, and direct-care staff. All of the researchers' results support the importance and relevance of trauma-informed care among various health professionals. Furthermore, the successful implementation of trauma-informed care among health professionals support the need for mental health professionals to apply the approach. Researchers have demonstrated the importance of trauma-informed care, and this further encourages researchers to continue to explore the topic among diverse mental health professionals.

Trauma-informed Care among Mental Health Professionals

Though researchers have explored trauma-informed care among diverse health professionals, minimal researchers explored trauma-informed care among exclusively mental health professionals. A reason for this may because trauma-informed care is often a system-wide approach adopted by organizations rather than clinicians who frequently work individually. Williams and Smith (2017) explored the impact of trauma-informed care training among 271 mental health clinicians and public health managers from public mental health and drug and alcohol services in Australia. Participants completed a survey a year after training, and they found that participants felt the training increased their awareness and knowledge and positively impacted their attitudes towards trauma-informed care. Clinicians felt the training had a moderate impact on their clinical work, and both groups of participants felt very limited success in making their workplace more trauma-informed citing organizational factors and workforce development. Both clinicians and managers identified workforce development and organizational factors as barriers to the implementation of trauma-informed care.

Additionally, Jordan-Cox (2018) quantitatively explored trauma-informed care attitudes among 134 substance-use disorder clinicians at addictions treatment centers. The researchers

investigated the relationship between participants' attitudes towards trauma-informed care and their adverse childhood experiences. Furthermore, Jordan-Cox (2018) found no significant relationship between participants' adverse childhood experiences and attitudes related to trauma-informed care, meaning those who have experienced four or more adverse childhood experiences were likely to have a similarly positive outlook on their workplace as those who have experienced fewer adverse childhood experiences. Though minimal researchers have explored trauma-informed care among general mental health professionals, several researchers have focused on child mental health professionals.

Trauma-Informed Care among Child Mental Health Professionals

Researchers have explored trauma-informed care among child mental health professionals, specifically child social workers (Lang et al., 2016), child welfare professionals (Kerns et al., 2016), residential youth service workers (Baker et al., 2018), school social workers (McKee, 2018), school psychologists (Gubi et al., 2019), and youth welfare employees (Schmid et al., 2020). Only one study explored trauma-informed care in play therapy (Woollett et al., 2020). Overall, scholars have created a body of research that demonstrates the effectiveness of implementing trauma-informed care approaches. These studies used a variety of participants in diverse settings.

Lang et al. (2016) investigated the results of the implementation of trauma-informed care training among 223 child social workers in Connecticut. Researchers assessed changes in system readiness and capacity to deliver trauma-informed care before implementation and two years after implementation using the Trauma System Readiness Tool. They found that participants significantly improved in their trauma-informed knowledge, practice, and collaboration across nearly all child welfare domains assessed, which suggests that system-wide improvements are

instrumental in ensuring staff are ready and able to provide trauma-informed care. Though participants' trauma-informed care readiness at follow-up was positive, it suggested more improvement was needed and two years of implementation was not sufficient to create a ''trauma-informed system.''

Working with a similar population to Lang et al. (2016), Kerns et al. (2016) conducted two studies on trauma-informed screening training and implementation. The first study explored how trauma-informed screening training impacted 44 child welfare professionals. The second study examined how a two-stage method trained child welfare professionals to create case plans for children's mental health. Participants in the second study were 71 newly hired professionals who received a 3-hour training and 55 professionals who participated in a full-day training. Researchers found in the first study that the training effectively increased participants' knowledge and skills in administering screening tools. In the second study, they found participants significantly gained competence in recognizing mental health needs and connecting children with evidence-based services. The researchers' findings in both studies provided evidence that trauma-informed approaches are effective in child welfare.

Kenny et al. (2017) evaluated the effectiveness of trauma-informed care training among 203 child advocacy center workers at three time points. Researchers performed a dependent sample t-test to explore workers' knowledge on the Trauma-Informed Care Questionnaire (TICQ) before and after training and a repeated measure one-way ANOVA to relate participants' knowledge on the TICQ before training, after training, and during the follow-up. Overall, the workers had similar knowledge of trauma-informed care before the training, but their knowledge level was significantly impacted by race, years of experience, and degree level. White participants had higher pretest scores than Black and Hispanic participants. Participants with

bachelors and graduate degrees scored higher than participants with only high school diplomas. Remarkably, participants with shorter work experiences (10-20 years) had significantly lower scores than groups with longer work experiences. Researchers also found that trauma-informed care knowledge significantly increased after training with an effect size of 0.71. Participants also responded to two open-ended questions about the most and least preferred parts of the training, and most indicated that they were content with the program. Overall, the researchers' results showed the importance of regular exposure to trauma-informed care training to be essential for workers who are regularly exposed to others' traumatic experiences.

Using a mixed-methods approach, Baker et al. (2018) explored the implementation and impact of trauma-informed care, specifically the curriculum-based Risking Connection and Restorative Approach trauma training programs, in residential youth services in Canada (n=116). In the first study, researchers using a repeated-measures ANOVA quantitatively evaluated the effect of the Risking Connection and Restorative Approach on staff at three points in time. In the second study, researchers gathered qualitative data from participants' observations and interviews about the implementation. The quantitative portion of the study found results similar to earlier findings (Brown et al., 2012) that Risking Connection improved favorable attitudes towards trauma-informed care, but they also found that staff experiences of vicarious trauma increased after trauma-informed care training (Baker et al., 2018). Researchers found no significant changes for compassion satisfaction, burnout scores moved in a negative direction, and secondary traumatic stress increased overall during the three time-points. Researchers found in the qualitative data that the division was successful in their execution of trauma-informed care, and participants felt more aware and open to discuss vicarious trauma, which was a possible reason for their increased vicarious trauma scores. Overall, the study shows how

training can improve trauma-informed care attitudes, but it is still a complicated endeavor (Baker et al., 2018).

McKee (2018) qualitatively explored seven school social workers' experiences providing trauma-informed care during a school crisis. Participants were all women ranging from 30 to 55 years old. The study aimed to explore whether school social workers used trauma-informed care approaches and how they might implement trauma-informed care to support their work. The researcher found the following themes: (a) school crises occur along a continuum, (b) role of the social worker, (c) self-care/self-awareness, (d) staff development, (e) ability to debrief after a crisis, and (f) problem-solving. Themes showed that school social workers needed continued professional development for staff that responds to school crises, and they needed processing after a school crisis to decrease or eliminate future school crises. Overall, researchers' results support social workers' using trauma-informed approaches in their work (McKee, 2018).

Also using mental health professionals in schools, Gubi et al. (2019) conducted a pilot study to explore how 82 school psychologists perceived their training in offering trauma-informed services, specifically their experiences, education, training, confidence, competence, barriers, and support. Participants worked most often (46.3%) with children who experienced neglect and 75.6% rated their education and training in trauma and trauma-informed care as none. In regards to their confidence, 79.3% rated their confidence in working with children who have experienced trauma as none, and 85.4% have not used trauma-related interventions in the past year. Overall, the researchers' results support the implementation of trauma-informed approaches among school psychologists (Gubi et al., 2019).

Schmid et al. (2020) explored the effectiveness of trauma-informed care in 14 residential youth welfare institutions in Switzerland among 47 youth welfare employees in a longitudinal

study by measuring hair cortisol concentration and occurrences of client physical aggression. Hair cortisol concentration measures long-term cortisol release, a stress indicator. Because trauma-informed care aims to lower staff stress levels, researchers compared whether there are long-term differences in hair cortisol concentration between employees from institutions with and without trauma-informed care practices. The intervention group were participants at institutions that had trauma-informed care practice, and the control group did not receive training in trauma-informed care. Researchers conducted a one-way repeated-measures ANOVA with hair cortisol concentration as a within-subject factor and group as a between-subject factor was conducted for testing differences in hair cortisol concentration. The intervention group showed significantly lower hair cortisol concentration at 36 months post-training than the control group, indicating reduced physiological stress levels. At 36 months post-training, the intervention group reported significantly less physical aggression than the control group. Overall, researchers' findings confirm the benefits of implementing a trauma-informed approach in the youth welfare setting (Schmid et al., 2020).

Only one study conducted on trauma-informed care involved play therapy. Woollett et al. (2020) conducted a mixed-methods pilot study utilizing trauma-informed cognitive behavioral therapy integrated with art and play therapy among school-age children and their mothers at a domestic violence shelter in New York City and Johannesburg. Researchers assessed the children for depressed and post-traumatic stress disorder (PTSD) symptoms before and after the intervention. Children participated in weekly group play sessions for one to two hours over 12 weeks, and mothers participated in three group sessions. Researchers collected quantitative data from pre-and post-intervention child self-reports ($n = 21$) and mother's reports ($n = 16$) of their children's depression and PTSD symptoms. Researchers also conducted interviews with 11

children and eight mothers. The interviews discussed what was most useful for them in the intervention, what challenged them the most, any components of the intervention they felt were unnecessary, any advice they had for other children in comparable situations, and anything they would want their mothers to know about. From pre-intervention to post-intervention, children's depressive symptoms were significantly reduced, and researchers found a non-significant trend towards PTSD improvement. In interviews with the children, they found the following themes: (a) expressing and managing overwhelming feelings, (b) drawing as a bridge to communicating difficult emotions, (c) intrinsic therapeutic value of relaxation and fun, (d) recognizing changes in behavior in self and others, (e) desire for emotional communication with mothers and validation of self, and (f) being seen through art products. Overall, researchers' results show that trauma-informed art and play therapy can be impactful in mitigating the effect of domestic violence on children. The successful implementation of trauma-informed care in play therapy and the lack of studies cite the need for more researchers to explored trauma-informed care among play therapists.

Trauma-informed Care and Social Justice Advocacy Among Helping Professionals

Researchers have explored trauma-informed care and social justice advocacy among middle school math students and teachers. Kokka (2019) used a case study approach to investigate how a Title I public middle school math classroom used social justice principles among nine students in the class. The researcher collected data through multiple methods including observation field notes, interviews, task sheets, and student work. The researcher found three themes: (a) students identified and discussed their feelings around social justice issues, (b) students analyzed structural conditions, such as how the minimum wage does not provide nearly enough income for residents to secure stable housing, understanding how systemic factors

influence living conditions, and (c) students expressed plans to take action in the community. Overall, the approach was effective in integrating topics of social justice into class and is potentially applicable to a variety of courses.

Post et al. (2020) explored the impact of child-teacher relationship training (CTRT) on 46 teachers' professional quality of life, social justice attitudes, attitudes aligned with the values of CTRT, attitudes related to trauma-informed care, and the ability to demonstrate the CTRT skills in the classroom. Participants were 21 teachers in the CTRT program, and 25 teachers in another school served as the control group. Most of the teachers were women (94%), Caucasian (58%) or Black (38%), and held a bachelor's degree (96%). Researchers' results showed the CTRT impacted teachers' attitudes about trauma-informed care, attitudes about CTRT, and the ability to implement CTRT skills in the classroom, but the intervention did not impact teachers' attitudes towards social justice. Additionally, the intervention and control group schools showed a decrease in their attitudes towards trauma-informed care, but teachers in the control group showed a stronger decrease in attitudes aligned with trauma-informed care than teachers in the intervention school. Overall, few researchers have examined the relationship between trauma-informed care and social justice advocacy.

Summary

Trauma-informed care is an innovative approach to working with those who have experienced trauma, and researchers in the literature demonstrate the diverse experiences of professionals and the benefits of implementing a trauma-informed approach. However, only one study (Woollett et al., 2020) has explored the impact of a play therapy-based trauma-informed care intervention. There is a gap in the literature regarding how play therapists' trauma-informed attitudes and values impact their social justice advocacy attitudes.

Cultural Humility

Recently, counseling scholars and researchers have shifted from a multicultural *competence* framework to a multicultural *orientation* framework to highlight the importance of being with clients versus a method of doing therapy (Owen et al., 2014). Researchers have defined three components within this multicultural orientation framework: (a) cultural humility; (b) cultural opportunities; and (c) cultural comfort. Cultural humility is the component focused on in this study. Professionals began discussing cultural humility when Tervalon and Murry-Garcia (1998) defined the concept in medical education as the "lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individual and defined populations" (1998, p. 117). Furthermore, Mosher et al. (2017) described inter- and intra- personal components of the concept, and the intrapersonal component of cultural humility involves being aware of limitations of one's cultural worldview and in one's ability to comprehend others' cultural backgrounds and experiences. People become aware of their limitations through life-long learning, cultural self-awareness, and interpersonal respect. The interpersonal component involves an other-oriented stance focusing on respect and lack of superiority towards clients' cultural background and experiences (Hook et al., 2013). This process of cultural humility is viewed as a virtue or disposition rather than a mixture of multicultural competencies.

Professionals have contrasted cultural humility with multicultural competency language in that multicultural competency provides a meta-message that one can achieve and become *competent* (i.e. arriving at a conclusion in their ability to understand the 'other,') which is inconsistent with the philosophy of cultural humility (Hook et al., 2013; Hook, 2014; Mosher et

al., 2017). Scholars have cited concerns about the concept of cultural competence because no matter how long people study a culture, they will not become competent in every culture (Fisher-Borne et al., 2015; Hook et al., 2013; Hook, 2014; Isaacson, 2014). Both cultural humility and cultural competence address inequality but their approaches are different; cultural competency models focus on attaining knowledge and cultural humility models focus on the need for individual and institutional accountability (Fisher-Bourne et al., 2015).

When discussing cultural humility, professionals need to consider the complexities of intersectionality (Ortega & Faller, 2011; Tervalon & Murray-Garcia, 1998). Davis (2008) defined intersectionality as "the interaction between gender, race, and other categories of difference in individual lives, social practices, institutional arrangements, and cultural ideologies and the outcomes of these interactions in terms of power" (p. 68). Professionals need to consider intersectionality when discussing cultural humility because cultural competency measures tend to focus on one aspect of culture, such as race, while ignoring other aspects, such as religion, gender, and sexual orientation (Kumaş-Tan et al., 2007). Cultural humility places clients as experts of their cultural view encouraging professionals to engage with clients from a not-knowing perspective (Tervalon & Murray-Garcia, 1998). By allowing clients to be experts of their culture, professionals can understand how cultural factors interact to create clients' identities and experiences.

Cultural Humility among Helping Professionals

Researchers have explored cultural humility among art therapists (Keselman & Awais, 2018), teachers-in-training (Lund & Lee, 2015; Tinkler & Tinkler, 2016), nursing students (Kako & Klingbeil, 2019; Sedgwick & Atthill, 2019), physical therapy students (Oosman et al., 2019), and hospital employees (Hook et al., 2016). Together, these scholars' studies support the need

for increasing awareness of adverse childhood experiences, attitudes towards trauma-informed care, and cultural humility by promoting social justice advocacy attitudes among diverse professionals.

Keselman and Awais (2018) investigated how cultural humility is integrated into medical art therapy. Researchers interviewed six medical art therapists using a semi-structured interview protocol, including a visual elicitation. For the visual elicitation, participants used art materials to create a visual example of a cross-cultural interaction they had with a client. Artwork created during the visual elicitation produced information used in the interviews, including the client's cultural identity and how the visual related to their patient interaction. Researchers asked participants how they defined culture, the evolution of that definition, and their understanding of the concept of cultural humility. Themes found included: (a) awareness of self in relation to others, (b) collaborative relationship with patients, and (c) consideration of art therapy within larger systems. Primarily regarding their definition of cultural humility, participants focused on how cultural humility acknowledges power imbalances. Overall, the researchers' results showed possible areas for growth in regards to art therapists' cultural humility.

Several researchers in the helping professions used study abroad experiences, global learning experiences, and service-learning to explore cultural humility (Kako & Klinbell, 2019; Lund & Lee, 2015; Sedwick & Atthill, 2019; Tinkler & Tinkler, 2016). Lund and Lee (2015) explored 10 teacher-in-trainings' experiences in a community-initiated service-learning project serving immigrant children. Researchers collected data from initial-placement interviews and post-placement interviews. All of the participants were females and nine participants were White. Researchers' themes were: (a) justice-based service-learning can enhance pre-service teachers' ability to self-reflect critically and to identify and appreciate strengths of children and

youth of immigrant families; (b) justice-based service-learning can foster cultural humility and greater self-awareness in pre-service teachers through building positive relationships with children of diverse backgrounds; and (c) professional education for cultural humility needs to anticipate and accommodate people with different motivations for being involved, unique life experiences, and a range of understandings of diversity. The themes from students' interviews showed the strengths of using a cultural humility approach, particularly service-learning, in teacher education.

Tinkler and Tinkler (2016) explored the learning outcomes of the service-learning experiences of 18 secondary education students embedded in a Reading in the Content Area course. Participants worked weekly with middle and high school age refugees at a community site providing academic support. Researchers collected qualitative data through participants' reflection portfolios, interviews, and a questionnaire about their learning gains, including specific examples, and how they connected the experience to course content. They found three themes among portfolios and journals: (a) discovery through stories, (b) care through affirming strengths, and (c) learning through reciprocal relationships. All three themes reflected cultural humility attributes throughout.

Sedwick and Atthill (2019) explored how global health service-learning encouraged nursing students' cultural humility and how the experience molded their self-knowledge and ability to develop empathetic intercultural relationships. Researchers collected data from written reflections of eight students and interviews with six students. They found four themes: (a) overcoming challenges, (b) opening our eyes, (c) seeing difference as a strength, and (d) learning with and from each other. Researchers found participants to be inherently ethnocentric, but the cultural humility process curtailed their appearance of superiority and enhanced their

intercultural relationships with their hosts. Overall, researchers found the global health service-learning experience was effective in enhancing nursing students' cultural humility.

Kako and Klinbeil (2019) explored how a short-term interprofessional study abroad program in Kenya created awareness of cultural humility among 21 nursing and health professions students. Researchers analyzed themes in students' journals to find how they applied cultural attunement to learn cultural humility when they interacted with people in Kenya. Researchers found the following themes: (a) students acknowledged the pain of oppression; (b) students acted with reverence; (c) students reported coming from a place of not knowing; engaged in acts of humility; (d) students engaged in mutuality; and (e) students reported attaining harmony, cooperation, and accord during the study abroad experience. Participants' themes showed how study-abroad programs can encourage cultural humility among nursing and health profession students.

Oosman et al. (2019) explored five Masters of Physical Therapy students' experiences in a community-based practicum in a Métis community, particularly their learnings around cultural humility and cultural safety. Researchers gathered data from exit interviews when students completed their practicum and found three themes: (a) realizing Métis community strengths; (b) learning from experiences and shaping future practice; and (c) prioritizing relationships. The themes encouraged the researchers that the participants engaged in culturally humble practices in the community-based practicum. Overall, the study highlighted the importance of community engagement in culturally humble practices.

Only one researcher studied helping professionals' cultural humility quantitatively (Hook et al., 2016). Hook et al. (2016) explored 2,011 hospital employees' perceptions of organizational cultural humility and hospital safety culture. Most (78.6%) of the participants

were nurses, technicians, or clerical staff. Researchers found higher perceptions of organizational cultural humility related to higher levels of general perceived hospital safety, as well as more positive ratings on non-punitive responses to error (i.e., mistakes of staff are not held against them), handoffs and transitions, and organizational learning. Cultural humility positively predicted perceptions of safety, non-punitive response to error, handoffs and transitions, and organizational learning. Overall, researchers took the first step in investigating the possible role of cultural humility in hospital settings.

This body of literature cited above shows researchers have explored cultural humility in nursing, physical therapy, education, and medicine. Furthermore, researchers in these diverse fields have connected cultural humility to self-awareness, intersectionality, and collaborative relationships. Researchers have connected these concepts through study abroad experiences and service-learning with a qualitative methodology. However, they have minimally explored participants' cultural humility attitudes quantitatively. Researchers have demonstrated the importance of exploring cultural humility, and this further encourages researchers to continue to explore the topic among diverse health and education professionals quantitatively.

Cultural Humility among Mental Health Professionals

Several mental health researchers have explored cultural humility (Cook et al., 2020; Davis et al., 2016; Gonzalez et al., 2020; Hook et al., 2013; Mcelroy-Heltzel et al., 2018; Owen et al., 2014; Owen et al., 2016). Most researchers who have explored cultural humility focused on clients' experiences of cultural humility and examined experiences retrospectively. Additionally, researchers have explored cultural humility among college students (Hook et al., 2013), therapy clients (Owen et al., 2014), interethnic couples (Mcelroy-Heltzel et al., 2018),

supervisors and supervisees (Cook et al., 2020), therapists and clients (Davis et al., 2016), and practicing counselors (Gonzalez et al., 2020).

First, Hook et al. (2013) conducted four studies to validate the Cultural Humility Scale including a pilot study, Study 1, Study 2, and Study 3. Hook et al. conducted the pilot study among 117 college students, exploring their cultural background and therapists' characteristics related to a therapy scenario. The pilot study aimed to examine how clients perceive cultural humility as an important component of a therapist. Researchers conducted a series of analyses of covariances, with knowledge and cultural humility as independent variables and confidence in developing a good relationship, expected effectiveness, and likelihood to continue as the dependent variables. They also controlled for past experience in therapy, race, and gender. Researchers found participants who rated their therapist higher in cultural humility reported a higher likelihood of developing a positive relationship with their therapist, expected therapy would be more effective, and reported a higher likelihood of continuing therapy with the therapist.

To develop a client-rated measure of the cultural humility of therapists and collect initial data about how clients' perceptions of their therapists' cultural humility were related to clients' outcomes, Hook et al. (2013) conducted Study 1 among 472 college students who rated their severity of presenting issue, working alliance with their therapist, and identified the aspect of their cultural background that was most significant to their identity. Researchers also asked participants about their counselors and to indicate their agreement or disagreement about statements regarding their counselors' views of the client's cultural identity. The researchers conducted a Scree Test and exploratory factor analysis to create the 12-item Cultural Humility Scale, with seven positive and five negative aspects of cultural humility. Additionally,

researchers, using a hierarchal regression, found cultural humility was significantly related to working alliance after controlling for the variance in other variables. Researchers found a relationship between positive and negative cultural humility and working alliance.

To duplicate and develop findings from Study 1 using participants who were presently participating in therapy, Hook et al. (2013) surveyed 134 adults, predominantly White (70.1%), to see if the scale's factor structure would be similar to Study 1. In Study 2, researchers used a hierarchal regression to examine the relationship between cultural humility and working alliance, controlling for multicultural counseling competencies. Researchers found that clients' perception of a therapists' cultural humility was positively related to high-quality alliances with their therapist.

In the final study (Hook et al., 2013), researchers replicated and expanded findings from previous studies on cultural humility by incorporating measures of client improvement in therapy and intentionally seeking a more diverse sample. Researchers surveyed 120 adults who self-identified as Black and currently attended therapy. Participants completed measures on improvement in psychotherapy, working alliance, and cultural humility. Because cultural humility is a relational variable and connected previously to working alliance between the clients and therapists in Study 1 and 2, researchers thought that cultural humility would be positively related to improvement in psychotherapy and mediated by working alliance. Researchers used a hierarchal regression to find that cultural humility, the predictor variable, indirectly affected improvement, the criterion variable, through working alliance, the mediator variable. A large effect size, about 37.2% of the variance in improvement, was explained by the mediated effect of cultural humility through working alliance. Overall, researchers created and validated a measure of therapists' cultural humility and provided evidence of validity and reliability.

Owen et al. (2014) sought to further confirm the results from Hook et al. (2013) when they explored how 45 self-identified religious and spiritual participants perceived their prior therapists' cultural humility. The study explored the extent to which clients' religious commitment moderates the association between their perceptions of their therapists' cultural humility and therapy outcomes. Researchers found perceptions of cultural humility were positively associated with therapy outcomes, and this effect was moderated by clients' religious commitment. The relationship between perceived cultural humility and outcomes was positive for clients with higher religious commitment. Researchers' findings encourage mental health professionals to consider clients' religious and spiritual commitment and cultural humility when considering positive client outcomes.

An additional study by Hook et al. (2016) explored racial microaggressions in counseling among 2,212 racial and ethnic minority clients. They explored the relationship between the perceived cultural humility of the counselor and racial microaggressions using two hierarchical regressions with racial microaggression frequency and racial microaggression impact as dependent variables. General competence, multicultural competence, and cultural humility altogether accounted for 28% of the variance.

Davis et al. (2016) explored how microaggressions impact counseling outcomes among 128 racial/ethnic minority individuals who had been in counseling within the past year. Researchers measured single items associated with the context of the microaggression, negative emotions due to rupture, working alliance, perceived improvement in counseling, and perceived cultural humility using path analysis. Participants were randomly assigned to either a general severe offense that was connected to their identity or a microaggression condition involving an issue in counseling. Both conditions evoked microaggressions to a similar level. Perceptions of

cultural humility mediated the relationship between negative emotion due to rupture and counseling outcomes.

Owen et al. (2016) examined 247 clients' perceptions of their therapists' (n=50) multicultural orientation, including cultural missed opportunities and cultural humility using hierarchal linear modeling. Clients who rated their therapists as being more culturally humble also reported stronger therapeutic outcomes. Conversely, clients who perceived that their therapists missed cultural opportunities in therapy reported weaker therapeutic outcomes. Additionally, researchers found therapists' cultural humility ratings moderated the association between cultural opportunities and therapy outcomes. Clients who rated their therapists as less culturally humble had a negative association between missed opportunities and client outcomes. Regarding clients who reported their therapists as more culturally humble, the degree to which the therapists discussed clients' culture was not associated with any outcomes.

Using a different population, Mcelroy-Heltzel et al. (2018) explored factors associated with relationship quality among 155 participants who were part of interethnic couples. Researchers predicted that higher levels of culturally based ineffective arguing would be negatively associated with relationship quality. Participants completed a survey on their demographics, conflict in their relationship, cultural humility, and relationship quality. Researchers found that cultural humility was positively related to relationship satisfaction and commitment and negatively related to ineffective arguing. Perceived partner cultural humility mediated the relationship between ineffective arguing and relationship satisfaction.

Cook et al. (2020) explored supervisors' cultural humility as a predictor of supervisees' nondisclosure among 101 post-master's counselors. Researchers found that when supervisors held more traits of positive cultural humility, i.e. being respectful and interested in learning

more, those traits predicted supervisees' intentional nondisclosure. Furthermore, supervisors' level of cultural humility explained 20% of the variance in their self-reported use of intentional nondisclosure. Specifically, participants' perceptions of their supervisors as having positive traits significantly predicted supervisee intentional nondisclosure. The researchers' findings provide more evidence of the need for cultural humility in the supervisor/ supervisee relationship.

Gonzalez et al. (2020) developed and tested a multidimensional cultural humility scale among 861 practicing counselors to measure counselor's cultural humility based on Foronda et al.'s (2016) five factors of cultural humility model. Participants completed the Multidimensional Cultural Humility Scale (MCHS), Situational Self-Awareness Scale (SSAS), and the Marlowe-Crowne Social Desirability Scale-Short Form. Researchers completed an exploratory factor analysis with 430 participants who completed the MCHS and found a model with five factors that explained 62.95% of the variance. Factors were labeled Openness, Self-Awareness, Ego-Less, Self-Reflection and Critique, and Supportive Interactions, to replicate Foronda et al.'s (2016) model. Additionally, researchers completed a CFA with 431 participants and found factor loadings from .57 to .88 for Openness, .56 to .72 for Self-Awareness, .68 to .78 for Ego-Less, .46 to .67 for Self-Reflection and Critique, and .47 to .51 for Supportive Interactions. The researchers explored the relationship between the MCHS and the SSAS and found that all five factors of the MCHS were positively correlated with all three subscales of the SSAS. Creating the MCHS offers counselors a method to assess their cultural humility and find areas to improve through supervision and consultation.

Based on the literature on cultural humility in the mental health field, it seems that cultural humility offers a flexible and thorough approach to multicultural work and is a beneficial addition to cultural competency, but more researchers need to explore the concept further,

including play therapists. Researchers have explored cultural humility as related to working alliance (Hook et al., 2013; Owen et al., 2014), improvement in psychotherapy (Hook et al., 2013), religious commitment (Owen et al., 2014), supervisee intentional nondisclosure (Cook et al., 2020), relationship satisfaction (Mcelroy-Heltzel et al., 2018), therapist multicultural orientation (Owen et al., 2016), and missed opportunity to discuss cultural issues (Davis et al., 2016). However, none of the researchers explored cultural humility among play therapists. Furthermore, only one researcher (Gonzalez et al., 2020) explored mental health professionals' self-assessment of their cultural humility or examined cultural humility among play therapists. The significant results in these studies on diverse populations, overall lack of studies among child mental health professionals, and lack of self-assessment of cultural humility cite the need for further exploration.

Cultural Humility and Social Justice Advocacy Among Mental Health Professionals

Cultural humility and social justice advocacy are related concepts because many social inequalities happen within the context of cultural diversity, such as systemic powers that decrease fair access to resources for marginalized people (Shriberg & Clinton, 2016). Shriberg and Clinton (2016) discussed that cultural humility and social justice are similar because both include proactively challenging systemic power imbalances that affect individuals' well-being and their capability to access services (Fisher-Borne et al., 2015). Though they are related constructs, researchers have not connected cultural humility to social justice advocacy in the empirical literature.

Summary

Researchers have explored the culturally humble attitudes of diverse professionals, but there is a gap in the exploration of how play therapists' personal experiences and values impact

social justice advocacy attitudes, including cultural humility. Ultimately, cultural humility is an important tool for framing these discussions for greater social justice and for preparing competent play therapists who can confront injustice at the local, national, and international levels.

Summary

This chapter presented a literature review including reasoning for exploring play therapists' attitudes and beliefs, the theoretical foundation for the outcome variable, social justice advocacy, along with empirical research. This chapter also introduced the predictor variables of adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility, including the theoretical and conceptual basis and empirical studies for each variable.

This literature review showed that there are few empirical studies that explored factors impacting play therapists' social justice advocacy attitudes. Furthermore, there is limited research on how specific factors, such as play therapists' adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility can theoretically influence their social justice advocacy attitudes. As no other researchers have explored the relationship among these variables, this study adds to the literature regarding factors related to social justice advocacy attitudes that may impact the implementation of related programs within counselor education and play therapy continuing education.

CHAPTER III: METHODOLOGY

Introduction

The purpose of this study was to investigate how adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility relate to social justice advocacy attitudes among play therapists. In this chapter, the methodology for the study will be described and divided into six sections. The first section will describe the proposed participants and setting, the second section will explain data collection procedures, the third section will provide instrumentation detail, the fourth section will describe the research design and research question, the fifth section will provide an overview of data analysis procedures, and the final section will summarize the chapter.

Participants

Participants in this proposed study included a purposive population sample of mental health professionals who practice play therapy recruited via multiple methods described in the following section. Inclusion criteria were: (a) participants who are professional counselors, social workers, psychologists, or school counselors with at least a master's degree, and (b) those who have conducted, supervised, or conducted research about play therapy. Exclusion criteria were professional counselors, social workers, psychologists, or school counselors with at least a master's degree who have not conducted, supervised, or conducted research about play therapy. The researcher stated the inclusion criteria at the beginning of the recruitment email, which will allow participants to verify if they are qualified to participate in this study. The researcher invited over 5,000 play therapists to participate through social media posts and emails from the Association for Play Therapy (APT) mailing list, CESNET listserv, and invited members of play therapy-related Facebook groups. In addition, a snowball sampling method was used by asking

participants to share the survey with other play therapists. Conducting a G*power analysis predicted that 176 participants were needed (f^2=0.10, alpha=0.05, power=0.95, number of predictors=3).

Procedures

The researcher obtained Institutional Review Board (IRB) approval at the University of North Carolina at Charlotte to conduct survey research with human subjects before collecting the data. The researcher provided resources for those that may have felt discomfort or distress due to the sensitive nature of the ACEs questionnaire such as websites providing information about adverse childhood experiences and toxic stress, the National Department of Human Health and Services (NDHHS), and the National Alliance of Mental Illness (NAMI). The researcher recruited participants online through social media posts and emails from the Association for Play Therapy (APT) mailing list, CESNET listserv, and invited members of play therapy-related Facebook groups.

Any self-identified play therapist who is a professional counselor, social worker, psychologist, or school counselor with at least a master's degree and has conducted, supervised, or conducted research about play therapy that receives a survey invitation and chose to participate clicked on a link to the Qualtrics website. Participants received an introductory letter explaining the purpose of the study and requesting their participation. Participants read an informed consent that fully explains the purpose of the research, risks and benefits of participating in the study and that participation was completely voluntary, anonymous, and confidential. Additionally, in the informed consent, the researcher informed participants they could stop at any time without penalty. When they click the link and agree that they have both read and understood the informed consent, all participants will complete the following:

Demographics Questionnaire, Social Issues Advocacy Scale (SIAS), ACE Questionnaire, Attitudes Related to Trauma-Informed Care Scale (ARTIC), and Multidimensional Cultural Humility Scale (MCHS). All instruments were merged into one survey on multiple pages using Qualtrics. The estimated time to complete the survey was 20-25 minutes. The researcher did not collect personally identifying data. The researcher downloaded the survey from Qualtrics into a Microsoft Excel spreadsheet and then uploaded the survey into Statistical Package for the Social Sciences (SPSS) software. Additionally, the researcher stored digital data in the digitally selective Dropbox drive of the primary researcher, in compliance with university Level 2 data storage guidelines. The researcher sent participation requests two times.

In addition to convenience sampling, the researcher used a snowball strategy to increase response rates, by asking participants to forward the survey to people who may meet the inclusion criteria. The snowball strategy helped researchers gain other participants who add knowledge to the study (Mertens, 2015). The researcher also used other approaches to increase response rates, such as asking limited questions at one time, displaying each item in the survey aligned with response categories in a series, numbering questions, listing categorical answers vertically, and offering direction where information is needed (Dillman et al., 2009). Additionally, Dillman et al. (2009) encouraged researchers to use vertical alignment when using sub-questions, manage space between questions and answers, avoid displaying double answer choices, and use clear and short phrases. Researchers randomly chose four participants who completed the survey to receive a $25 Amazon gift card. Participants interested in the giveaway prize submitted their email on a separate form after completing the survey.

Instrumentation

Demographic Questionnaire

The self-report demographic questionnaire included questions about participants' age, gender, race, years of experience, region, professional degree, work setting, number of multicultural CEs in the past year, and percentage of non-White clients served. The demographic questionnaire also included a question if the participants meet the study criteria and use play therapy as their primary modality.

Social Issues Advocacy Scale

The Social Issues Advocacy Scale (SIAS; Nilsson et al., 2011) measures a person's advocacy attitudes. This scale will help understand actions that participants take to support and to speak on behalf of other individuals or groups. The scale consists of 21 items on a 5-point Likert-type scale (1= strongly disagree; 5= strongly agree). Creators of the SIAS identified four subscales using an EFA: (a) Political and Social Justice Advocacy (8 items), (b) Political Awareness (6 items), (c) Social Issues Awareness (4 items), and (d) Confronting Discrimination (3 items) (Nilsson et al., 2011). Researchers in the literature have used SIAS in their studies to understand social justice advocacy among school counselors (Feldwisch & Whiston, 2015) and counseling psychologists (Beer et al., 2012). Reliability has been estimated to be .93 (Nilsson et al., 2011). Additionally, researchers found strong discriminant validity as evidenced by nonsignificant correlations between the SIAS and measures of self-esteem ($r = .04, p = .39$) and life satisfaction ($r = .07, p = .132$). No evidence for test-retest reliability was found in the literature.

A sample statement in the Political and Social Advocacy subscale is "I participate in demonstrations or rallies about social issues that are important to my profession." A sample statement in the Political Awareness subscale is "I keep track of important bills/legislative issues that are being debated in Congress that affect my profession." A sample statement in the Social

Issues awareness subscale is "Societal forces (e.g., public policies, resource allocation, human rights) affect individuals' health and well-being." Finally, a sample statement in the Confronting Discrimination subscale is "I am professionally responsible to confront colleagues who display signs of discrimination toward the elderly" (Nilsson et al., 2011). Possible total scores range from 21 to 105. High scores on the subscales indicate a strong endorsement for the items in that subscale (Nilsson et al., 2011). For this study, the researcher used total scores on the SIAS to assess the play therapists' social justice advocacy attitudes.

Adverse Childhood Experiences (ACEs) Questionnaire

Felitti et al.'s (1998) Adverse Childhood Experience study created a 10-item, self-report questionnaire retrospectively surveying possibly traumatic events in participants' lives before the age of eighteen including: (a) physical abuse, (b) physical neglect, (c) emotional abuse, (d) emotional neglect, (e) sexual abuse, and household dysfunction such as, (f) divorce, (g) living with an adult experiencing mental illness, (h) living with an adult experiencing substance abuse, (i) witnessing violence within the home, and (j) incarceration of a family member. The ACEs questionnaire takes 2-3 minutes to complete. Participants' ACE score is the total number of "yes" responses to each of the 10 experiences.

The Cohen's kappa coefficient measuring test-retest reliability are as follows: emotional abuse and neglect = .66, physical abuse and neglect= .55, sexual abuse = .69, witnessing substance abuse = .75, mental illness = .51, mother treated violently = .71, incarcerated household member = .46, and parental separation or divorce = .86 (Dube et al., 2003). Four or more ACEs were generally observed as the threshold for high ACE exposure, marking a significantly increased likelihood of negative adult health outcomes (Dube et al., 2003).

An example physical abuse question is “Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?” An example divorce question is “Was a biological parent ever lost to you through divorced, abandonment, or other reason?” An example incarceration of a family member question is “Did a household member go to prison?” Total scores range from 0 to 10. Higher scores indicate a higher number of adverse childhood experiences. For the purposes of this study, participants were asked to count the number of ACEs categories they have experienced and to record only the total number of ACEs experiences. In this way, participants’ identification of which individual ACEs they experienced were not be asked or recorded.

Attitudes Related to Trauma-Informed Care (ARTIC) Scale

The Attitudes Related to Trauma-Informed Care (ARTIC) Scale (Baker et al., 2016) is an instrument created using trauma-informed principles, and the premise is that if attitudes towards trauma-informed care are favorable, then professionals can implement the right support systems to meet the needs of individuals impacted by trauma (Baker et al., 2016). The ARTIC is divided into two setting-specific categories: one for human services settings and one for educational institutions (Traumatic Stress Institute, 2015). Within the human services category, researchers created three different scale lengths of the ARTIC: a 45-item scale version to be used in settings that have already adopted a trauma-informed approach, a 35-item scale version to be used in settings that have not yet adopted a trauma-informed approach, and a 10-item scale version to be used when time or resource limitations make the longer versions impractical or unusable (Traumatic Stress Institute, 2015).

The ARTIC-35 human services version was used in this study. The scale consists of 35-items on a 7-point Likert scale with a favorable attitude paired with an opposite or unfavorable

attitude. Each set of items begins with the statement, "I believe that..." The instrument has five subscales: (a) underlying causes of problem behavior and symptoms, (b) responses to problem behavior and symptoms, (c) on-the-job behavior, (d) self-efficacy at work, and (e) reactions to the work. Each subscale has seven items, and 19 items are reversed scored. The ARTIC has been used with direct care staff (Berkhout, 2018), substance-use disorder clinicians (Jordan-Cox, 2018), and psychiatric hospital professionals (Niimura et al., 2019). ARTIC-35 has internal reliability of .91, and subscales range from .71 to .81. The test-retest reliability was .84, and construct validity was strong for the scores.

A sample positive attitude statement is "Being very upset is normal for many of the clients I serve," whereas the opposite, unfavorable attitude statement is, "It reflects badly on me if my clients are very upset" (Baker et al., 2016). This allows for a response on a bipolar spectrum and is designed to reduce socially desirable responses. Possible average scores for this instrument range from 1-7. Higher subscale and total scores demonstrate more favorable attitudes towards trauma-informed care (TIC). For this study, the researcher used total scores on the ARTIC-35 to assess play therapists' attitudes related to trauma-informed care.

Multidimensional Cultural Humility Scale

The Multidimensional Cultural Humility Scale (MCHS; Gonzalez et al., 2020) measures interpersonal dimensions of humility in regards to the cultural backgrounds and experiences of others. The scale consists of 15 items on a 6 point Likert-type scale (1= strongly disagree; 6= strongly agree). Creators of the MCHS identified five subscales using an exploratory factor analysis: (a) Openness (3 items), (b) Self-awareness (3 items), (c) Ego-less (3 items), (d) Supportive Interactions (3 items), and (e) Self-reflection and Critique (3 items). The Supportive Interactions subscale is reverse scored. The MCHS has been used with practicing counselors

(Gonzalez et al., 2020). The Cronbach's alpha ranges from .59-.78. No evidence for test-retest reliability was found in the literature.

A sample Openness item is "I am comfortable asking my clients questions about their cultural experience." A sample Self-awareness item is "I incorporate feedback I receive from colleagues and supervisors when I am faced with problems regarding cultural interactions with clients." A sample Ego-less item is "I ask my clients to describe the problem based on their cultural background." Possible total scores range from 15 to 90. Possible subscale scores range from 3 to 18. Higher subscale and total scores indicate higher cultural humility. For this study, the researcher used total scores on the MCHS to assess play therapists' cultural humility.

Research Design

This study used a correlational research design to explore the relationship between a set of variables (Balkin & Kleist, 2017). A standard multiple regression was used to determine how the predictor variables of adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility were related to the outcome variable of social justice advocacy attitudes. The outcome variable was social justice advocacy as measured by the Social Issues Advocacy Scale. The predictor variables were adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility.

Research Question

The research question is: How do adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility relate to social justice advocacy attitudes among play therapists in the United States?

Data Analysis

Screening Data

Before running the standard multiple regression analysis, the researcher screened the data. Screening intends to pinpoint issues within the data, such as incomplete entries, outliers, accuracy, normality, homoscedasticity, linearity, and collinearity.

Descriptive Statistics

The researcher utilized descriptive statistics to describe the participants in the study. Descriptors included information about participants' age, gender, race, years of experience, region, professional degree, work setting, and percentage of non-White clients served. Descriptive analyses were presented based on the frequencies and percentages for categorical variables and means, standard deviations, and central tendency measures for continuous variables.

Standard Multiple Regression

The researcher used a multiple regression analysis because there are multiple predictor variables and a single outcome variable. A regression is a "statistical technique for finding the best-fitting straight line for a set of data" (Gravetter & Wallnau, 2007, p.551). Regressions are often used for prediction, and the researcher chose this statistical test to determine how each predictor variable relates to social justice advocacy. Particularly, regression analysis determined the amount of variance accounted for in social justice advocacy attitudes by the predictor variables: a) adverse childhood experiences, b) attitudes related to trauma-informed care, and c) cultural humility. The researcher used *t*-tests to establish the statistical significance of the predictor variables and partial eta squared was used to estimate the amount of unique variance for each predictor variable. The data was entered into SPSS and analyzed to determine the relationship between adverse childhood experiences, attitudes related to trauma-informed care, cultural humility, and social justice advocacy attitudes among play therapists.

Summary

This chapter has described the methodology, including participants, data collection procedures, and instrumentation. Additionally, the research design, research questions, and data analysis have been described to explain the process by which the predictor variables were examined for their predictive relationship to the outcome variable, social justice advocacy attitudes among play therapists.

CHAPTER IV: RESULTS

The purpose of this study was to examine how adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility are related to social justice advocacy attitudes among play therapists. This chapter presents findings by the discussing reliability of the instruments in the first section followed by the description of the participants. The third section includes information about data screening, and the fourth section presents the Pearson correlations. The results of the major analysis present in the fifth section, and the final section provides a summary of the chapter.

Description of Participants

This study used convenience and snowballing sampling to recruit therapists who practice play therapy in the United States through the Association for Play Therapy (APT), CESNET listserv, and play therapy-related Facebook groups. Because of the sampling methods that were used, the researcher does not know how many individuals received the invitation to participate in this study. A total of 580 participants responded, and a total of 409 participants finished the surveys. All participants signed the consent form and were eligible to be included in this study.

Demographic data was collected to describe the population. Frequencies and percentages of the demographic variables are provided in Table 1. As shown in Table 1, the majority of participants identified as White (84.6%; *n*=346) females (91.4%; *n*=374) with a masters' degree (76.3%; *n*=312). Participants were located all across the United States, mostly in the Southeast (27.1%; *n*=111), followed by the Midwest (25.2%; *n*=105), then the West (18.6%; *n*=76), and the Northeast (15%; *n*=53). Most of the participants identified as professional counselors (57.9%; *n*=237), followed by social workers (23.2%; *n*= 95), then psychologists (5.6%; *n*=23), other (5.4%; *n*=22), university professors (4.4%; *n*=18), and school counselors (3.2%; *n*=13).

Regarding work setting, most participants worked in private practice (59.2%; *n*=242), then community clinics (14.9%; *n*=61), schools (10%; *n*=41), other settings (9.5%; *n*=39), and universities (6.1%; *n*=25).

Table 1: *Demographic Information, Totals, and Percentages (Categorical Variables)*

Variable	Frequency	Percent
Gender		
Male	29	7.1%
Female	374	91.4%
Other	4	1.0%
Race		
Caucasian	346	84.6%
African-Amer/ Black	21	5.1%
Hispanic/ Latinx	20	4.9%
Amer Indian/ Native Amer	3	0.7%
Asian	5	1.2%
Multiracial	9	2.2%
Other	4	1.0%
Highest Degree		
Masters	312	76.3%
Doctorate	83	20.3%
Post-Doctoral	4	1.0%
Other	9	2.2%
Region		

West	76	18.6%
Midwest	105	25.2%
Southeast	111	27.1%
Northeast	53	15.0%
Professional Identity		
Professional Counselor	237	57.9%
School Counselor	13	3.2%
Social Worker	95	23.2%
University Professor	18	4.4%
Psychologist	23	5.6%
Other	22	5.4%
Work Setting		
Private Practice	242	59.2%
School	41	10.0%
University	25	6.1%
Community Clinic	61	14.9%
Other Settings	39	9.5%

Other demographic information was collected, including the number of multicultural continuing education (CE) hours in the past five years, percent of non-White clients in caseload, age, and years of experience are displayed in Table 2. Of interest, also is that of participation in multicultural educational activities, 94.6% of participants said yes. The percent of non-White clients on caseload ranged from 0-100 with a mean of 33.66 (*SD*=27.63). The mean age of

participants was 42.82 (*SD*= 12.44) and ranged from 23 to 79. Additionally, the mean number of years of experience was 11.52 with a standard deviation of 9.37.

Table 2: *Other Demographic Information (Continuous Variables)*

	Mean	SD	Range
Number of multicultural CE hours in the past 5 years	24.40	59	0-250
Percent of non-White client caseload	33.66	27.63	0-100
Age	42.82	12.44	23-79
Years of experience	11.52	9.37	0-45

Reliability of Instruments

In Table 3, the alpha coefficients, number of items, means, standard deviations, and ranges for the Social Issues Advocacy Scale (SIAS) and the Adverse Childhood Experience questionnaire (ACE), Attitudes Related to Trauma-Informed Care (ARTIC), and Multidimensional Cultural Humility Scale (MCHS) are shown. Cronbach's alpha internal consistency measures were used to estimate the reliability of SIAS and the ACE, ARTIC, and MCHS.

Table 3: *Cronbach's alpha, number of items, means, standard deviations, and range*

Instrument	Cronbach's α	Items	M	SD	Range
SIAS	.89	21	77.98	13.14	24-103
ACE		10	2.76	2.44	0-10
ARTIC	.91	35	5.41	0.53	3.34-6.37
MCHS	.75	15	74.36	6.83	42-90

Cronbach's Alpha for the SIAS was .89, ARTIC was .91, and MCHS was .75 indicating the SIAS and ARTIC had high levels of internal consistency. The MCHS had low levels of internal consistency. The SIAS scale consists of 21 items on a 5-point Likert scale. Scores in this study ranged from 24 to 103. Higher scores indicate attitudes more favorable social justice advocacy attitudes. The ACE questionnaire consists of 10 items. Scores in this study ranged from 0 to 10. Higher scores indicate more experiences of adverse childhood events. The ARTIC scale consists of 35 items on a 7-point Likert scale. Scores in this study ranged from 3.34 to 6.37. Higher scores indicate more favorable trauma-informed care attitudes. The MCHS consists of 15 items on a 6-point Likert scale. Scores in this study ranged from 42 to 90. Higher scores indicate more culturally humble attitudes.

Screening Data

Before running the standard multiple regression analysis, the data were screened for missing values, assessed for outliers, and checked for assumptions. Only 2% of the data were missing and Little's MCAR test suggested the data could be treated as missing completely at random. The variation inflation factors (VIFs) for the predictor variables were 1.03 for adverse childhood experience, 1.22 for attitudes related to trauma-informed care, 1.25 for cultural humility, which indicated that all were below the value of 10.0 suggesting multicollinearity was not problematic. In addition, the assumption of normality is met as the normal probability plot (P-P) of standardized residuals showed that points were completely in line.

Pearson Correlations

A Pearson coefficient was conducted to examine the correlations of the predictor variables (ACEs, ARTIC, and MCHS) and the outcome variable (SIAS), and the results are shown in Table 4.

Table 4: *Pearson correlation matrix between predictor and outcome variables*

Variable	SIAS	ACE	ARTIC	MCHS
SIAS		.111*	.217*	.288**
ACE			-.003	.161**
ARTIC				.398**

Note. * Indicates significant correlation at $p < .05$ level (2-tailed).
** Indicates significant correlation at $p < .001$ level (2-tailed).

As shown in Table 4, the three predictor variables (adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility) were significantly correlated with the outcome variable (social justice advocacy attitudes); however, these correlations were low. The highest correlation was between attitudes related to trauma-informed care and cultural humility ($r = .398$, $p < .001$).

Multiple Regression Analysis

A standard multiple regression using SPSS was conducted to examine how adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility predict social justice advocacy attitudes. The results revealed that the model was a significant predictor of social justice advocacy by adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility ($R^2 = .105$, F (3, 396) = 15.53, $p < 0.01$) with adjusted square R^2 of .098. The unstandardized regression coefficients (B), intercept, the standardized regression coefficients (β), and semi-partial correlations (sri) are reported in Table 5.

Table 5: *Standard Multiple Regression Analyses Measuring the Relationship Between Predictor And Outcome Variables*

Variable	B	SE	β	sr^2	R^2	*p*-value
					.105	
ACE	0.421	0.262	0.078	.081		.108
ARTIC	3.917	1.331	0.154	.146		.003*
MCHS	0.401	0.102	0.208	.193		.000**

Note: * Indicates significance at $p < .05$ level.
** Indicates significance at $p < .001$ level.

The variance accounted for (R^2) equaled .105 (adjusted $R^2 = .098$), which was significantly different from zero (F (3, 396) = 15.53, p < 0.01). The R^2 value of .105 indicates that 10.5% of the variance in the model was accounted for by the predictor variables. Two of the three predictor variables, attitudes related to trauma-informed care ($B = 3.92$) and cultural humility ($B = .401$), contributed significantly to the prediction of social justice advocacy.

Summary

The aim of this study was to explore the relationship between adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility in relation to social justice advocacy attitudes among play therapists. The data were collected from 409 participants. The instruments were found to have adequate reliability for making inferences about participants. The majority of the participants were White (84.6%) females (91.4%). The standard multiple regression analysis revealed that attitudes related to trauma-informed care and cultural humility had statistically significant relationships in predicting social justice advocacy attitudes.

The R^2 indicates that around 11% of the variability in social justice advocacy attitudes was predicted by the predictor variables.

CHAPTER V: DISCUSSION

The purpose of this study was to examine how adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility are related to social justice advocacy attitudes among play therapists. This chapter will provide an overview of the study, discussion and conclusions, contributions of the study, limitations of the study, implications of the findings, recommendations for future research, and concluding remarks.

Overview of the Study

Overall, the United States' population of children is becoming more racially and ethnically diverse. From 2000 to 2017, the percentage of the United States school-age children who were White decreased from 62% to 51% (National Center for Education Statistics, 2019). In contrast, the percentages of students from other racial/ethnic groups increased from 2000 to 2017: Hispanic children, from 16% to 25%; Asian children, from 3% to 5%; and multiracial children, from 2% to 4%. Racial and ethnic diversity is increasing, but children in these groups face many challenges, including poverty (US Census Bureau, 2017), unequal educational opportunities (US Census Bureau, 2019), discriminatory practices (Pascoe & Smart Richman, 2009), trauma (Sacks & Murphey, 2018), mental health diagnoses, and inadequate mental health services. Play therapists are developmentally responsive mental health professionals who can respond to these challenges.

Though play therapists need to respond to these challenges, few researchers have explored factors impacting play therapists' social justice advocacy attitudes. Those who have examined the impact of belief in a just world, political ideology, percentage of time receiving and providing supervision with a multicultural focus, quality of supervision provided, years of experience, color-blind attitudes, and number of multicultural activities/workshops. Researchers

have not examined other factors that may impact social justice advocacy attitudes. Consequently, this study aimed to add to the literature by examining how adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility are related to social justice advocacy attitudes among play therapists. Study results are based on 409 play therapists who completed surveys regarding social justice advocacy attitudes, adverse childhood experiences, attitudes related to trauma-informed care, cultural humility, and demographic information. This study provides insights for play therapy educators to create responsive continuing education opportunities for professionals and coursework for play therapy students with regard to their social justice advocacy attitudes. Finally, this research provides implications for counselor educators and state and federal policy to emphasize the integration of social justice advocacy and cultural humility topics into schools and organizations.

Discussion and Conclusions

The discussion section of the study highlights demographic findings and conclusions regarding the findings. All results are discussed in relation to previous literature and research.

Demographic Data

The data analysis demonstrated that the participants in this study were mostly Caucasians (84.6%) females (91.4%) with a master's degree (76.3%). This finding shows a lack of diversity in the sample, which is consistent with prior studies that also used a sample of play therapists which a majority of them were also Caucasian (84.6%) females (92.9%) (Ceballos et al., 2012; Parikh et al., 2013). This lack of diversity is also similar to Elmadani (2020) who also had participants who were mostly Caucasian (81.6%) females (90%). The researcher aimed to increase the diversity of the participants by using various recruitment methods, such as the APT mailing list, CESNET listserv, and play therapy-related Facebook groups. This approach did not

increase diversity among play therapists because participants' race and gender distributions were comparable to similar research studies focusing on play therapists' social justice advocacy attitudes and multicultural competence. This may be because most counselors, comparable to play therapists, who were members of these professional organizations, are White females, and though diversity among children is increasing, membership diversity has not increased. Participants in this study mainly included participants who were professional counselors (57.9%) and worked in private practice (59.2%). This finding is similar to what has been reported in terms of play therapists' work setting and professional identity (Elmandani, 2020; Penn & Post, 2012), demonstrating that many practitioners who provide mental health services are professional counselors working in private practices.

Participants' Social Issues Advocacy Scale scores ranged from 24 to 103 with a mean score of 77.98 (*SD* = 13.14). These findings are slightly higher compared to what was reported by the developer of this assessment (Nilsson et al., 2011), where the scores ranged from 21 to 105, and the mean score was 65.70 (*SD* = 12.85). A possible explanation for this higher score is participants' social justice advocacy attitudes are becoming more positive as the population in the United States is continuing to diversify. Additionally, scores are becoming higher over time as evidenced by Elmadani (2020), whose average score on this scale was 77.50 (*SD*=11.70) and collected data with the same population, play therapists, a year before. Participants' scores in this study are also higher than school counselors' scores (*M*=72.17; Feldwisch & Whiston, 2016). Overall, this evidence shows that as awareness of social justice advocacy and multicultural competence increases, play therapists may become more aware of social justice advocacy issues.

Participants' ACE ranged from 0 to 10, with a mean score of 2.76 (*SD* = 2.44). Participants had lower overall ACE scores than teachers (*M*=3.55; Grybush, 2020) and substance

use clinicians (*M*=3.45; Jordan-Cox, 2018). Also, participants in this study had similar ACE scores to direct support professionals (*M*=2.50; Keesler, 2018) and childcare workers (*M*=2.00; Esaki & Larkin, 2013). In the original ACE study by Felitti et al. (1998), 10.3% of participants had an ACE score of 3. This result showed that participants scored lower than average compared to the scores that were reported from the developer of this assessment (Felitti et al. 1998). Findings regarding the ACE score in this study needs to be interpreted with caution because it was one of the questions that participants most frequently did not complete. Furthermore, other researchers explored the individual adverse childhood experiences compared to this study, which asked participants to count their total ACE score and record that number. Another explanation for this finding is that the original study researchers collaborated with Kaiser Permanente, and the population that participated was mainly over 60 years old (46%), White (75%), high school graduate (93%) individuals with private health insurance (100%; Felitti et al., 1998). Original results should be viewed keeping those demographics in mind. Though the researcher did not find adverse childhood experiences to be statistically significant in this study, the results highlight the prevalence of adverse childhood experiences and the importance of further assessing the impact of childhood trauma on play therapists' social justice advocacy attitudes.

Participants' scores on the ARTIC scale ranged from 3.34 to 6.37, with a mean score of 5.41 (*SD* = 0.53). Norming scores are still being established on the relatively new ARTIC scale (Baker et al., 2016). Participants' scored higher than the mean of the assessment (*M*=4) demonstrating play therapists have attitudes that are strongly aligned with trauma-informed care. Participants had more favorable attitudes than teachers (*M*=5.07, Grybush, 2020; *M*= 5.16-5.33, Post et al., 2020).

Participants' scores on the Multidimensional Cultural Humility Scale ranged from 42 to 90, with a mean score of 74.36 (*SD* = 6.83). Norming scores are still being established on the relatively new Multidimensional Cultural Humility Scale (Gonzalez et al., 2020). This finding showed participants had moderately high cultural humble attitudes.

Pearson Correlations

A Pearson correlation was conducted using social justice advocacy, adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility. The results showed small and positive statistically significant correlations between social justice advocacy and all of the predictor variables: adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility. These results indicated that participants who scored higher on social justice advocacy attitudes also scored higher on adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility. Consistent with previous research, the results did not show significant correlations between attitudes related to trauma-informed care and adverse childhood experiences among residential treatment staff (Berkhout, 2018) and teachers (Grybush, 2020).

Multiple Regression

The regression findings indicated that the predictor variables (adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility) contributed significantly to the prediction of social justice advocacy attitudes. Specifically, about 10.5% of the variance in social justice advocacy attitudes was accounted for by the predictor variables. Two of the three predictor variables, attitudes related to trauma-informed care and cultural humility, contributed significantly to the prediction of social justice advocacy attitudes. Cultural humility made the largest contribution.

Previous researchers exploring social justice advocacy attitudes have found various factors to account for only a small amount of the variance. For example, Parikh et al. (2013) found that 9% of the variance accounted for in social justice advocacy attitudes were from the predictor variables. Additionally, Elmadani (2020) found that 12% of the variability in social justice advocacy attitudes was predicted by the predictor variables. Results from this study and previous studies show that researchers still do not know what variables account for social justice advocacy attitudes.

These results add to the small, but growing body of knowledge regarding play therapists' social justice advocacy attitudes. Participants in this study reported higher social justice advocacy attitudes than past studies. This finding may indicate that play therapists' social justice advocacy attitudes are becoming higher over time.

Contributions of the Study

The findings from this study make numerous contributions to the existing play therapy literature. While researchers have started to examine social justice advocacy attitudes among play therapists, no researchers have explored play therapists' adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility in relation to their social justice advocacy attitudes. In addition, this study contributes to the minimal research about the personal characteristics of play therapists that influence social justice advocacy attitudes. In examining a sample of play therapists, this research study offers valuable information on the characteristics and attitudes of play therapists that have not been studied before. Furthermore, this study focuses on mental health professionals who provide services to children, and as research showed, mental health professionals experience more childhood adversity than the general population (Keesler, 2018; Steen, 2016; Thomas, 2017). Additionally, this study contributes to the sizable body of

research regarding adverse childhood experiences, offering further evidence that overall, the number of adverse childhood experiences are experienced by play therapists in this sample was lower than that of the original study. Though participants' ACE scores were low, researchers need to interpret this finding with caution because many participants did not complete this measure.

This study is one of the few studies that empirically examined social justice advocacy attitudes among play therapists, and it is the only study to-date that has examined adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility as predictors of social justice advocacy attitudes. The outcomes confirm the relationship between attitudes related to trauma-informed care, cultural humility, and social justice advocacy attitudes.

Implications of the Findings

This research contributes to the play therapy literature by adding an empirical study on factors impacting social justice advocacy attitudes. The findings from this study have several implications for play therapists, counselor education programs, and state and federal policy. The researcher explored three variables (adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility) that the researcher hypothesized were related to social justice advocacy attitudes. From the correlation analysis, a relationship between adverse childhood experiences, attitudes related to trauma-informed care, cultural humility, and social justice advocacy attitudes emerged. Additionally, from the regression analysis, attitudes related to trauma-informed care and cultural humility emerged as significant predictors of social justice advocacy attitudes.

For play therapists, there are implications regarding continuing education opportunities. Results of this study suggest that play therapists should regularly participate in education,

training, and programs focusing on increasing cultural humility to become stronger social justice advocates. Also, the findings indicate that as play therapists engage in training about trauma-informed care, they will have more positive attitudes about social justice advocacy. Most research in play therapy and social justice advocacy focuses on participants' attitudes. This study has shown that there is a need for more researchers to examine participants' actions rather than just their attitudes.

Additionally, the findings of this study have implications for counselor education programs. Attitudes related to trauma-informed care and cultural humility contributed significantly to the prediction of social justice advocacy attitudes. The results imply a need for counselor educators to implement trauma-informed care education and encourage the development of cultural humility in counselor trainees. Counselor educators could have an intentional focus on social justice advocacy attitudes by incorporating simulation exercises, leading class discussions, offering relevant case studies, engaging in service learning, and presenting key topics relevant to both social justice and counseling course content. Additionally, most researchers in play therapy and social justice advocacy have focused on participants' attitudes. Counselor education programs need to be intentional about recruiting students from diverse backgrounds with hopes that the future play therapists more closely match racially the children they serve.

Furthermore, this study has notable implications for state and federal policy. Given the increasing diversity of the population and challenges that people of diverse backgrounds face, state and federal organizations need to prioritize social justice advocacy efforts. They can do this by offering schools and universities funding and grants to offer research, training, and workshops

about social justice issues. Overall, this study has notable implications for play therapists, counselor education programs, and state and federal policy.

Limitations of the Study

Though researchers need to consider the implications of this study, several limitations should be acknowledged which includes social desirability, generalizability, lack of diversity among the sample, and response rate. Social desirability is a limitation in this study because the researcher collected the data through self-report methods. Because the data is self-reported, participants may provide more socially desirable answers that reflect upon them more favorably (Callagaro, 2008).

With regard to generalizability, the study results cannot be generalized to all play therapists, such as play therapists who are not on the APT mailing list, Facebook, or the CESNET listserv. Additionally, generalizability is limited based on the purposive, convenience sample where only professional counselors, school counselors, psychologists, and social workers who practiced, researched, or supervised play therapy were targeted.

Though the researchers disseminated the survey through several methods discussed previously, the participants' demographics were not diverse. As described above, these demographics show a lack of diversity among the sample, consistent with previous similar play therapy studies (Ceballos et al., 2012; Parikh et al., 2013). This limitation demonstrates that the field of play therapy professionals is not diverse and further efforts need to be made to increase diversity among play therapists.

The final limitation of this study was the response rate. Though 587 play therapists responded to the survey, only 409 participants had complete data that was in the analysis. One reason for this could be data occurred during peak times of the Coronavirus (COVID-19)

outbreak. Perhaps any additional stressors that brought up to participants' sensitive issues, such as items on the ACE questionnaire, could have led to participants not completing the measures. Though the study had notable limitations, the results provide the basis for potential future research studies.

Recommendations for Future Research

The results of this study provide a basis and raise questions for future research on factors related to social justice advocacy attitudes among play therapists. Researchers could conduct more studies to explore this critical area of knowledge because of the increasing diversity of children in the United States. Researchers could conduct more qualitative studies to explore deeply play therapists' views and experiences of social justice advocacy work. Also, this study focused on attitudes and not behaviors. Future studies could focus on play therapists' and play therapy educators' social justice advocacy behaviors and not just their attitudes. Additionally, researchers could explore how counselor educators are addressing trauma, cultural humility, and social justice advocacy with counselors-in-training who work with children. Researchers could also explore different methods to increase response rates about questions referring to trauma, including in-person data collection or including additional resources about trauma before the ACE question. Furthermore, researchers could also implement other methods to achieve a more diverse sample such as posting in race-specific mental health groups or organizations, such as the Black Mental Health Symposium or the Black Play Therapy Symposium. Researchers could also aim for a more diverse sample of play therapists by specifically targeting school counselors who use play therapy. In this study, only 3.2% of participants were school counselors, and future researchers could use more intentional methods, such as the American School Counseling Association (ASCA) and state-specific school counseling organizations, to target this population.

In addition, researchers could conduct intervention studies to explore what intervention could be used to increase social justice advocacy attitudes. For example, conducting a study examining the impact of multicultural play therapy courses or training on social justice advocacy could be impactful. These studies could provide meaningful research that can extend the work of this study.

Concluding Remarks

The increasing diversity of children in the United States and challenges diverse children face call researchers to understand factors impacting play therapists' social justice advocacy attitudes. Research on social justice advocacy attitudes among play therapists is relatively recent, and research focusing on play therapists in relation to adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility was non-existent. This study aimed to address this critical gap in the research by exploring adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility among play therapists as predictors of social justice advocacy attitudes. The findings indicate that attitudes related to trauma-informed care and cultural humility statistically significantly predicted play therapists' social justice advocacy attitudes. These findings offer an empirical base for further exploration.

Play therapists and play therapy educators can provide professional development to play therapists and play therapy students that encourage them to build strong relationships with diverse children by responding empathetically to those who experienced trauma and other challenges. The results of this study indicate that play therapists and play therapy educators who have more positive attitudes related to trauma-informed care and cultural humility do have more positive attitudes about social justice advocacy. This finding highlights the importance of counselor preparation programs offering intentional trauma-informed and cultural humility

focused courses or infusing trauma-informed principles and culturally humble practices into existing coursework.

Play therapists' positive social justice advocacy attitudes are essential to providing responsive mental health services to children. Therefore, educators and continuing education providers need to give play therapists the tools to work with diverse populations. When play therapists possess culturally responsive skills, knowledge, and awareness, and positive social justice advocacy attitudes, they can become advocates for change and make a difference in children's mental health services. When discussing advocates of change, we follow in the footsteps of leaders who came before us. Key among those is Ruth Bader Ginsburg, whose statement captures the true essence of this study, "Real change, enduring change, happens one step at a time." The aim of this study was to make one step towards real and enduring change for play therapists, play therapy educators, and the children they serve.

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APPENDIX A: RESOURCES FOR PARTICIPANTS

The following are a list of resources that are available to you should you want additional support or information regarding childhood adversity.

SAMHSA
https://www.samhsa.gov
1-800-662-4357 phone

NAMI
https://www.nami.org
1-800-950-6264 phone

ACEs too high
https://acestoohigh.com/

Harvard Center on the Developing Child
https://developingchild.harvard.edu/

Child Trends
https://www.childtrends.org/?s=ACEs

APPENDIX B: INTRODUCTORY LETTER

Dear Play Therapist,

I am a doctoral candidate in the Counselor Education and Supervision program, in the Department of Counseling, at the University of North Carolina at Charlotte. My dissertation chair is Dr. Phyllis Post.

My dissertation study is on factors related to social justice advocacy attitudes among play therapists. Specifically, this study aims to understand how adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility relate to social justice advocacy attitudes.

I am inviting you to participate in this study if you meet the following criteria:

- You are professional counselor, social worker, psychologist, or school counselor with at least a master's degree.
- You have conducted, supervised, or conducted research about play therapy.

We also ask you to pass this email to someone you think is eligible to participate in this study. Your participation is entirely voluntary and responses will be confidential. You may choose to leave the survey at any time with no explanation. Completing the survey will take approximately 20 to 25 minutes.

This study has been approved by the University of North Carolina at Charlotte's Institutional Review Board. If you decide to participate in this study, please read and sign the inform consent electronically to proceed to the survey by clicking in the link below.

Thank you in advance for your participation, which will contribute to empower play therapy literature, training, and practice. If you have any questions, please contact me or my chair.

Sincerely,

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Department of Counseling
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APPENDIX C: INFORMED CONSENT FORM

Department of Counseling
9201 University City Boulevard, Charlotte, NC 28223-0001

Consent to be Part of a Research Study

An Exploration of Factors Impacting Play Therapists' Social Justice Advocacy Attitudes

Principal Investigator: Lauren Chase, MS, LMHCA, NCC, Doctoral Candidate, UNC Charlotte
Faculty Advisor: Phyllis Post, PhD, LMHCS, RPT, Professor, UNC Charlotte
Study Sponsor: Multicultural Play Therapy Center at UNC Charlotte

You are invited to participate in a research study. Participation in this research study is voluntary. The information provided is to help you decide whether or not to participate. If you have any questions, please ask.

Important Information You Need to Know:

- The purpose of this study is to investigate factors impacting social justice advocacy attitudes of play therapists.
- You will be asked to take an online survey.
- If you choose to participate it will require 20-25 minutes of your time.
- Risks or discomforts from this research include mild discomfort responding to some of the questions on the Adverse Childhood Experience (ACE) questionnaire. We do not expect this risk to be common, and you may choose to skip questions that you do not want to answer. Should you feel discomfort, resources have been made available to you on a separate page for your reference.
- You will receive no direct benefits from participating in this study. However, your participation will contribute to the play therapy field. Implications from this study will inform training, education, and research. Your participation will help researchers to understand more about social justice advocacy attitudes among play therapists.
- If you choose not to participate, you may quit the survey at any time without explanation.

Please read this form and ask any questions you may have before you decide whether to participate in this research study.

Why are we doing this study?

The purpose of this study is to investigate the relationship between adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility in relation to the social justice advocacy attitudes of play therapists.

Why are you being asked to be in this research study?
You are being asked to be in this study because you are a professional counselor, social worker, psychologist, or school counselor with at least a master's degree and have conducted, supervised, or conducted research about play therapy.

What will happen if I take part in this study?
If you choose to participate in this study, you will be asked to complete a 77-item survey (adverse childhood experiences, attitudes about trauma-informed care, cultural humility, and social justice advocacy attitudes), and 11 questions about yourself (race, age, etc.). Your time commitment will be about 20 minutes.

What are the benefits of this study?
While there is no direct benefit to the participants in this study, their responses will contribute to the body of knowledge about social justice advocacy attitudes.

This study will provide important and necessary information for researchers about factors impacting social justice advocacy attitudes, which can inform training and continuing education for school counselors, mental health counselors, psychologists, and social workers who practice play therapy. This information can also inform the training needed in comprehensive counselor education and play therapy programs. Additionally, the study will provide important and necessary information to counselor education programs that will inform the training of future school counselors and mental health counselors working with children.

What risks might I experience?
You may feel mild discomfort responding to some of the questions on the Adverse Childhood Experience Questionnaire. Some of the questions asked of you are personal and sensitive. For example, you will be asked about the types of stressful experiences you've had as a child that includes household dysfunction, abuse, or neglect. You might experience some mild emotional discomfort when answering these questions. Should you feel discomfort, resources have been made available to you on a separate page at the end of the survey. We do not expect this risk to be common and you may choose to skip questions you do not want to answer.

How will my information be protected?
We plan to publish the results of this study. To protect your privacy, we will not include any information that could identify you. Your participation and responses to the assessment in this study are completely confidential. The survey does not ask for any identifying information about you and cannot be linked back to you in any way. All electronic data will only be stored in the primary researcher's Selective Sync Dropbox.

How will my information be used after the study is over?
After this study is complete, unidentifiable study data may be shared with other researchers for use in other studies without asking for your consent again or as may be needed as part of

publishing our results. The data we share will NOT include information that could identify you.

Will I receive an incentive for taking part in this study?
The researcher will randomly select four participants who will complete the survey to receive a $25 Amazon gift card. Therefore, if you are interested in the giveaway prize, you will need to submit your email to the researchers through the Google form that is provided at the end of the survey. The Google Form is a separate survey from the study survey and your email address and survey responses will never be linked. The incentive will be drawn after data is collected. If your total payments from UNC Charlotte exceed $600 in a calendar year, this information will be submitted to the Internal Revenues Service (IRS) for tax reporting purposes. By law, payments to subjects are considered taxable income.

What are my rights if I take part in this study?
It is up to you to decide to be in this research study. Participating in this study is voluntary. Even if you decide to be part of the study now, you may change your mind and stop at any time. You do not have to answer any questions you do not want to answer.

Who can answer my questions about this study and my rights as a participant?
For questions about this research, you may contact Lauren Chase, lchase6@uncc.edu, 404-538-9254, or Dr. Phyllis Post, ppost@uncc.edu, 704-687-8961.

If you have questions about your rights as a research participant or wish to obtain information, ask questions, or discuss any concerns about this study with someone other than the researcher(s), please contact the Office of Research Protections and Integrity at uncc-irb@uncc.edu.

ELECTRONIC CONSENT
Please select your choice below. You may print a copy of this consent form for your records. Clicking on the "Agree" button indicates that:

- You have read the above information.
- You voluntarily agree to participate.
- You have conducted, supervised, or conducted research about play therapy.

☐ Agree

☐ Disagree

APPENDIX D: SOCIAL ISSUES ADVOCACY SCALE

Directions. For each question, please respond to SIAS items using the 5 point Likert scale (1 = strongly disagree; 5 = strongly agree).

1	2	3	4	5
Strongly Disagree				Strongly Agree

1. ____I participate in demonstrations or rallies about social issues that are important to my profession.
2. ____I make telephone calls to policy makers to voice my opinion on issues that affect my profession.
3. ____I volunteer for political causes and candidates I believe in.
4. ____I participate in demonstrations or rallies about social issues that are important to me.
5. ____I meet with policy makers (e.g., city council, state and federal legislators, local elected officials) to advocate for social issues that I personally believe in.
6. ____I volunteer for political causes and candidates that support the values of my profession.
7. ____I make financial contributions to political causes or candidates who support the values of my profession.
8. ____I use letters or e-mail to influence others through the media regarding issues that affect my profession.
9. ____I keep track of important bills/legislative issues that are being debated in Congress that affect my profession.
10. ____I keep track of important bills/legislative issues that are being debated in Congress that I am personally interested in.
11. ____I discuss bills/legislative issues that are important to my profession with friends and family.
12. ____I work to elect policy makers who support the views of my professional organization on important social issues.
13. ____I discuss bills/legislative issues that are important to my profession with coworkers and acquaintances.
14. ____I vote in most local elections.
15. ____Societal forces (e.g., public policies, resource allocation, human rights) affect individuals' health and wellbeing.
16. ____State and federal policies affect individuals' access to quality education and resources.
17. ____State and federal policies affect individuals' access to social services.
18. Societal forces (e.g., public policies, resource allocation, human rights) affect individuals' educational performance.
19. ____I am professionally responsible to confront colleagues who display signs of discrimination toward the elderly.

20. ____It is my professional responsibility to confront colleagues who display signs of discrimination toward disabled individuals.
21. ____It is my professional responsibility to confront colleagues who I think display signs of discrimination toward culturally/ethnically different people or groups.

Source. Nilsson, J. E., Marszalek, J. M., Linnemeyer, R. M., Bahner, A. D., & Misialek, L. H. (2011). Development and Assessment of the Social Issues Advocacy Scale. *Educational and Psychological Measurement*, *71*(1), 258–275. https://doi.org/10.1177/0013164410391581
Permissions. This scale can be used for non-commercial research and educational purposes without seeking written permission.
Scoring protocol. The scores on the overall scale and on the four subscales are reliable. Therefore, this study will use the total score which is the sum of all items.

APPENDIX E: ADVERSE CHILDHOOD EXPERIENCES QUESTIONNAIRE

Total ACEs score (possible 1-10) from the following page.

Only the total number of "Yes" responses from the following page is requested here.

_____

Non-proprietary Adverse Childhood Experiences Questionnaire (ACE)
(CDC, 1997, Felitti et al., 1998)

Adverse Childhood Experiences (ACE) Questionnaire

Finding your ACE Score

While you were growing up, during the first 18 years of life:

1. Did a parent or other adult in the household often… • Swear at you, insult you, put you down, or humiliate you? OR • Act in a way that made you afraid that you might be physically hurt?	Yes	No
2. Did a parent or other adult in the household often… • Push, grab, slap, or throw something at you? OR • Ever hit you so hard that you had marks or were hurt?	Yes	No
3. Did an adult or person at least 5 years older than you ever… • Touch or fondle you or have you touch their body in a sexual way? OR • Try to actually have oral, anal, or vaginal sex with you?	Yes	No
4. Did you often feel that… • No one in your family loved you or thought you were important or special? OR • Your family didn't look out for each other, feel close to each other, or support each other?	Yes	No
5. Did you often feel that… • You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? OR • Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	Yes	No
6. Were your parents ever separated or divorced?	Yes	No
7. Was you mother or stepmother: • Often pushed, grabbed, slapped, or had something thrown at her? OR • Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? OR	Yes	No

- Ever repeatedly hit over at least a few minutes or threatened with a gun or a knife?

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	Yes	No
9. Was a household member depressed or mentally ill or did a household member attempt suicide?	Yes	No
10. Did a household member go to prison?	Yes	No

Add up your "Yes" answers and record only the TOTAL on the previous page.

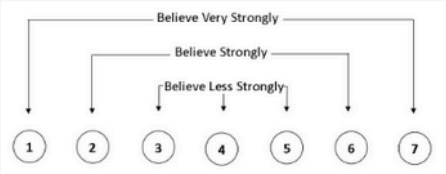
Source. Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading cause of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245-258.

Permissions. This scale can be used for non-commercial research and educational purposes without seeking written permission.

Scoring Protocol. The scores on the overall scale and on the subscale are reliable. This study will use the total score which is the sum of all items.

APPENDIX F: ATTITUDES RELATED TO TRAUMA-INFORMED CARE

***I believe that...**



	1	2	3	4	5	6	7	
1. Clients' learning and behavior problems are rooted in their behavioral or mental health condition.	○	○	○	○	○	○	○	Clients' learning and behavior problems are rooted in their history of difficult life events.
2. Focusing on developing healthy, healing relationships is the best approach when working with people with trauma histories.	○	○	○	○	○	○	○	Rules and consequences are the best approach when working with people with trauma histories.
3. Being very upset is normal for many of the clients I serve.	○	○	○	○	○	○	○	It reflects badly on me if my clients are very upset.
4. I don't have what it takes to help my clients.	○	○	○	○	○	○	○	I have what it takes to help my clients.
5. It's best not to tell others if I have strong feelings about the work because they will think I am not cut out for this job.	○	○	○	○	○	○	○	It's best if I talk with others about my strong feelings about the work so I don't have to hold it alone.

Source. Baker, C., Brown, S., Wilcox, P., Overstreet, S., & Arora, P. (2015). Development and psychometric evaluation of the attitudes related to trauma-informed care (ARTIC) scale. *School Mental Health*, *8*(1), 61–76. https://doi.org/10.1007/s12310-015-9161-0

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Scoring Protocol. The scores on the overall scale and on the subscale are reliable. This study will use the overall average score which is the average of all items.

APPENDIX G: MULTIDIMENSIONAL CULTURAL HUMILITY SCALE

Multidimensional Cultural Humility Scale

Instructions: Please take a moment and read each of the following statements. Then, rate the level of agreement for which each statement best reflects your work with clients from diverse cultural backgrounds.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

Openness						
1. I am comfortable asking my clients questions about their cultural experience. (1)	1	2	3	4	5	6
2. I seek to learn more about my clients' cultural background. (2)	1	2	3	4	5	6
3. I believe that learning about my clients' cultural background will allow me to better help my clients. (4)	1	2	3	4	5	6
Self-Awareness						
4. I seek feedback from my supervisors when working with diverse clients. (11)	1	2	3	4	5	6
5. I incorporate feedback I receive from colleagues and supervisors when I am faced with problems regarding cultural interactions with clients. (13)	1	2	3	4	5	6
6. I am known by colleagues to seek consultation when working with diverse clients. (14)	1	2	3	4	5	6
Ego-less						
7. I ask my clients about their cultural perspective on topics discussed in session. (12)	1	2	3	4	5	6
8. I ask my clients to describe the problem based on their cultural background. (27)	1	2	3	4	5	6
9. I ask my clients how they cope with problems in their culture. (28)	1	2	3	4	5	6
Supportive Interactions						
10. I wait for others to ask about my biases for me to discuss them. (Reversed coded) (42)	1	2	3	4	5	6
11. I do not necessarily need to resolve cultural conflicts with my client in counseling. (Reverse coded) (43)	1	2	3	4	5	6
12. I believe the resolution of cultural conflict in counseling is the clients' responsibility. (Reverse coded) (44)	1	2	3	4	5	6
Self-Reflection and Critique						
13. I enjoy learning from my weaknesses.(49)	1	2	3	4	5	6
14. I value feedback that improves my clinical skills. (50)	1	2	3	4	5	6
15. I evaluate my biases. (52)	1	2	3	4	5	6

Source. Gonzalez, E., Sperandio, K., Mullen, P., & Tuazon, V. (2020). Development and Initial Testing of the Multidimensional Cultural Humility Scale. *Measurement and Evaluation in Counseling and Development*, 1–16. https://doi.org/10.1080/07481756.2020.1745648
Permissions. The author have given written permission to use this scale through email.
Scoring Protocol. The scores on the overall scale and on the subscale are reliable. This study will use the total score which is the sum of all items. The following item is reverse scored: 11.

APPENDIX H: DEMOGRAPHIC QUESTIONAIRRE

What is your age? _____

What is your gender?
____Female _____Male ____Non-Binary _____Other

How would you identify yourself?
_____Caucasian/White, _____African American/Black ,_____Hispanic/Latino, _____American Indian/Native American, _____Asian, _____Native Hawaiian/Other Pacific Islander, _____Multiracial, _____Other

How many years have you been practicing play therapy?
_____

What region of the country do you live in?
___ West ___Midwest___ Southeast___ Northeast___ Southwest

What is the highest degree you obtained?
___ Master's Degree___ Doctoral degree ___ Post-doctoral Degree ___Other

How would you identify your profession?
___ Professional Counselor
___ School Counselor
___ Social Worker
___ Psychologist
___ University Professor/Instructor
___ Other

What is your work setting?
____School (K-12) ____University ____Community Clinic _____Private Practice
_____ Other

Have you participated in any multicultural educational activities such as workshops or trainings?
___Yes ___No

If yes, approximately how many total hours of workshops, training, or professional development related to multicultural aspects have you taken in the last five years?
_____

What percentage of your caseload is non-White clients? _____%