EXPLORING FACTORS RELATED TO THE USE OF CHILD-CENTERED PLAY THERAPY AMONG ELEMENTARY SCHOOL COUNSELORS

by

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ABSTRACT

SHERÉE DANIELLE HARPER. Exploring Factors Related to the Use of Child-Centered Play Therapy among Elementary School Counselors.
(Under the direction of DR. SEJAL PARIKH FOXX)

Overall, the United States' population continues to substantially increase in cultural diversity (NCES, 2018; NCES, 2020a; NCES, 2020b), therefore increasing the overall diversity of students in school settings. Children from minoritized groups have a higher risk of experiencing poverty (US Census Bureau, 2017), problem behaviors (Post et al., 2019), adverse childhood experiences (ACEs; Post, 1999; Post et. al, 2019; Ray et al., 2021), trauma (CYW, 2017), mental health concerns and inadequate mental health treatment or counseling (National Survey of Children's Health, 2011-2012; National Survey of Children's Health, 2019-2020). Effective, culturally and developmentally appropriate interventions are needed to address the mental health needs of racially/ethnically minoritized youth in elementary school settings. Professional School Counselors (PSCs) are charged with addressing the ongoing social/emotional, behavioral, academic, and mental well-being of all students, including those racially/ethnically minoritized. One way that PSCs can address these needs is through child-centered play therapy (CCPT). A logistic regression was utilized to explore how the amount and quality of play therapy training, adverse childhood experiences (ACEs) of the PSCs, and attitudes toward cultural humility are related to the use of play therapy/CCPT in addressing student's mental health needs among elementary school counselors (N=256). Results indicated that there was a significant relationship between the amount and quality of play therapy training, attitudes toward cultural humility, and the use of play therapy, but not ACEs. The results also indicated that there was not a significant relationship between the amount and quality of play therapy training, ACEs, attitudes toward cultural humility, and the use of CCPT.

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DEDICATION

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CHAPTER 1: INTRODUCTION

The United States (U.S.) population continues to substantially increase in cultural diversity (NCES, 2018; NCES, 2020a; NCES, 2020b), therefore increasing the overall diversity of students in public school settings. Recent data has shown that hate crimes and bullying rates have increased as diversity expands (Human Rights Campaign, 2017). Children from minoritized groups have a higher risk of experiencing poverty (US Census Bureau, 2017), problem behaviors (Post et al., 2019), adverse childhood experiences (ACEs; Post, 1999; Post et. al, 2019; Ray et al., 2021), trauma (CYW, 2017), mental health concerns and inadequate mental health treatment or counseling (National Survey of Children's Health, 2011-2012; National Survey of Children's Health, 2019-2020). Therefore, effective, culturally, and developmentally appropriate interventions are needed by Professional School Counselors (PSCs) to address the mental health needs of racially/ethnically minoritized youth in elementary school settings.

According to the 2020 U.S. Census, the total population of the U.S. was 331,449,281 (U.S. Census Bureau, 2022). Of this population, 75.5% were White or Caucasian; 13.6% were Black or African American; 1.3% were American Indian and Alaska Natives; 6.3% were Asian; 0.3% were Native Hawaiian and other Pacific Islander, and 3.0% were Two or More Races. The Hispanic and/or Latino population contributes to 18.7% of the U.S. total population (U.S. Census Bureau, 2022). In 2022, 16% of children under the age of 18 reported living in poverty (Annie E. Casey Foundation, 2023). Living and growing up in poverty is one of the largest threats to children's healthy development; further, poverty and financial stress can directly impede and impact children's cognitive, behavioral, social, emotional, and overall health (Annie E. Casey Foundation, 2023). There is clear evidence that there is a relationship between race and poverty. In 2022, 11.2% of White or Caucasian children 18 years or younger in the U.S. were living in

poverty; 29.8% were Black or African American; 28.7% were American Indian and Alaska Native; 10.1% were Asian; 22.2% were Native Hawaiian and other Pacific Islander; and 24.2% were Some Other race (ACS, 2022; 2022 Census Bureau). Those of Hispanic origin (any race) accounted for 17% of the U.S. population (U.S. Census Bureau, 2022). The mix and intersectionality of oppression, race, culture, and socioeconomic status (SES) form a group of marginalized children (Carey, Yee, & DeMatthews, 2018). As research shows, children from minoritized groups and lower SES are more likely to be at risk for problem behaviors and challenges later in life (Post et al., 2019). For these reasons, this research study focused on elementary school settings and racially/ethnically minoritized student populations.

Approximately 35 million children in the U.S. are living with emotional and psychological trauma; furthermore, 47.7% of children and adolescents aged 3-17 with a mental/behavioral condition have not received mental health treatment or counseling (National Survey of Children's Health, 2011-2012; National Survey of Children's Health, 2019-2020). Children experiencing ongoing, severe, and frequent adversity raise even higher concerns of long-lasting impacts on mental health and overall well-being. The Center for Youth Wellness (2017; CYW) defines adverse childhood experiences (ACEs) as "stressful or traumatic events that children experience before age 18, such as violence at home, neglect, abuse, or having a parent with mental illness or substance dependence." ACEs affect 34.8 million children placing them at even greater risk for health, behavioral, and learning problems (Child and Adolescent Health Measurement Initiative, 2013). Felitti et al. (1998) indicated that ACEs are associated with behavior problems and negative adult health outcomes. Other research has highlighted the effects on the structure and functioning of the developing brain and its correlation to impacts on behavioral, cognitive, and emotional development (De Bellis & Zisk, 2014), which can cause

negative physical and mental health problems throughout the life span (Post et al., 2020; Sciaraffa, Zeanah, & Zeanah, 2018). The Centers for Disease Control and Prevention (CDC) has reiterated the prevalence of ACEs by highlighting that about 64% of U.S. adults reported they had experienced at least one type of ACE before age 18, and nearly 1 in 6 (17.3%) reported they had experienced four or more types of ACEs (CDC, 2023; Swedo et al., 2023). Wade et al. (2014) highlighted that minorities and low-income urban populations disproportionately experience ACEs, which increases the likelihood of adversity and developmental issues. For the aforementioned reasons, it is critical to address ACEs among children who are at higher risk and are vulnerable to trauma and ACEs. Additionally, these reasons highlight a need to explore PSC's ACE scores and the potential impacts on their work in supporting students.

Over the decades, public health research has continued to illuminate the impactful physical and mental health effects of ACEs, and research has expanded to other disciplines (Brown et al., 2022; Campbell et al., 2016; Frampton et al., 2018). In more recent years, counseling literature has highlighted the necessity of understanding the implications of ACEs on clients' mental health. Yet there has been no examination of ways in which a counselor's or school counselor's own experience of ACEs may affect their work (Brown et al., 2022; Wheeler et al., 2021; Zyromski et al., 2020). This area's lack of research is significant based on reported information that ACE scores of mental health workers are among the highest in the helping profession (Brown et al., 2022).

As highlighted, there is a need for effective, culturally, and developmentally appropriate interventions to address the mental health needs of racially/ethnically minoritized youth in elementary school settings, including urban and rural settings. Research has outlined the need for culturally responsive practices in urban schools to assist with positive mental health outcomes

(Fallon & Mueller, 2017). As noted by Larson et al. (2017), urban youth have a higher risk of exposure to trauma and are less likely to have access to mental health services. Youth in urban schools are underserved by mental health systems, are less likely to receive mental health services and are more likely to receive inappropriate services (Peterson et al., 2017). Other research has shown that youth mental and behavioral health needs in rural schools and communities are prevalent and difficult to manage (Hirsch & Cukrowicz, 2014; Garbacz et al., 2022). For instance, youth in rural areas have reported experiencing higher rates of depression and suicide as compared to their peers in urban areas (Fontanella et al., 2015). Furthermore, alcohol and other drug-related issues continue to worsen in rural communities which has led to increased rates of overdoses and deaths (Meiman et al., 2015). As Garbacz et al. (2022) outline, rural areas significantly vary in their ability to provide adequate and effective youth mental and behavioral health services, and many areas encounter significant barriers in adopting and implementing school mental health practices. As mental health, psychological, behavioral, and traumatic concerns of children continue to mount in the school setting, it is imperative to consider effective and developmentally appropriate approaches of Professional School Counselors in addressing the holistic needs of racially/ethnically minoritized children.

As Van Horne et al. (2018) notes, Professional School Counselors (PSCs) provide critical access points in that they are often the first to identify and address student's mental health needs. School counselors in the elementary setting are charged with addressing the ongoing social/emotional, behavioral, academic, and mental well-being of students. One way that PSCs can address these needs is through play therapy. Play therapy, more specifically child-centered play therapy (CCPT), is a widely recognized and empirically supported intervention (Bratton et al., 2005; Davis & Pereira, 2014; Landreth et al., 2009; Ray et al., 2015). Further, CCPT is

culturally sensitive and developmentally appropriate approach (Bratton, 2010; Landreth et al., 2009; Post et al., 2019; Ray et al., 2015; Van Horne et al., 2018) in treating racially/ethnically minoritized student populations. School counselors with play therapy training are in an optimal position to utilize play therapy skills with students in the urban and rural elementary school settings. Identifying current variables related to school counselors' use and nonuse of play therapy is important as well as needed.

Theoretical Base

The theoretical base explored in this study was person-centered or client-centered therapy, which extends to child-centered play therapy (CCPT). Carl Rogers is the founder of what is originally called non-directive therapy, which was later changed to client-centered therapy (Rogers, 1942; Casemore, 2011). Client-centered or person-centered therapy was formally introduced in 1940, during the nondirective years, and during this time of 1940-1950, an emphasis was placed on the formation of client relationships by creating a very liberal context with the client (Gladding, 2005). The Reflective period of 1950-1957 followed, which is characterized by emphasis on creating non-threatening relationships (Gladding, 2005). Rogers formalized person-centered therapy during the Experimental period of 1957-1980 in which he introduced the core conditions of counseling: empathy, unconditional positive regard or acceptance, congruence, and genuineness (Gladding, 2005).

Client-centered therapy has an existential-humanistic framework, and it emphasizes the importance of focusing on the present, free will, and developing an egalitarian relationship with clients (Rogers, 1942; Casemore, 2011). The humanistic belief is that all individuals have a natural potential that can be actualized and through such, meaning can be found (Kirschenbaum, 1979). Rogers believed that facilitating client growth in a non-directive manner was the most

effective way of helping clients (Rogers, 1942). This theoretical approach stresses the ability of clients to determine the issues important to them and to solve their own problems (Bott, 2001); further, focuses on the strengths and abilities of the client (Kirschenbaum, 1979). According to Rogers (1957; 1959), there are six necessary conditions outlined as requirements for therapeutic change to occur: client-therapist relationship, congruence, genuineness, unconditional positive regard, empathic understanding, and client perception. Rogers believed that facilitating client growth in a non-directive manner was the most effective way of helping clients (Rogers, 1942).

Based on person-centered theory, child-centered play therapy emerged as a medium to counsel children through a humanistic lens. The Association for Play Therapy defines play therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (The Association for Play Therapy, 1997, p. 4). Play therapy, and more specifically CCPT, and the likelihood of its use by Professional School Counselors was explored in this study. CCPT is based on person-centered therapy, and as Ray et al. (2015) highlight, CCPT is based in the belief that all individuals have an innate ability to enhance behaviors, emotions, and self in a safe and nurturing environment.

CCPT is rooted in the belief that the child-therapist relationship is the primary healing agent for children experiencing developmental, inner, and environmental challenges (Jayne & Ray, 2016). As noted, Carl Rogers is the founder of what was originally called non-directive therapy, or client-centered (or person-centered) therapy (Rogers, 1942; Casemore, 2011). In the 1940's, Virginia Axline utilized and built upon Carl Rogers' person-centered therapy to expand non-directive play therapy's development in the U.S. (Landreth, 2012). Axline (1947) and

Landreth (2002) both identified basic principles consistent with a child-centered philosophy of working with children, which include: children's natural language is play; play is a developmentally appropriate way that children express themselves; children have an inherent tendency toward growth and maturity; children are themselves capable of positive self-direction; and children possess the capacity to act responsibly (Axline, 1947; Landreth, 2002; Ray et al., 2005).

Trice-Black et al. (2013) noted that the utilization of play in counseling young children was an effective and empirically supported intervention. Many of the urgent and intensive mental health, academic, and behavioral needs of children are first recognized and addressed in the school setting. Ray et al. (2005) also highlighted the use of play therapy as a counseling medium for elementary school counselors. Van Horne et al. (2018) emphasized that although research supports the effectiveness of using play therapy in schools, play therapy is not used in many elementary schools by Professional School Counselors.

Professional School Counselors (PSCs)

According to the American School Counselor Association (ASCA; 2019b; ASCA, 2022), Professional School Counselors (PSCs) build comprehensive school counseling programs that are equitable and meet the unique developmental needs of all students, including students historically and currently marginalized by the education system. PSCs' role is to help every student achieve academically, gain personal/social/emotional awareness, and understand career decision-making (ASCA, 2019b; ASCA, 2022). ASCA (2003) developed national standards around working with children and providing direct services as a model for schools. The ASCA School Counselor Professional Standards & Competencies (2019b) provide the mindsets and behaviors school counselors need to meet the ongoing demands of the profession and needs of

pre-K–12 students. Additionally, the standards and competencies help to ensure all school counselors are well equipped to establish and sustain a comprehensive school counseling program.

Introduction of Variables

Use of Child-Centered Play Therapy

Elementary school counselors are charged with addressing the ongoing social/emotional, mental health, and overall developmental needs of racially/ethnically minoritized students in the school setting. Play therapy provides a culturally sensitive, safe, and open space for children to freely express themselves through exploration (Allen & Barber, 2015; Blanco et al., 2017). Child-centered play therapy (CCPT) is a widely recognized and empirically supported intervention (Bratton et al., 2005; Davis & Pereira, 2014; Landreth et al., 2009; Ray et al., 2015) that is a culturally sensitive and developmentally appropriate approach (Bratton, 2010; Landreth et al., 2009; Post et al., 2019; Ray et al., 2015; Van Horne et al., 2018). PSCs with play therapy training are in an optimal position to utilize play therapy skills in addressing the holistic needs of racially/ethnically minoritized children in elementary school settings. For this reason, the dependent variable in this study was the likelihood of the use or nonuse of CCPT in elementary schools with racially/ethnically minoritized students.

Play Therapy Training

Given that there is scarcity of training on play therapy provided at universities and within counseling preparation programs (Anderson, 2022; Ebrahim et al., 2012; Jones & Rubin, 2005; Shin & Gonzalez, 2018), understanding how the amount and quality of play therapy training is related to play therapy utilization is essential. Research has highlighted that an obstacle to receiving play therapy training through graduate coursework is due to the limited number of

programs across the country that offer play therapy (Jones & Rubin, 2005). Many counselors lack the training, through university counselor education programs, about counseling children using play therapy (Ebrahim et al., 2012; Shin & Gonzalez, 2018). The significance of this problem is that children have different developmental and emotional needs compared to adults (Landreth, 2012; Ray et al., 2005), and these needs coupled with growing evidence-based support, particularly addressed in play therapy, suggests the need for an enhanced understanding of training for counselors (Anderson, 2022; Carnes-Holt & Weatherford, 2013; Flasch et al., 2017; McNary et al., 2019; Pereira & Smith-Adcock, 2013; Thanasiu et al., 2018). For this reason, the first independent variable in this study was play therapy training. Training consists of identifying the amount of training received specific to play therapy and perception of the quality of the play therapy training they received.

ACEs of PSC

The second independent variable was ACEs of PSC. Research continues to highlight and outline increasing rates of adverse childhood experiences (ACEs) and their detrimental effects on individuals across the lifespan (Metzler et al., 2017; Parker et al., 2021). ACEs was first explored in Felitti et al.'s (1998) study. Felitti et al. (1998) examined adult participant's experiences with specific traumatic occurrences before the age of eighteen, including (physical, psychological, and sexual) abuse, neglect, and household dysfunction. Results from the study indicated that ACEs were prevalent among participants; more than half reported at least one childhood traumatic event, while 25% reported at least two (Felitti et al., 1998). While there is ample literature on school counselors addressing ACEs of students, there is no research on outlining school counselors' own ACE scores. Further, how their total ACE scores could relate to the likelihood

of their use or nonuse of play therapy in the school setting with young racially/ethnically minoritized students. For this reason, the second independent variable was ACEs of PSC.

Attitudes towards Cultural Humility

The concept of cultural humility was introduced and defined by Tervalon and Murry-Garcia (1998) 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 non-paternalistic clinical and advocacy partnerships with communities on behalf of individual and defined populations" (1998, p. 117). Cultural humility consists of engagement in self-reflection, learning of biases, openness to diverse cultures, and commitment to authentically collaborate in reassessing imbalances of power (Minkler, 2012). It is valuable to explore given that the U.S. is becoming more racially diverse, and children in minoritized groups have many disadvantages beyond their control including higher risk of trauma exposure and mental health concerns. Professional School Counselors are charged with addressing the ongoing social/emotional, mental health, and overall developmental needs of racially/ethnically minoritized students in the school setting. It is important for PSCs to be equipped as social justice advocates and provide culturally responsive support and services to racially/ethnically minoritized students due to their vulnerability to trauma exposure and mental health concerns. For this reason, the final independent variable was attitudes toward cultural humility.

Significance of the Study

While the use of play therapy has been highlighted as a counseling medium for elementary school counselors (Ray et al., 2005) and has been shown to be an empirically supported intervention in counseling young children (Trice-Black et al., 2013), it is not utilized in many elementary schools by Professional School Counselors (Van Horne et al., 2018). This

study sought to examine the implementation of play therapy/CCPT in the elementary school setting. The results of this study are helpful to PSCs and counselor preparation programs by examining play therapy training, PSCs own adverse childhood experiences, and attitudes towards cultural humility and how these factors may be related to the likelihood of the use of play therapy among elementary school counselors who work with a predominance of racially/ethnically minoritized children. The results increase attention to the need for more play therapy/CCPT training within counselor preparation and counselor education programs to equip school counselors with effective, developmentally appropriate, and culturally responsive practices in meeting racially/ethnically minoritized student's holistic needs. The results reiterate play therapy/CCPT utilization in the school setting, which can be used to further advocate for appropriate roles and resources for school counselors.

Purpose of the Study

The purpose of this study was to explore how the amount and quality of play therapy training, adverse childhood experiences (ACEs) of the PSCs, and attitudes toward cultural humility are related to the use of child-centered play therapy (CCPT) in addressing student's mental health needs among elementary school counselors.

Research Questions

This study has four research questions:

1. How are the amount of play therapy training, quality of play therapy training, adverse childhood experiences, and attitudes toward cultural humility related to the probability of using play therapy/CCPT among elementary school counselors?
2. How does ACEs moderate the relationship between the quality of play therapy training and the probability of using CCPT?

3. How does ACEs moderate the relationship between attitudes toward cultural humility and the probability of using CCPT?
4. How is the use or non-use of CCPT different among PSCs who are in schools with at least 50% racially/ethnically minoritized versus at least 50% non-racially/ethnically minoritized student populations?

Operational Definitions

Elementary Professional School Counselors (PSCs)

Professional School Counselors are professionally and provisionally licensed or certified individuals who work in elementary schools to help students succeed in their academic, personal, social, and career development (ASCA, 2023). In this research study, only Professional School Counselors who work in elementary school settings were included. Participants indicated their status as a current practicing elementary school counselor using self-report on the adapted Elementary School Counselor Play Therapy Survey created by Van Horne (2014).

Use of Child-Centered Play Therapy (CCPT)

Child-centered play therapy (CCPT) is based on person-centered therapy (Rogers, 1942; Axline, 1947) and in the belief that all individuals have an innate ability to enhance behaviors, emotions, and self in a safe and nurturing environment (Ray et al., 2015). CCPT use was determined by self-report of respondents on the Adapted Elementary School Counselor Play Therapy Survey. It was coded dichotomously as 1 (use of play therapy) or 0 (non-use of play therapy). Inclusion criteria included a) Professional School Counselors who work in the elementary setting.

Play Therapy Training

Play therapy training was determined by respondents' self-report regarding the amount of training they received specific to play therapy and their perception regarding the quality of the training on the Elementary School Counselor Play Therapy Survey. For the amount of play therapy training, participants chose between no training, minimal training (e.g., one workshop, seminar, and/or in-service training), moderate training (e.g., a couple of workshops), or substantial training (e.g., multiple workshops, semester-long course, certificate, other extensive formal training). The perception of play therapy training was identified through semantic differential items (Osgood et al., 1957). The four 6-point Likert scales of bipolar adjectives indicated; bad - good, weak - strong, partial -thorough, and shallow - deep (Osgood et al., 1957).

Adverse Childhood Experiences (ACEs) of PSCs

Adverse Childhood Experiences (ACEs; Felitti et al., 1998) are defined as traumatic events in a child's life. These events include physical and emotional abuse and neglect, sexual abuse, and household dysfunction such as divorce; living with an adult experiencing substance abuse or mental illness; witnessing violence within the home; or the incarceration of a family member. ACEs were measured by the participants' total score on the 10-item ACEs questionnaire (Felitti et al., 1998).

Attitudes towards Cultural Humility

Cultural humility is defined as possessing a sense of respect for and an absence of superiority toward another's culture (Hook et al., 2013). Cultural humility was 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. The MCHS is a counselor-report scale that measures clinician's perceived cultural humility as a way to better

understand their self-awareness (Gonzalez et al., 2020). Cultural humility was measured by participants' mean score on the MCHS scale.

Racially/Ethnically Minoritized Student Population

The total percentage of racially diverse students were assessed by a self-report question on the demographic questionnaire to indicate the overall percentage of students at their school who are of a different racial background outside of White or Caucasian. Inclusion criteria for participation was over 50% of racially/ethnically minoritized students in their school setting.

Research Design

This study used a non-experimental correlational research design to examine the proposed research questions. To answer research questions 1-3, a logistic regression was utilized to determine how the predictor variables of play therapy training, ACEs of Professional School Counselors, and attitudes toward cultural humility are related to the outcome variable use of play therapy/CCPT. To answer research question 4, a chi-square analysis was utilized.

Assumptions

The assumptions that guided the study were:

- The participants represented the target population.
- The surveys being utilized are valid and measure the variables accurately.
- All participants responded to the self-report instrument honestly.

Delimitations

The factors the researcher can control in this study are:

- This purposive, convenience population sample included Professional School Counselors who are currently practicing as elementary school counselors in the sample.

- Participants included individuals with varying levels of school counseling experience and student populations.
- Participants included individuals who practice play therapy/CCPT in elementary school settings.
- Data were collected electronically and remotely.

Limitations

The study could cause bias in only focusing on elementary school counselors who use CCPT. Convenience, volunteer sampling could create a biased sample. The data was obtained from participants who received an email and/or post through the American School Counselor Association (ASCA), Association of Play Therapy (APT), CESNET-L, and social media, including snowball sampling, to members of elementary school counselors and play therapy-related social media groups. The limitations are school counselors who are not in the identified groups that are sampled. Findings cannot be generalized to non-elementary school counselors. Social desirability by participants could be a limitation of the results reported. This study was correlational. Thus, no causal inferences can be made. Additional limitations include the lower reliability of the ACE Questionnaire, as well as the way of calculating the ACE score.

Threats to Internal Validity

In quantitative research, when changes in the dependent variable can be credited to the effect of the independent variable and not to unrelated variables, it is called internal validity (Johnson & Christensen, 2004; Mertens, 2015). Threats to internal validity in this study included instrumentation and social desirability. This study used the Elementary School Counselor Play Therapy Survey, which is a newer instrument that was adapted and may further validate this instrument. The other instruments being utilized (ACE Questionnaire and Multidimensional

Cultural Humility Scale) have been adequately evaluated in prior studies and regarded as reliable and valid. In terms of social desirability, participants' responses were anonymous and therefore allowed participants to provide more truthful responses which may have reduced bias associated with social desirability (McMillian, 2008).

Threats to External Validity

In quantitative research, when results from studies can be generalized to the population to increase the social relevance of the study, it is called external validity (Johnson & Christensen, 2004; Mertens, 2015). In this study, a convenience sample was utilized and elementary school counselors who responded to this study were investigated. Threats to external validity included results that may not be generalizable to populations and school settings other than elementary settings. The results are generalizable only to other elementary school counselors who serve in elementary schools.

Summary

With the prevalence of mental health, psychological, and trauma concerns in children in the elementary school setting, it is imperative to consider effective and developmentally appropriate approaches to addressing the holistic needs of racially/ethnically minoritized children. This chapter included a brief overview of the theoretical base, the dependent variable, use or nonuse of child-centered play therapy, and the independent variables: quality and amount of play therapy training, adverse childhood experiences, and attitudes toward cultural humility. The purpose of the study, significance of the study, research questions, research design, assumptions, delimitations, limitations, threats to validity, and operational definitions were all presented.

Organization of the Study

This dissertation includes five chapters. The first chapter is an overview of the issue and the need for and significance of the study. The second chapter is a comprehensive literature review of the variables of interest that are explored. The literature review highlights the theoretical framework of CCPT and its use and effectiveness, the importance of play therapy training, prevalence of adverse childhood experiences, and significance of attitudes toward cultural humility. Chapter Three covers the methodology used in the research. It provides information on participants, data collection, instrumentation, research design, and data analysis. Chapter Four summarizes the data collected in the study. It presents the results of the analyses conducted. The final chapter includes a discussion of the results and conclusions. It outlines what this research adds to the existing literature on play therapy and its use among PSCs. Chapter Five examines the implications and limitations of this research study and suggests directions for future research.

CHAPTER 2: LITERATURE REVIEW

The purpose of this study was to explore how the amount and quality of play therapy training, adverse childhood experiences (ACEs) of the PSCs, and attitudes toward cultural humility are related to the use of child-centered play therapy (CCPT) in addressing student's mental health needs among elementary school counselors. In this chapter, a comprehensive literature review of the variables of interest are explored. The literature review begins with a discussion of the theoretical framework, CCPT. The next section provides an overview of the outcome variable, use of CCPT, followed by a literature review focusing on how the predictor variables, quality and amount of play therapy training, PSCs adverse childhood experiences, and attitudes toward cultural humility are related to PSCs use of CCPT. The final section will present a summary of the chapter and the conclusions drawn from the review of the literature.

Play Therapy/Child-Centered Play Therapy (CCPT)

The Association for Play Therapy defines play therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (APT, 2015a). Play therapy, and more specifically child-centered play therapy (CCPT), and its use by Professional School Counselors is being explored in this study. CCPT is based on person-centered therapy and was developed by Virginia Axline in 1947 as a person-centered approach to counseling children. Axline utilized and built upon Carl Rogers' person-centered therapy to expand non-directive play therapy's development in the U.S. (Landreth, 2012), and Garry Landreth further expanded the approach.

As outlined, child-centered play therapy (CCPT) is a non-directive, person-centered approach to counseling children. The CCPT approach utilizes a variety of toys and play-based

materials in a safe and nurturing environment where toys represent the child's words and their language is expressed and represented through their play (Landreth et al., 2009). Both Axline (1969) and Landreth (2002) formulated basic principles rooted in child-centered philosophy to guide therapists in implementing play therapy in their work with children. These basic principles include the following: (1) children's natural language is play, (2) play is a developmentally appropriate way that children express themselves, (3) children have an inherent tendency toward growth and maturity, (4) children are themselves capable of positive self-direction, and (5) children possess the capacity to act responsibly (Axline, 1969; Landreth, 2002).

The child-centered approach is not intended to control or change the child and is based on the theoretical belief that a child's behavior is caused by the drive to achieve overall self-realization (Landreth, 2012). Children's language development is delayed compared to their cognitive development, therefore children communicate and express awareness of their worlds through play. To add, play bridges the gap developmentally between concrete experience and abstract thinking. In other words, play is a child's natural symbolic language of self-expression, and the utilization of toys enables them to transfer fears, fantasies, anxieties, and guilt to objects versus people. Child-centered play therapists rely on the relationship with the child to facilitate the development of the child's constructive attitudes and behaviors; furthermore, they meet the child where the child is with acceptance, care, and warmth to relate to the child therapeutically (Glover & Landreth, 2015). It is vital that those who utilize play therapy/CCPT are knowledgeable in child development, are trained as a helping professional and have completed specialized training in play therapy (Glover & Landreth, 2015).

In essence, play is an important medium for children because it is a natural language from which children express themselves (Landreth, 2002; Ray et al., 2005). Play developmentally

bridges the gap between concrete experience and abstract thought (Landreth, 2002; Piaget, 1962). It provides opportunities for children to organize their complicated and abstract real-life experiences, while gaining a sense of control and learn coping skills (Landreth, 2002; Ray et al., 2005). Play therapy offers children a therapeutic environment for their play, and through the safe, interpersonal child and therapist relationship, children can fully explore and express self.

Play Therapy Research

As previously noted, play therapy is an empirically supported intervention that is culturally sensitive and developmentally appropriate in treating racially/ethnically minoritized student populations (Baggerly & Parker, 2005; Bratton et al., 2005; Bratton, 2010; Davis & Pereira, 2014; Landreth et al., 2009; Post et al., 2019; Ray et al., 2015; Shen, 2002; Van Horne et al., 2018). Ray et al. (2005) found that play therapy not only strengthened the remedial and preventative aspects of a comprehensive, developmental school counseling program, it was also decreased student referrals and increased academic success and classroom behavior. Ray et al. (2015) concluded that CCPT allowed children to overcome emotional limitations hindering expression of intelligence and propelled children to demonstrate their full potential. CCPT can aid in addressing children experiencing the following: abuse, depression, divorce, dependency, learning disabilities, lack of self-control, socially inappropriate behavior, regressive behavior, physical disabilities, and many other problems (Landreth, 1993).

Research has referenced play therapy as being an appropriate approach to addressing internalized and externalized behaviors of students in the school setting (Lin & Bratton, 2015; Post, 1999; Ray et al., 2015). Furthermore, play therapy has been reported to be an effective intervention with children having faced adverse childhood experiences and children who live in poverty (Haas & Ray, 2020; Post et. al, 2019; Ray et al., 2021). The research to follow will

highlight the use play therapy/CCPT and its overall effectiveness, including its effectiveness with children at-risk and those who have experienced ACEs, as well as its use in schools.

Post (1999) addressed the impact of CCPT on the self-esteem, locus of control, and anxiety level of at-risk 4th-6th grade children. The total number of participants were (n = 168), and they were placed into two group, one who received play therapy and the other did not receive play therapy. The study's results showed that the children who do not participate in play therapy exhibited a decrease in both self-esteem and locus of control throughout the school year. The findings from the study indicated that the intervention of play therapy was an appropriate referral for at-risk children with externalized behaviors. Further, the study found play therapy as beneficial and needed in preventatively addressing at-risk children's lowering self-esteem and reduced these children's sense of responsibility for their academic successes and failures. The study emphasized the need for more systemic research on the impact of play therapy services.

Haas & Ray (2020) implemented a single-case research study with 2 participants to examine the influence of CCPT on children with 4 or more ACEs. Both participants in the study significantly decreased in all areas of concern and had lasting change through the play therapy intervention. Additionally, they were able to build self-acceptance and self-confidence. Similar to Post (1999) findings, CCPT was shown to be a promising modality and intervention in working with children who have experienced multiple or ongoing ACEs. The study suggested that continued research of CCPT can assist in adding to the evidence-based literature for children with ACEs.

Ray et al. (2021) conducted a randomized controlled trial (n = 120) that explored the impact of child-centered play therapy (CCPT) among children with two or more ACEs. The study specifically focused on improvement of social/emotional well-being and behavioral

problems. Findings from the study highlighted statistically significant improvement in social/emotional components, including empathy, self-regulation/responsibility, and social competence in children who have experienced ACEs and participated in CCPT. Additionally, and similarly to Hass & Ray (2020), children with multiple ACEs were shown to have significantly fewer behavioral issues after participating in CCPT. The results demonstrated the efficacy of CCPT among racially/ethnically minoritized children with 52.9%-87.8% of participants identifying as economically disadvantaged and 50%-66.6% at-risk. Results of this study further substantiates research supporting the effectiveness of CCPT as an intervention among children who have experienced ACEs and who are at-risk for complex trauma.

Lin and Bratton (2015) examined the overall effectiveness of CCPT interventions through a meta-analytic review of 52 controlled outcome studies between 1995-2010. Of the 52 treatment-control comparison studies, overall treatment effect size was .47 with a standard error of .06, which was statistically significantly (t ratio = 7.660, $p < .001$; 95% CI [0.35, 0.59]), indicating a moderate treatment effect in using CCPT interventions for children. The meta-analytic review found that there were limited number of studies targeting specific ethnic groups outside of Caucasian. The studies were categorized into four categories: (a) Caucasian (60% or more), (b) non-Caucasian (60% or more), (c) mixed groups (none of the ethnic groups were more than 60%), and (d) not stated. The studies with African American, Latino/Hispanic, Asian/Asian American, and other ethnic minority groups had a mean effect size of .76, which was statistically significantly higher than the mean effect size of .33 for Caucasian studies (t ratio = –2.721, p = .009). According to the findings, CCPT has a greater benefit for non-Caucasian populations, is particularly responsive to the needs of diverse children, and its' implementation cross-culturally is supported. The study also found that CCPT showed more benefits for younger children 8 years

and younger, which provides support for CCPT's use and implementation in the elementary school setting. It is strongly suggested that CCPT is supported as a culturally responsive counseling intervention for children. The findings from the study further supports the overall effectiveness of CCPT modality as a child-counseling intervention across presenting concerns, as well as provides evidence that CCPT is a developmentally and culturally responsive treatment.

Ray et al. (2015) also conducted a meta-analysis and systematic review that examined 23 studies, which evaluated the effectiveness of CCPT implemented in elementary schools. The purpose of the study was to determine how effective CCPT is in reducing problematic behaviors or characteristics of elementary-aged children. Results from the study revealed statistically significant effects for the following: externalizing problems (d = 0.34), internalizing problems (d = 0.21), total problems (d = 0.34), self-efficacy (d = 0.29), academic (d = 0.36), and other behaviors (d = 0.38), indicating small to medium size effects. The study indicated similar results to Lin & Bratton (2015) in that CCPT is an appropriate intervention for children experiencing a variety of presenting issues and symptoms. The study implicated that CCPT is an appropriate, relevant, and effective intervention in the school setting with children with racially/ethnically minoritized backgrounds and issues by school mental health professionals.

Post et. al (2019) explored literature on the impact of CCPT conducted on marginalized children. The outcome of the studies reviewed highlighted that CCPT was effective with marginalized children, and to note, all of the CCPT interventions were conducted in the school setting. The implications further support Post (1999) and the other study's findings that CCPT intervention can assist at-risk children with their academic achievement, self-esteem, and externalized behaviors. Though the study highlighted the promotion of future training at the

university level and through continuing education for play therapists who work in school settings, the same implications are applicable to PSCs in the elementary school setting.

As evidenced by the reviewed literature, CCPT is an appropriate, effective, relevant, and culturally sensitive intervention in addressing elementary aged children's racially/ethnically minoritized background, behavioral issues, and presenting concerns. The research substantiates the effectiveness of CCPT with children who are at-risk, have experienced ACEs, trauma, and other circumstances outside of their control. The research highlights the effectiveness of play therapy/CCPT as a means of counseling elementary school students in the school setting, yet there has been little research conducted on the use and practice of play therapy by elementary school counselors. Because of this lack of knowledge and gap in literature, this research study seeks to add to the literature by surveying elementary school counselors on their play therapy training and use of play therapy/CCPT.

Use of CCPT Among Professional School Counselors (PSCs)

The American School Counselor Association (ASCA) National Model declares that professional school counselors (PSC) create opportunities for all students to learn, ensure access to quality school curriculum, collaborate with stakeholders, advocate to eliminate barriers, and promote systemic change (ASCA, 2003, 2023). Play therapy can be an effective counseling intervention with students by elementary school counselors given a solid developmental understanding of children (Ray et al., 2005). Landreth (2002) has advocated for the use of play therapy in schools by justifying its aim to help children prepare to benefit from the learning experiences within the classroom. As Ray et al. (2005) highlighted, school counselors can utilize play therapy to effectively assist children in their developmental growth. Researchers over the

years have examined the use of play therapy among elementary school counselors (Ebrahim et al., 2012; Ray et al., 2005; Van Horne et al., 2018).

Ray et al. (2005) conducted a study surveying elementary school counselors, who were American School Counselor Association (ASCA) members, about their play therapy practices in the school. The participants (n = 381) were asked about their play therapy training, use of play therapy, and perceived limitations to using play therapy in the schools. Ray et al. (2005) found that though school counselors believed in the utilization of play therapy in the schools, certain barriers were present that impacted its implementation. Some of those primary barriers included lack of time available with students (reported by 70% of the participants) and lack of training in play therapy. The study indicated that there was a relationship between a lack of training and the number of hours using play therapy was statistically significant, x^2 (n = 376) = 14.19, p = .0002. Ray et al.'s (2005) study concluded that many elementary school counselors hold the belief that play therapy is a developmentally appropriate way to provide counseling to young children. This study substantiated the support needed to address the identified barriers in implementing play therapy and to provide more pre-service play therapy training to future school counselors.

Ebrahim et al. (2012) conducted a similar study surveying elementary school counselors (n = 359), who were members of ASCA, about their perceived barriers to implementing play therapy and strategies used to combat those barriers. The results from the study showed that elementary school counselors perceive play therapy to be helpful but many experience barriers related to training, time, space, resources, and administration. The top barriers reported were lack of play therapy training and lack of time. About 56% of participants reported to some extent not feeling adequately trained to use play therapy and more than 55% reported not using play therapy because of not having enough time during the day. To overcome these barriers, school

counselors used methods including training, play therapy education for faculty and administrators, personal funding to purchase play therapy materials, and creative use of time. The study further highlighted the need to increase awareness by adding to the literature on elementary school counselor's use of play therapy, and to provide more formal training to elementary school counselors in play therapy to overcome barriers to implementation.

Van Horne et al. (2018) also examined elementary school counselors (n = 192) who were ASCA members. The study examined variables related to the use or nonuse of play therapy in elementary schools. The study found that 57% of participants used play therapy, while 42% did not use play therapy. Similar to Ray et al. (2005) and Ebrahim et al. (2012), participants in this study indicated little training in play therapy; only 29% of elementary school counselors had taken a graduate course in play therapy. Other barriers to training included: lack of training opportunities, time, budget, belief in play therapy being ineffective, lack of support from administrators, lack of supervision, and limited space. It was also found that elementary school counselors were more likely to use play therapy when they perceived themselves as effective in implementing play therapy. A need to strengthen knowledge about play therapy and supervision experiences of elementary school counselors were implicated. The study highlighted the need to increase the understanding of factors that impact school counselors' use of play therapy in schools.

As evidenced in the literature, play therapy has been identified as an appropriate intervention with elementary-aged children. Studies have shown that there are barriers to implementing play therapy in the elementary setting by school counselors. One common barrier present in the studies explored was play therapy training. There is a need to continue to fill the gap in literature since there are only a minute number of studies specifically exploring

elementary professional school counselors use of play therapy. Furthermore, there is a need to explore the impacts of school counselors' lack of play therapy training, as well as factors related to the use and nonuse of play therapy in schools by elementary school counselors.

Use of Child-Teacher Relationship Training (CTRT) in Schools

Child–teacher relationship training (CTRT; Landreth & Bratton, 2006) focuses on strengthening the preexisting relationship between teachers and students by using CCPT attitudes and skills. As evidenced in the research, studies have shown that schools with over 50% racially/ethnically minoritized populations not only utilized CTRT interventions (CCPT skills used by teachers) but they were effective with these populations (Post et al., 2020; Post et al., 2020; Post et al., 2022). Post et al. (2020) highlighted that among the kindergarten participants, 52% identified as Black/African American, 20% identified as Hispanic, 19% identified as White, and 8% identified as Other (other racial groups or multiracial). In another study, Post et al. (2020) highlighted that both schools within the study had a high percentage of students of color (86% intervention school; 70% control-group school). Similarly in Post et al. (2022)'s study, both schools had a high percentage of economically disadvantaged students (46% intervention school; 61% control school).

The results to these studies showed the positive impact of CTRT on helping teachers learn the attitudes and skills of CTRT, develop stronger relationships with students, reduce teacher's stress, build self-esteem of students, and improve student behaviors; additionally, the CTRT intervention significantly increased the ability for CTRT skills implementation in the classroom, and teachers' knowledge and skills related to child-centered values of CTRT (Post et al., 2020; Post et al., 2020; Post et al., 2022). To note, all three studies were conducted in a county where over 50% of children aged 0–17 scored 1 or greater on an ACEs assessment;

additionally, the percentage of children who experienced two or more ACEs were higher than the state or national average (Child and Adolescent Health Measurement Initiative, 2015). These CTRT studies reiterates CCPT's effectiveness in schools, and substantiates the need for CCPT's utilization in schools with at least 50% racially/ethnically minoritized student populations.

Play Therapy Training

As previously noted, there is a scarcity in training on play therapy provided at universities and within counseling preparation programs (Anderson, 2022; Ebrahim et al., 2012; Jones & Rubin, 2005; Shin & Gonzalez, 2018), which substantiates the need to understand how the amount and quality of play therapy training is related to play therapy utilization. For these reasons, play therapy training is one of the predictor variables in this research. The following sections will review the essentialness of play therapy training, play therapy training history, the lack of play therapy training programs, as well as the importance of play therapy training for school counselors.

A factor that may influence the use of play therapy in elementary schools is play therapy training. Play therapy is a fast-growing profession in the mental health field. A concern noted by past research is that play therapy should be provided by clinicians with expertise and training in play therapy procedures to ensure children receive quality assistance from highly competent play therapists (Cohen, 1995; Landreth, 1991). Parker and O'Brien (2011) acknowledged that school practitioners must be trained specifically in play therapy to have a successful play therapy program in a school setting. Moustakas (1958) highlighted that teaching the principles and philosophy of play is the first step in training a practitioner to use play therapy. Landreth and Wright (1997) emphasized the importance of training, a working knowledge of the play therapy principles, in addition, supervision. Ebrahim et al. (2012) echoed the importance of elementary

school counselors having proper training and noted a major barrier of implementation was lack of training. One can conclude that training is essential for effective play therapy to be best utilized.

Research has highlighted that an obstacle to receiving play therapy training through graduate coursework is due to the limited number of programs across the country that offer play therapy (Jones and Rubin, 2005). Many counselors are lacking hours of training to counsel children using play therapy through university counselor education programs (Ebrahim et al., 2012; Shin & Gonzalez, 2018). The significance of this problem is that children have different developmental and emotional needs than adults (Landreth, 2012; Ray et al., 2005), and these needs combined with growing evidence-based support, particularly addressed in play therapy, suggests the need for a better understanding of training for counselors (Anderson, 2022; Carnes-Holt & Weatherford, 2013; Flasch et al., 2017; McNary et al., 2019; Pereira & Smith-Adcock, 2013; Thanasiu et al., 2018). The following sections explore play therapy training history, play therapy training among counselors/play therapists and Professional School Counselors (PSCs), play therapy training and use of play therapy/CCPT among PSCs, as well as a summary and highlighting gaps in literature.

Play Therapy Training History

In terms of adequate training in play therapy, Landreth (1991) suggested that play therapists have a master's degree in an area of a helping profession and knowledge of relevant content areas including child development, counseling/psychotherapy, and group counseling. They should also (1) experience personal counseling, (2) attain the equivalent of 45 clock hours of instruction in play therapy, (3) apply knowledge/skills in observation and case analysis of typical and maladjusted children, (4) critique sessions of experienced play therapists, and (5)

receive supervision by a professional skilled in play therapy (Landreth, 1991). The Association for Play Therapy (APT, 2006, 2023) established guidelines and criteria training for earning the Registered Play Therapist™ and School-Based Registered Play Therapist™ credentials. These criteria require a current mental health license or certification for clinical practice; a masters or doctoral degree in a mental health specialty; completed core graduate coursework in several areas; and at least 150 hours of specific instruction in play therapy (APT, 2006, 2023).

According to Jones and Rubin (2005), the limited number of programs across the country that offer play therapy is a barrier to receiving play therapy training. It is important to note the progression of play therapy training offered over the years. In 1993, 56 universities throughout the U.S. and Canada offered at least one full semester or equivalent graduate course in play therapy (Bratton et al., 1993). In 1995, this number decreased to 46 universities; however, another 24 universities offered play therapy as a part of another course (Kranz et al., 1996). In 2004-2005, 109 universities across the country reported offering courses in play therapy, demonstrating a 25% increase since 2000 (Landreth et al., 2004). While it is essential that those who implement play therapy receive specialized, quality training and supervision, there are currently only 31 approved centers of play therapy education and 149 universities that offer play therapy instruction according to the Association for Play Therapy's directory (The Association for Play Therapy, n.d.).

In earlier research, Kao and Landreth (1997) explored 66 (37 experimental group, 29 control group) graduate students who had no previous play therapy training or play therapy experience. The participants' treatment for the experimental group was a comprehensive CCPT training course. Both the experimental and control groups completed the Play Therapy Attitude, Knowledge Skill Survey (PTAKSS). The study revealed significant improvement in the

knowledge, attitudes, and beliefs in working with children, as well as demonstrated the positive impacts of play therapy training on graduate students in counseling. Additionally, the study showed how CCPT training enhanced students' play therapy knowledge and confidence in applying play therapy skills.

Shen and Herr (2003) hypothesized that play therapy training may be related to school counselor's implementation of play therapy in schools. Cerio et al. (1999) conducted a national survey of school counselor training programs, largely consisting of larger colleges and urban settings. Of the 117 programs, over half reported providing some form of play therapy training; however, only 3% required a play therapy course, 9% offered a play therapy elective course, and 21% offered play therapy training as part of a required course (Cerio et al., 1999). It was concluded that "much of what programs label as "training" in play therapy consists of minimal exposure to general information about this approach" (Cerio et al., 1999, p. 60). Results from the study revealed that play therapy was seen as therapeutically useful by trainers. Additionally, they recommended that school counseling training programs include play therapy courses and that the use of play therapy in the school setting is appropriate (Cerio et al., 1999).

Over the years, researchers have examined the training in play therapy of counselors (Abrams et al., 2006; Ebrahim et al., 2012; Lambert et al., 2007; Ray et al., 2005; Ryan et al., 2002; Van Horne et al., 2018). Ryan et al. (2002) surveyed 891 members of APT and found that 54% received pre-service play therapy through coursework and/or practicum. Child-centered play therapy training accounted for 56% of responses; 76% of participants received individual play therapy supervision of one hour per week; and 61% reported receiving supervision from a Registered Play Therapy-Supervisor (Ryan et al., 2002). Ray et al. (2005) reported that 21% of respondents had completed one university-level course in play therapy; 12% completed two or

more university level courses; 67% had not enrolled in a play therapy course; and more than 53% had no formal training in play therapy. Abrams et al. (2006) conducted a study of APT members and found that 40% of participants received coursework specific to play therapy. Lambert et al. (2007) conducted a study with 978 play therapists, who indicated that they completed 1.5 graduate level courses in play therapy. The majority of the play therapists, 67%, identified their primary theoretical orientation as child-centered play therapy (Lambert et al., 2007).

Later studies, such as Ebrahim et al. (2012), reiterated similar trends and found that 56% of their ASCA survey participants confirmed lack of training was a barrier to the implementation of play therapy in their schools. They also found that 51.5% of respondents did not have a graduate level course in play therapy from an accredited institution (Ebrahim et al., 2012). Van Horne et al. (2018) emphasized that although research supports the effectiveness of using play therapy in schools, play therapy is not used in many elementary schools by professional school counselors.

As evidenced by the findings in the literature, there are obstacles and barriers to implementing play therapy and this may be due to school counselors' lack of training in play therapy and to the limited number of graduate programs offering play therapy classes. Research has outlined the need to strengthen both play therapy knowledge and supervision for elementary school counselors, especially seeming that a predictor for school counselor's use of play therapy is based on their perceived effectiveness. The findings from the aforementioned research studies provide further evidence of the necessity for play therapy training in reducing the barrier of effectively implementing in the school setting by elementary school counselors.

Play Therapy Training Among PSCs

As previously highlighted, Ray et al. (2005) found that approximately 67% (*n* = 300) of elementary school counselor participants had no prior training in play therapy. There was a significant relationship found between formal training in play therapy and the use of play therapy by school counselors. School counselors with more play therapy training reported a higher frequency of implementing play therapy to students in their schools. Other prior research studies showed that barriers to play therapy training included a lack of training opportunities, time, budget, views of ineffectiveness, and lack of administration support (Ebrahim et al., 2012; Shen, 2008; Van Horne et al., 2018), lack of supervision (Shen, 2008; Van Horne et al., 2018), and limited space (Ebrahim et al., 2012; Van Horne et al., 2018). The following sections explore professional development and training in play therapy among school counselors.

More recent studies (Anderson, 2022; Juang et al., 2023; Maddox et al., 2023) have explored school counselors' professional development, perception of play therapy training, play therapy courses in school counseling programs, as well as the impact of an intensive CCPT workshop for school counselors. Anderson (2022) examined the relationships between professional development and attitudes, knowledge, and skills in play therapy among professional elementary school counselors and licensed professional counselors who work with children 3-12 years of age in the U.S. Professional development included various methods of training and/or Association for Play Therapy membership. Elementary school counselors made up approximately 20% of the total sample size (*n* = 333). Among the total school counselor sample, 44% of elementary school counselors reported no university coursework in play therapy, 56% had no institute/professional conference training, and 30% had no workshop training in play therapy.

The Play Therapy Attitudes, Knowledge, and Skills Survey Revised (PTAKSS-R) survey was utilized in this study. The results from this study concluded the following: counselors with university-level training had higher levels of attitudes, knowledge, and skills; knowledge in play therapy predicted high skill levels of the counselors; and there was a relationship between APT membership and higher levels of knowledge and skills. The major implication of this study was that professional development in play therapy influences attitudes, knowledge, and skills in play therapy among counselors. Therefore, counselors who receive instruction in play therapy within graduate level counseling programs will be more equipped to enter the profession with higher attitudes, knowledge, and skills in play therapy and more prepared to address the counseling needs of children aged 3-12. The study highlighted the concern consistent with Shin and Gonzalez (2018), that school counselors do not have an opportunity to take graduate-level coursework in play therapy because many universities do not offer play therapy coursework. The study suggested that university counselor education programs consider providing more play therapy course offerings. These findings reiterate the need for more professional development and training in graduate school counseling programs in play therapy, particularly for elementary school counselors.

Using a phenomenological approach, Juang et al. (2023) examined 21 pre-service elementary school counselors' perceptions of play therapy training in Taiwan. The data was collected through an Introduction to Play Therapy course for those seeking to be elementary school counselors. Twenty-one students served as play therapy session facilitators implementing play therapy with children. The qualitative analysis highlighted four major themes: (a) enhanced understanding of children's world, (b) the power of toys and play, (c) value of play sessions and observers' feedback, and (d) enhanced self-awareness and professional growth. The findings

revealed that due to the play therapy course, participants gained a deeper understanding of children's social/emotional and behavioral needs, advanced their developmentally appropriate skills in working with children, and demonstrated both personal and professional growth. Though the study was based in Taiwan, the implications are still applicable, and much can be learned from school counseling preparation programs in Taiwan since many offer play therapy as an elective course. Similar to Anderson (2022), the findings further support the need for pre-serve training in play therapy for elementary school counselors.

Maddox et al. (2023) conducted a mixed-method study exploring the impact of an intensive play therapy workshop that included a micro-practicum for 18 practicing school counselors, as well as their experiences regarding their training for addressing mental health needs in schools and their experiences following the workshop. Of the 15 total participants, 44.4% (n = 8) participants reported having no prior clinical experience in play therapy, 33.3% (n = 6) reported under 1 year of experience, 5.6% (n = 1) reported 2 years of experience, 5.6% (n = 1) reported 3 years of experience, and 11.1% (n = 2) reported more than 3 years of clinical experience in play therapy. The intensive play therapy workshops with micro-practicums occurred over a two-day period in a university-based training clinic, with two fully equipped playrooms designed for live supervision. The workshop included lecture, discussion, and brief role-plays among the participants focusing on basic CCPT skills. In aligning with previous research that indicated most school counselors have never had play therapy training or experience (Ebrahim et al., 2012; Ray et al., 2005), the results indicated that attending a two-day long intensive play therapy training with a practicum experience that included both practice and role-plays had an impact on school counselors' perspectives, abilities, and self-efficacy in using play therapy. The findings also suggest the need to incorporate more experiential learning

opportunities into workshops and training for school counselors. The results demonstrated how participants viewed CCPT as a proactive approach in addressing and supporting the mental health needs of students. The study highlighted that school counselors' increase in confidence after play therapy training can assist them changing the way they interact and support students, as well as feeling better equipped to address and support the mental health needs of students.

As the literature shows, there is a significant relationship between play therapy training, their attitudes, knowledge, and skills, and the use of play therapy by school counselors in the school setting. School counselors across research studies have reported limited or lack of play therapy training. As previously mentioned, a major barrier to play therapy training is the limited to no play therapy training available through graduate coursework and limited professional development opportunities in play therapy. The findings from the outlined research further substantiates the need for more universities and graduate school counseling programs to offer play therapy courses. There is a need for elementary school counselors to be equipped with the training, knowledge, and skills, and professional development in play therapy to effectively address and support the ever-growing mental needs of children in the elementary school setting.

Summary

Play therapy training is essential for PSCs to effectively implement play therapy with confidence in the elementary school setting. Prior research studies showed barriers to play therapy training included a lack of opportunities, time, budget, views of ineffectiveness, and lack of administration support (Ebrahim et al., 2012; Shen, 2008; Van Horne et al., 2018), lack of supervision (Shen, 2008; Van Horne et al., 2018), and limited space (Ebrahim et al., 2012; Van Horne et al., 2018). The literature emphasizes that play therapy training is scarce at universities and within counseling preparation programs. There are only three studies that specifically

explore elementary professional school counselors' use of play therapy. As evidenced, research has highlighted the effectiveness of play therapy and CCPT in schools. Further, it has shown that CCPT is an empirically supported intervention that is culturally sensitive and developmentally appropriate in addressing the mental health needs of children 3-12 years of age. This study sought to fill the gap by building upon prior research examining whether having play therapy training (amount and quality) is related to PSCs' use of play therapy/CCPT.

Adverse Childhood Experiences (ACEs)

Research continues to highlight and outline increasing rates of adverse childhood experiences (ACEs) and their detrimental effects on individuals across the lifespan (Metzler et al., 2017; Parker et al., 2021). Trauma is defined in current research and literature as an emotionally painful event that overwhelms a person's ability to effectively cope (van der Kolk, 2017). Numerous traumatic events can have substantial negative long-term impacts on physical and mental health (Felitti et al., 1998). ACEs was first explored in Felitti et al.'s (1998) study, which examined adult participant's experiences with specific traumatic occurrences before the age of eighteen, including (physical, psychological, and sexual) abuse, neglect, and household dysfunction. Results from the study indicated that ACEs were prevalent among participants; more than half reported at least one childhood traumatic event, while 25% reported at least two (Felitti et al., 1998).

The Child and Adolescent Health Measurement Initiative (2013) notes that ACEs affect 34.8 million children across socio-economic lines, placing them at greater risk for health, behavioral and learning problems. As the Center for Youth Wellness (CYW) notes, high or frequent exposure to traumatic events can cause dysregulation in children's stress response; further, ACEs causes toxic stress, changes in brain development, affect attention, decision-

making, learning, and response to stress (2017). As other studies have found, ACEs increase risk of experiencing chronic health problems, cognitive impairments, difficulties with executive functioning, emotion regulation, impulse control, lower self-esteem, high-risk behaviors, future violence and victimization, premature death, among others (Brown et al., 2009; Copeland et al., 2007; Felitti et al., 1998; Gilbert et al., 2015). Van der Kolk (2017, p. 401) indicated childhood trauma as the "single most important health challenge in the United States" due to the overwhelming number of children experiencing trauma and its sustaining negative impacts. Schools are a primary vehicle to help support the needs of students who have experienced traumatic events through systemic, comprehensive trauma-informed programming (Reinburgs et al., 2018). Understanding the overall impact and effects of ACEs necessitates the need for effective and appropriate counseling approaches, interventions, and treatment, as well as its potential impacts on school counselors' work in addressing and supporting student needs.

Felitti et al. (1998) indicated that ACEs are associated with behavior problems and negative adult health outcomes. Other research has highlighted the effects on the structure and functioning of the developing brain and its correlation to impacts on behavioral, cognitive, and emotional development (De Bellis & Zisk, 2014), which can cause negative physical and mental health problems throughout the life span (Post et al., 2020; Sciaraffa et al., 2018). The Centers for Disease Control and Prevention (CDC) has reiterated the prevalence of ACEs by highlighting that approximately 64% of U.S. adults reported experiencing at least one type of ACE before age 18, and nearly 1 in 6 (17.3%) reported experiencing four or more types of ACEs (CDC, 2023; Swedo et al., 2023). Zyromski et al. (2020) noted that the prevalence of ACEs within marginalized communities, such as ethnic minority populations, make ACEs "a social justice issue" (p. 352). With ACEs being very prevalent in the U.S., it is also important to note and

explore if school counselors have experienced adverse events and their overall impact on their well-being, work in supporting racially/ethnically minoritized student populations, and implementation of play therapy/CCPT with racially/ethnically minoritized students.

ACEs Among Mental Health Professionals

There is scarcity in research related to the impact of ACEs on mental health professionals and graduate students in helping professions (Brown et al., 2022). Research studies have examined ACEs among helping and mental health professionals, including child social work providers, social work students, licensed social workers, mental health professionals, and play therapists (Brown et al., 2022; Chase and Post, 2022; Esaki & Larkin, 2013; Mott & Martin, 2019; Steen et al., 2021; Thomas; 2016). Many studies have focused on the ACEs of clients or students and not the mental health professionals themselves. Furthermore, there is no research that outlines professional school counselor's own ACEs scores and their potential impact on the support and work they do with students, including students who are racially/ethnically minoritized. The following studies highlight the occurrence of ACEs and various factors related to the potential impact of helping and mental health professionals' ACEs as it relates to their work and career.

Esaki and Larkin (2013) explored the adverse childhood experiences among 94 child social service providers. The study found that 70.1% of participants reported at least one adverse childhood experience, 53.8% reported two or more, and 15.9% reported four or more ACEs. As compared to Felitti et al.'s (1998) seminal ACE study, the occurrence of ACEs among participants were significantly higher in this study. The study suggested more research on exploring whether ACEs backgrounds increase empathy among providers, help with the ability to create a compassionate culture, and the impact client outcomes. This study supports similar

results found by Thomas (2016) and Steen et al. (2021) that mental health professionals have a higher ACE than the general population.

Thomas (2016) examined the prevalence of ACEs among 79 Master of Social Work (MSW) students. The study found that more than 79% of the participants had at least one adverse childhood experience, almost 38% had experienced one to three, 42% had four or more ACEs, and almost 25% had six or more. The most frequently reported ACEs were divorce/separation of parents (48.6%), followed by physical abuse (43%), and then both emotional neglect and household member substance abuse (40.5%). More than one-third (36.7%) of participants reported mental illness among their family members, and 35.4% experienced emotional abuse. The results showed the higher prevalence of ACEs among those studying to be social workers and reiterated the need for best practices in training social work students to ensure resiliency and competency as licensed social workers.

Steen et al. (2021) also explored the prevalence and types of ACEs among licensed social (n = 5,540) through their study. The study examined the (1) occurrence and types of ACEs, (2) connection between ACEs and wellness factors, and (3) overall relationship between ACEs and stress and compassion fatigue in the workplace. The study found that participants reported an average of 2.1 ACEs., and approximately 24% reported experiencing four or more. The results indicated that higher ACE scores were significantly related to greater health issues and heightened workplace stress.

Mott and Martin (2019) explored mental health providers (n = 371) and how self-care moderates various self-compassion outcomes. The study focused on participants' self-care, ACEs, burnout, secondary traumatic stress, and compassion satisfaction. The results found that participants who had ACEs (82.5%) had stronger negative compassion outcomes versus those

who did not have ACEs. Through hierarchal multiple regressions, the study found that participants' support of the use of self-care activities significantly predicted their burnout and compassion satisfaction.

Brown et al. (2022) also examined the impact of ACEs on mental health counselors (n = 140). The study specifically looked at the impact of ACEs and positive childhood experiences on mental health professionals' compassion satisfaction, burnout, and secondary traumatic stress. The mean ACE score of participants in the study was 3.42. Almost half of the participants (42.9%) met the threshold of four ACEs. Results indicated significant relationships between counselors' rates of ACEs, positive childhood experiences (PCEs), compassion satisfaction, and burnout. The results also indicated that higher ACE scores positively correlated with burnout, and that PCEs may serve as protective factors. The study found that some individuals who are drawn to the counseling profession have a higher likelihood of having ACEs in their personal histories. The study further highlighted that being a minoritized counselor actually predicted higher compassion satisfaction and lower burnout. Similar to the other studies identified, this study indicated that counselors had higher rates of ACEs across all 10 experiences versus the original Felitti et al. (1998) study. The study suggested that counselors increase their awareness of how their own experiences of ACEs and PCEs may impact their current practice.

These studies support researchers' further investigation on mental health professionals' ACEs and the need to continue to examine the impact of ACEs on these professionals. There is an overall lack of literature examining the ways in which PSCs' own experience of ACEs may affect their work. The gap in research is highly significant given research on helping professionals reporting higher rates of ACEs. Studies continue to highlight the impact and detrimental effects of ACEs over the lifespan. Considering the negative outcomes associated with

the experiences of ACEs, it is important to explore the relationship between ACEs and other variables, such as use of play therapy/CCPT, among PSCs.

ACEs Among Play Therapists

As previously noted, there is limited research on ACEs of counselors, including PSCs, and its impact on their use of CCPT in supporting racially/ethnically minoritized children. Chase and Post (2022) explored how adverse childhood experiences, attitudes related to trauma-informed care, and cultural humility impact social justice advocacy attitudes among play therapists. The participants (n = 409) were mental health professionals who practiced play therapy. Approximately 58% of the participants were professional counselors, 23% were social workers, 6% were psychologists, 5% were Other, 4% were university professors, and 3% were school counselors. Roughly 10% of the participants worked in the school setting.

Participants from the study completed the following surveys: SIAS (actions taken to support and advocate on behalf of other individuals or groups), ACE (traumatic events) Questionnaire, ARTIC Scale (trauma-informed principles), and Multidimensional Cultural Humility Scale (interpersonal dimensions of humility toward cultural backgrounds and experiences of others). The participants' mean ACE score was 2.76 (SD = 2.44). A Pearson correlation coefficient was conducted to examine the relationships between the predicator variables (ACEs, ARTIC, and MCHS) and the outcome variable (SIAS). The predicator variables were all significantly positively related to the outcome variable. Additionally, there were statistically significant positive correlations between ACEs and cultural humility ($r = .163$, $p < .001$) and between ARTIC and cultural humility ($r = .390$, $p < .001$). A standard multiple regression examined how ACEs, ARTIC, and cultural humility predicted social justice advocacy

attitudes. The results indicated that that the model was two of the three independent variables, ARTIC and cultural humility, significantly predicted social justice advocacy.

Though ACEs were not found to be statistically significant in the regression analysis in this study, the results still highlight the presence and prevalence of adverse childhood experiences and the essentialness of assessing their impacts on play therapists and counselors, including PSCs. Chase and Post's (2022) findings of a low, but significant relationship between ACEs and cultural humility calls for further research to examine this relationship as it pertains to PSC's use of CCPT in the school setting. To date, there has been no research on the relationship between ACE scores and use of play therapy/CCPT among PSCs.

Summary

With ACEs being prominent in the U.S., it is important to note and explore if PSCs have been impacted by ACEs, and if these impacts effect their work in supporting racially/ethnically minoritized student populations and use of play therapy/CCPT. The studies substantiate the need to explore the impact of ACEs on counselors and PSCs given the findings that mental health and helping professionals report higher rates of ACEs. There are currently no studies examining PSC's own experience of ACEs and their effects, signifying a major gap in the literature. This study is the first of its kind to examine PSC's total ACE scores and use of play therapy/CCPT (including with a higher percentage of racially/ethnically minoritized students) in the elementary setting.

Cultural Humility

Tervalon and Murry-Garcia (1998) introduced and defined the concept of cultural humility 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 non-paternalistic clinical and advocacy partnerships with communities on behalf of individual and defined populations" (1998, p. 117). Cultural humility involves possessing a sense of respect for and an absence of superiority toward another's culture (Hook et al., 2013). The concept of cultural humility shifts from the focus of multicultural competency knowledge to emphasizing the need to continuously learn (Fisher-Borne et al., 2015; Fouad & Arredondo, 2007).

Cultural humbleness involves the ability and willingness to admit to limitations and recognize own potential to make mistakes (Fouad & Arredondo, 2007). Intersectionality should be considered when discussing cultural humility to focus on the many aspects of culture and how one self-identifies with multiple identities (Kumaş-Tan et al., 2007). 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). The racially/ethnically minoritized student populations PSCs serve have a variety of needs; therefore, adapting a cultural humility mindset is imperative to understanding and meeting student's unique needs.

Cultural humility can serve as a beneficial tool in developing PSC's cultural sensitivity and competency. Instilling a cultural humility mindset is critical for counselors and PSCs and it assists with engagement in self-reflection, learning of biases, openness to diverse cultures, and commitment to authentically collaborating in reassessing imbalances of power (Minkler, 2012). Trusty et al. (2002) reiterates the notion of creating a culturally affirmative environment. Openly addressing issues of diverse ethnic relationships, evaluating the degree of acculturation, allowing counseling session flexibility, allowing other family members to participate, and being open to

integrating indigenous interventions with Western traditions (Trusty et al., 2002) are all efforts that can help with offsetting barriers in supporting diverse populations.

A factor that may influence use of play therapy among PSCs in elementary schools is attitudes of cultural humility. There is minimal empirical research within the field of play therapy on cultural humility outside of Chase and Post's (2022) study. While there is a desire to possess a cultural humility mindset, there are factors that may impede its development. The following research reviews cultural humility among play therapists (Chase and Post, 2022), and mental health professionals (Davis et al., 2016; Gonzalez et al., 2020; Hook et al., 2013; Hook et al., 2016), including PSCs (Placeres et al., 2022). Cultural humility and the use of play therapy/CCPT are also reviewed.

Cultural Humility Among Mental Health Professionals

There have been research studies that have explored cultural humility among mental health professionals as previously mentioned. Many researchers who have explored cultural humility focused on clients' experiences of cultural humility and examined experiences in retrospect. Research on cultural humility has examined play therapists (Chase & Post, 2022), college students (Hook et al., 2013), therapy clients (Davis et al., 2016; Hook et al., 2016), practicing counselors (Gonzalez et al., 2020), and school counselors (Placeres et al., 2022). The following section reviews these studies on cultural humility.

As previously noted, Chase and Post (2022) explored how adverse childhood experiences (ACEs), attitudes related to trauma-informed care (ARTIC), and cultural humility impact social justice advocacy attitudes among play therapists. The participants (n = 409) were mental health professionals who practiced play therapy. Approximately 58% of the participants were professional counselors, 23% were social workers, 6% were psychologists, 5% were Other, 4%

were university professors, and 3% were school counselors. Roughly 10% of the participants worked in the school setting. The study found that ACEs, ARTIC, and cultural humility were all significantly positively correlated with social justice advocacy attitudes. The study suggested that future research examine how counselor educators address social justice advocacy, adverse childhood experience, trauma-informed care, and cultural humility, with counselors-in-training who work with children.

Hook et al. (2013) conducted four studies, including a pilot and 3 studies, to provide evidence for the approximate reliability and construct validity of the Cultural Humility Scale, which measures a therapist's cultural humility. The purpose of the pilot study was to collect evidence of whether individuals perceive cultural humility as an important aspect of a therapist. The researchers hypothesized that participants would report a therapist's cultural humility as an important aspect in searching for a therapist; further, that cultural humility would be more important than other aspects of multicultural competencies (MCCs). The participants consisted of 117 college students, ranging from ages 18-52 years old. About 29.9% were Caucasian, 38.5% African American, 21.4% Latino, 7.7% Asian, 0.9% Indigenous, and 1.7% Multiracial. The Cross-Cultural Counseling Inventory-Revised was used to measure MCCs. A series of analysis of the covariances were conducted by the researchers with cultural humility and knowledge as independent variables and confidence in forming a good relationship, expected effectiveness, and the likelihood to continue therapy as the dependent variables. Additionally, the researchers controlled the past experience in therapy, race, and gender. The study found that for the dependent variables, there was a large effect for humility, signifying participants who rated a therapist high in cultural humility reported a higher likelihood of developing a good relationship

with the therapist, expected therapy would be more effective, and reported a higher likelihood of continuing therapy with the therapist.

For Hook et al. (2013) Study 1, the purpose was to develop a client-rated measure of a therapist's cultural humility and to gather evidence that client perceptions of their therapist's cultural humility related to client outcomes. The researchers hypothesized that client perceptions of their therapists' cultural humility would be positively associated with a strong working alliance. Participants consisted of 472 college students, who were 59.1% Caucasian, 12.6% African American, 12.8% Latino, 6.6% Asian, 0.9% Indigenous, and 8.1% Multiracial. The researchers measured participants' rating of severity of presenting issue, working alliance with their therapist, and identified the aspect of their cultural background that was most salient to their identity. A Scree test and a parallel analysis were conducted to create the 12-item Cultural Humility Scale with two factors that represented positive and negative aspects of cultural humility. The Cronbach's alphas for the full scales and subscales were .93 for the full scale, .93 for the Positive subscale, and .90 for the Negative subscale. The researchers assessed their hypothesis with a hierarchical regression with working alliance as the criterion variable and found that cultural humility was significantly related to working alliance after controlling for the variance in the other variables. It also found a relationship between both positive and negative cultural humility and working alliance.

For Hook et al. (2013) Study 2, the researchers examined clients who were currently in therapy versus using a retrospective design like the prior studies. The purpose of this study was to replicate and expand on Study 1's findings. The participants consisted of 134 adults currently in therapy. About 70.1% were Caucasian, 6.7% African American, 6.7% Latino, 8.2% Asian, and 8.2% Multiracial. The researchers aimed to explore whether a clients' perception of

therapist's cultural humility predicted the development of a strong working alliance while controlling for other culturally significant variables used in previous studies. The researchers utilized a hierarchal regression to examine the relationship between cultural humility and working alliance, controlling for MCCs. Researchers found that clients' perceptions of their therapists' cultural humility was a significant predictor of working alliance; furthermore, client's perception of a therapist's cultural humility was positively related to a high-quality alliance with their therapist.

For Hook et al. (2013) final study, Study 3, researchers replicated and expanded on the results from Studies 1 and 2 by incorporating measures of client improvement in therapy and intentionally seeking a more racially/ethnically diverse sample. The participants consisted of 120 self-identified Black or African American adults, aged 18-55 years old, who were currently attending therapy. Participants completed measures on improvement in psychotherapy, working alliance, and cultural humility. The researchers hypothesized that client perceptions of therapist's cultural humility would be positively related with perceived improvement to date in therapy, and that this relationship would be mediated by the working alliance. Using regression analysis, the results showed that when controlling for beginning severity and gender, the direct association between cultural humility (predicator variable) and improvement (criterion variable) was significant. Additionally, the direct association between cultural humility and working alliance was significant. Lastly, controlling cultural humility, the association between working alliance and improvement was significant. The researchers found that cultural humility indirectly affected improvement through working alliance. With a large effect size, about 37.2% of the variance in improvement was supported by the mediated effect of cultural humility through working alliance. Overall, from the four studies, researchers created the Cultural Humility Scale, a

measure of therapists' cultural humility, and provided further validity and reliability of the scale. The author's reiterated that the attitude of cultural humility is especially imperative to the development of a strong working alliance with clients who are culturally diverse.

Davis et al. (2016) evaluated Hook et al.'s (2013) hypothesis that microaggressions cause clients to view their counselors as less culturally humble, consequently damaging the working alliance in counseling. The study examined microaggressions and their impact on counseling outcomes among 128 racial/ethnic minority individuals who attended counseling within the past year. Using path analysis, researchers measured individual items associated with the context of the microaggression, negative emotions due to rupture, working alliance, perceived improvement in counseling, and perceived cultural humility. Participants were chosen at random and assigned to a general severe offense toward their identity or a microaggression issue in counseling. At similar levels, both conditions induced microaggressions. It was found that perceptions of cultural humility mediated the relationship between negative emotion due to rupture and counseling outcomes.

An additional study by Hook et al. (2016) also investigated racial microaggressions in counseling among 2,212 racial/ethnic minority participants. They examined the relationship between the perceived cultural humility of the counselor and racial microaggressions. Most of the participants (81%) reported experiencing at least one racial microaggression in counseling, and the most reported racial microaggressions included lack of awareness of stereotypes and bias, and avoidance of addressing cultural issues. The study found a relationship between client's perceived cultural humility of the counselor and frequency (and impact) of microaggressions experienced in counseling. The finding reiterated the importance of developing self-awareness in one's own racial and cultural background, as well as cultural humility.

Gonzalez et al. (2020) developed and implemented an initial testing of the Multidimensional Cultural Humility Scale (MCHS), which is a counselor-report scale measuring counselor's cultural humility. The total sample consisted of 861 practicing counselors, including (64.2%) Caucasian, (16.5%) Hispanic/Latino, (9.5%) Black/African American, (3.3%) Multiracial, (1.2%) Asian 10 (1.2%), (0.6%) American Indian/Alaska Native, and (4.5%) Other. Participants completed the Multidimensional Cultural Humility Scale (MCHS), which is based on five dimensions of cultural humility Foronda et al. (2016) identified, as well as the 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. A model with five factors (Openness, Self-Awareness, Ego-Less, Self-Reflection and Critique, and Supportive Interactions) that accounted for 62.95% of the variance was produced. Researchers completed a Confirmatory Factor Analysis with a second sample of 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 examined the relationship between the MCHS and the SSAS and found that all five factors from the MCHS were positively associated with all three subscales of the SSAS. The development of the MCHS provides counselors with a way to assess their own cultural humility and overall increase their multicultural sensitivity. The study implied that continual assessment of cultural humility assists with the exploration of cultural humility's imperativeness among the counseling profession.

Placeres et al. (2022) explored the relationship between self-reported multicultural competence (MCCs) and social issues awareness among school counselors and raters' assessment of multicultural orientation skills, including cultural humility and cultural comfort.

The study consisted of 80 school counselors with a mean age of 38.8 years old. Most participants identified as certified school counselors (80%) and (20%) as school counseling graduate students. The study assessed MCCs through the 32-item Multicultural Counseling Competence and Training Survey-Revised (MCCTS-R), social justice advocacy through the 21-item Social Issues Advocacy (SIA), cultural humility through the 12-item Cultural Humility Scale (CHS), and cultural comfort though the 10-item Cultural Comfort Scale (CCS). The study revealed a positive relationship between multicultural competence and cultural comfort, but self-reported multicultural competence was not correlated with cultural humility. Cultural comfort was also correlated to multicultural knowledge and multicultural awareness. This study was the first to show the association using evaluator' perceptions of school counselors' cultural comfort. The study's findings revealed that school counselors generally reported higher levels of multicultural competence (53.8% self-reported) but generally had lower scores in cultural humility as evidenced by rater's evaluations. The researchers suggested addressing school counselor's training needs at each level of P-12 with developmentally responsive approaches, including play therapy.

Cultural Humility and the Use of Play Therapy/CCPT

In addition to play therapy training, other measures are needed to prepare PSCs who utilize play therapy/CCPT with diverse student populations, including ongoing assessment of cultural humility. O'Connor (2005) proposed that play therapists assessed themselves through Pederson's (1988) awareness, skills, and knowledge (ASK) model in their journey towards multicultural competency. Sue's (1998) exploration of cultural competency found that scientific mindedness, dynamic sizing (i.e., knowledge about generalizing and individualizing in a flexible and valid manner), and culture-specific expertise (i.e., knowledge and understanding of own

worldviews, knowledge of the cultural groups with whom they work, understanding of sociopolitical influences, and possessing intervention skills needed to work with culturally different groups, including culturally based interventions) are three important aspects of cultural competency.

In addition to skill development and assessing one's own cultural competencies and cultural humility, there is a need to have the knowledge base in understanding toys used in diverse cultures, play behaviors across cultures, and intervention strategies most appropriate for diverse children's cultures. CCPT therapists use materials that are culturally sensitive to each child's culture (Killian et al., 2017; Shen, 2016). Furthermore, CCPT is appropriate in assisting minoritized children by acknowledging cultural considerations, accommodating cultural adaptations, and focusing on the children's natural language, play. Several studies have highlighted cultural humility and its connection to play therapy/CCPT (Lin & Bratton, 2015; Shen, 2016; Ray et al., 2021).

Shen (2016) surveyed 86 school counselors applying play therapy across cultures. Of the participants, 77.6% were Caucasian, 14.1% Hispanic/Latinos/Latinas, and 7 Other ethnicities. About 62.4% worked at elementary schools, 21.1% at secondary schools, and 16.5% at mixed levels. Geographically, 32.6% worked in rural areas, 24.4% suburban, 16.3% in urban, 22.1% metropolitan, and 3.5% in multiple or unidentified areas. The study explored elementary and secondary school counselors' play therapy practices with culturally diverse students and adaptations of play therapy use. Based on comparing the students' response to play therapy versus talk therapy, the results showed that counselors perceived students of most ethnic groups (M = 2.87–2.97, SD = .68 –.81) responded more to play therapy than talk therapy alone. Similar results were found among students with special needs (M = 3.45, SD = .55). Approximately

71.2% of counselors noticed similar responsiveness in both boys and girls. A Pearson correlation indicated that there was a significant, positive, and strong correlation between counselor's observation of positive responses to play therapy (versus talk therapy) from each cultural group and counselor's multicultural exposure (r (7) = .73, $p < .05$) (except for Indigenous children). The findings also highlighted that 48.6% of school counselors modified techniques based on students' ethnicity, 77.9% based on students' special needs; additionally, 73.2% of school counselors modified play materials based on ethnicity and 83.3% based on special needs. The researcher emphasized that there is an urgent need to empirically examine the cross-cultural use of play therapy by school counselors to better serve the rapidly growing racially/ethnically minoritized student populations.

Lin and Bratton (2015) examined the overall effectiveness of CCPT approaches through a meta-analytic review of 52 controlled outcome studies between 1995-2010. The study sought to address the overall effectiveness of CCPT and if any relationships existed between CCPT's effectiveness and study variable. Through a hierarchical linear modeling, there was a statistically significant moderate treatment effect size (.47) for CCPT found, as well as statistically significant relationships between effect size and study characteristics (including child's age, ethnicity, caregiver involvement, treatment integrity, publication status, and presenting issue. The study indicated and emphasized that CCPT is a culturally responsive intervention. As previously noted, the study reiterated that CCPT is a developmentally and culturally responsive counseling intervention that is effective across presenting issues. Further, CCPT deserves recognition as a practical treatment within the field of counseling children. Ray et al. (2021) also emphasized that the implementation of CCPT in the school setting is an effective way to address barriers to mental health needs for racially/ethnically diverse children who experience poverty.

Their results found that children across identity groups improved in behaviors, empathy, self-regulation, responsibility, and social competence. The findings suggest that through the use of CCPT, culturally inclusive principles can be effectively implemented.

Research involving play therapy has addressed multicultural competency but not cultural humility, except for Chase and Post's (2022) study, whose results concluded that attitudes related to trauma-informed care and cultural humility contributed significantly to the prediction of social justice advocacy attitudes among play therapists. With the diversity of student populations within the school setting continuing to increase, it is imperative that school counselors are culturally sensitive and responsive in addressing the unique and holistic needs of racially/ethnically minoritized students. PSCs who utilize play therapy/CCPT in the elementary school setting should continuously evaluate their beliefs, values, worldview, and feelings about the racially/ethnically minoritized student populations they assist and support. Overall, there is a gap in literature and no research focusing on how PSCs' cultural humility as if is related to the use of play therapy/CCPT in the elementary school setting, and this study seeks to fill this gap.

Summary

Based on the literature, cultural humility is an important construct for mental health professionals, including PSCs. There is minimal empirical research within the field of play therapy on cultural humility outside of Chase and Post's (2022) study; however, several studies have highlighted cultural humility and its connection to play therapy/CCPT. Research has reiterated the importance of empirically examining the cross-cultural use of play therapy by PSCs to better serve the rapidly growing racially/ethnically minoritized student populations. Studies have examined cultural humility as it relates to working alliance, improvement in psychotherapy, therapist's multicultural orientation, mental health professionals' cultural

humility self-assessment, and school counselor's self-reported MCCs and multicultural orientation skills (Davis et al., 2016; Gonzalez et al., 2020; Hook et al., 2013; Hook et al., 2013; Owen et al., 2016; Placeres et al., 2022). However, no studies have explored cultural humility among PSCs and their use of play therapy/CCPT. This study sought to fill the gap of understanding PSC's attitudes toward cultural humility and whether these attitudes are related to their use of play therapy/CCPT in the elementary school setting.

Chapter Summary

In this chapter, a comprehensive literature review of the variables of interest were explored. The literature review began with a discussion of the theoretical framework for the study, CCPT. The next section provided an overview of the outcome variable, use of CCPT, followed by a literature review that focused on the predictor variables, quality and amount of play therapy training, PSCs' adverse childhood experiences, and attitudes toward cultural humility are their relation to PSCs use of play therapy/CCPT. The research highlighted the effectiveness, developmental appropriateness, and culturally responsiveness of play therapy/CCPT as a counseling modality for racially/ethnically minoritized children in the elementary school setting. The research has shown that there are barriers to implementing play therapy in the elementary setting by PSCs. There is a need to continue to fill the gap in literature by exploring elementary PSC's use of play therapy. There is an overall lack of literature examining the ways in which PSCs' own experience of ACEs may affect their work. Additionally, there is minimal empirical research within the field of play therapy on cultural humility, and there is a need to explore PSC's attitudes about cultural humility. This study sought to explore elementary school counselors' use of play therapy/CCPT and whether play therapy training, total ACE scores, and attitudes toward cultural humility are factors that may be

related to their use of play therapy/CCPT in schools. To add, this study sought to examine whether ACEs moderates the relationship between the amount and quality of play therapy training and use of play therapy/CCPT, as well as to determine whether ACEs moderates the relationship between attitudes toward cultural humility and use of CCPT among PSCs.

CHAPTER 3: METHODOLOGY

The purpose of this study was to explore how the amount and quality of play therapy training, adverse childhood experiences (ACEs) of the PSCs, and attitudes toward cultural humility are related to the use of child-centered play therapy (CCPT) in addressing student's mental health needs among elementary school counselors. In this chapter, the methodology for the study is described and divided into sections. The first section provides details of the participants and setting. In the second and third sections, data collection procedures and instrumentation details are discussed. The fourth, fifth, and final sections include the description of the research design, research questions, an overview of data analysis procedures, and summary of the chapter.

Participants

Participants in this research study included a convenience sample of elementary school counselors who practice child-centered play therapy. Recruitment was via multiple methods described in the section following. Inclusion criteria included a) licensed/certified and provisionally licensed/certified Professional School Counselors who work in the elementary schools. An a priori power analysis was conducted with G*Power for given a given alpha of .05 and various levels of effect sizes reported by previous research and power. Table 1 presents the results of the power analysis:

Table 1

Minimum Sample Size needed for the Logistic Regression

Effect Size	Power = .80	Power = .90	Power = .95
.04	227	265	327
.09	90	119	147
.13	63	83	102

Description of Participants

This study used a convenience sample of elementary school counselors and a snowball strategy to recruit participants. Participants were school counselors who worked in the elementary school setting in the United States. It is difficult to estimate how many elementary school counselors were invited to participate due to sampling strategies, however it is known that over 47.3k messages and direct emails were sent through the ASCA Member Community forum and APT mailing lists (in addition to thousands receiving recruitment message within private Facebook groups geared towards School Counselors and Play Therapy). A total of 256 participants consented to participate and 243 participants fully completed the survey.

As shown in Table 2, most participants identified as White or Caucasian (78.9%; *n* = 202) and female (66%; *n* = 169). Of the participants, males comprised of 34% of the sample (*n* = 87). Most of the participants worked in the urban school setting (53.1%; *n* = 136), and public schools (62.9%; *n* = 161). Most of the participants indicated that they were currently practicing as elementary school counselors (93%; *n* = 238) and they conducted four play therapy sessions in the past year (93.4%; *n* = 239). Most respondents worked in the South region (41.5%; *n* = 106), followed by the West region (30.9%; *n* = 79). Participants reported that they currently receive play therapy supervision (72.7%; *n* = 186). Of the 256 participants, 54.7% identified as being in the age range of 29-39 (*n* = 140), with the total age range from 18-73 plus. There was a range of reported years of experience from one year to twenty-one plus, with most of the participants falling in the four-eight years of experience range (57%; *n* = 148).

Table 2

Demographic Information, Frequency, and Percentages

Variable	*n*	Percent
Gender		
Female	169	66
Male	87	34
Nonbinary	0	0
Transgender Female	0	0
Transgender Male	0	0
Other	0	0
Race		
African American/Black	14	5.5
American Indian or Alaska	22	8.6
Native or Indigenous		
Asian or Pacific Islander	3	1.2
Biracial or Multiracial	3	1.2
Caucasian/White	202	78.9
Hispanic/Latinx	10	3.9
Other	2	.8
Age		
18-28	17	6.6
29-39	140	54.7
40-50	71	27.7
51-61	23	9

Table 2 (Continued)

Demographic Information, Frequency, and Percentages

Variable	*n*	Percent
62-72	4	1.6
73+	1	.4
Currently Practicing		
Yes	238	93
No	18	7
Four Play Therapy Sessions in Past Year		
Yes	239	93.4
No	17	6.6
Years of Experience		
1-3	45	18
4-8	148	57
9-14	46	18
15-20	11	4
21+	5	2
Missing value	1	1
School Setting		
Urban	136	53.1
Rural	79	30.9
Suburban	41	16
School Type		

Table 2 (Continued)

Demographic Information, Frequency, and Percentages

Variable	*n*	Percent
Public	161	62.9
Private	77	30.1
Charter	18	7
Region		
West	79	30.9%
Midwest	43	16.9%
South	106	41.5%
Northeast	27	10.7%
Receiving Play Therapy Supervision		
Yes	186	72.7
No	62	24.2
Missing	8	

Description of Play Therapy Training

Of the 248 participants who responded, the majority (39.8%; *n* = 102) reported that they had received substantial training in play therapy, followed by 35.9% (*n* = 92) who reported receiving moderate play therapy training. A total of 19.5% (*n* = 50) received minimal training, and only 1.6% (*n* = 4) reported no training. See Table 3 below.

Table 3

Play Therapy Training Amount, Frequency, and Percentages

Variable	*n*	Percent	Range	Min	Max	Mean	SD
PT Training Amount	248	96.9	4	1	4	3.18	.805
No Training	4	1.6					
Minimal Training	50	19.5					
Moderate Training	92	35.9					
Substantial Training	102	39.8					

Note. Total of 8 missing values (3.1%)

For quality of play therapy training, the mean scores are displayed below in Table 4. Participants reported high quality of play therapy training received according to the means of the four semantic differential item scales (0-6). Bad-Good (M = 5.52, SD = 1.23), Weak-Strong (M = 5.40, SD = 1.23), Partial-Thorough (M = 5.34, SD = 1.35), and Shallow-Deep (M = 5.32, SD = 1.34).

Table 4

Play Therapy Training Quality, Frequency, and Percentages

Variable	*n*	Percent	Range	Min	Max	Mean	SD
PT Training Quality	248	96.9	6	0	6		
Bad-Good						5.52	1.23
Weak-Strong						5.40	1.26
Partial-Thorough						5.34	1.35
Shallow-Deep						5.32	1.34

Note. Total of 8 missing values (3.1%)

Predictors of Elementary School Counselor's Use of Play Therapy/CCPT

The dependent variable was a binary, "yes" or "no" response to whether participants utilized play therapy/CCPT in the elementary school setting. As shown in Table 5, the vast majority of respondents indicated that they used play therapy (94.9%; $n = 243$). Only 5.1%, or 13 elementary school counselors, reported that they do not use play therapy. Of the 256 participants, child-centered play therapy was identified as the play therapy orientation most frequently utilized (34.4%; $n = 88$). The independent variables were scores on play therapy amount and play therapy quality scales, the total ACE Questionnaire scores, and total scores on the MCHS. The extent of play therapy was determined by mean scores of participants' perceived amount of training received (i.e., no training, minimal, moderate, or substantial training). The quality of play therapy training was determined by mean scores of participants' perceived quality of training received (i.e., bad-good, weak-strong, partial-thorough, and shallow-deep). See Table 3 and 4.

Table 5

Use of Play Therapy, Frequency, and Percentages

Variable	*n*	Percent
Use of Play Therapy		
Yes	243	94.9
No	13	5.1
Play Therapy Orientation Most Frequently Used		
Adlerian	22	8.6
Child-centered	88	34.4
Cognitive/Cognitive Behavioral	58	22.7

Table 5 (Continued)

Use of Play Therapy, Frequency, and Percentages

Variable	*n*	Percent
Eco-systemic	26	10.2
Jungian	12	4.7
Solution-Focused	26	10.2
Theraplay	20	7.8
Other	4	1.6

Procedures

The researcher obtained Exemption Determination by the Institutional Review Board (IRB) at the University of North Carolina at Charlotte to conduct survey research with human subjects before collecting the data. The researcher stated the inclusion criteria at the onset of the recruitment allowing participants to verify their qualification to participate in this study. The researcher invited Professional School Counselors to participate through posts on the American School Counselor Association (ASCA) Community board, the Association for Play Therapy (APT) mailing list, CESNET-L listserv email, LinkedIn, and social media posts on private elementary school counselor and play therapy-related Facebook groups. Additionally, a snowball sampling method was utilized by asking participants to share and disseminate the survey to other elementary school counselors they know may meet the inclusion criteria. All participants were provided informed consent information fully explaining the risks and benefits of participating in the study.

Participants read the informed consent (see Appendix C) that fully explained the purpose of the research, risks and benefits of participating, and explanation that participation is

completely voluntary, anonymous, and confidential. The informed consent also informed participants that they can choose to terminate their participation at any time for any reason without penalty. Once participants read, understood, and agreed to the informed consent, they provided demographic information (see Appendix D), as well identified their number of years as a school counselor, use of CCPT, amount and quality of play therapy training, percentage of racial/ethnic distribution of students in their school setting and play therapy theoretical orientation most frequently used.

All participants completed the following: Adapted Elementary School Counselor Play Therapy Survey (Van Horne, 2014), which included background as school counselor, demographics, CCPT use, and the amount and quality of play therapy training. The participants also completed the Adverse Childhood Experiences (ACE) Questionnaire to calculate their total ACE scores, as well as the Multidimensional Cultural Humility Scale (MCHS) to determine cultural humility total score. There were no personal identifying data collected. All instruments were merged into one questionnaire on separate pages using Qualtrics. The estimated time to complete the full survey was approximately 15 minutes. There were no personal identifying data collected such name and email addresses in order to complete the survey.

The survey remained open for multiple weeks to collect the data. The researcher sent the survey through CESNET-L once versus three total times as planned. The researcher posted in the ASCA Member Community forum twice (totaling over 42k members), sent one email to the entire APT mailing list (totaling over 5,300), and posted once in the following Facebook groups: School Counselor Educators' Discussion group, School Counselors Connect, Professional School Counselors of Color, Elementary School Counselor Exchange, and Play Therapy & Counseling Activities. The researcher utilized a snowball strategy to increase response rates and add

knowledge to the study (Mertens, 2015) by asking participants to forward the survey to individuals who meet the inclusion criteria. Participants interested in the incentive submitted their email on a separate Google form after completing the survey. Once surveys were completed, the researcher randomly chose 10 participants who received a $20 Amazon gift card. The researcher uploaded the data from Qualtrics and analyzed the data with the Statistical Package for the Social Sciences (SPSS) software. In addition, the researcher stored the digital data in the digitally secure Dropbox drive of the primary researcher, in compliance with university Level 2 data storage guidelines.

Instrumentation

The data were obtained from the Elementary School Counselor Play Therapy Survey (see Appendix D), which also merged the Adverse Childhood Experiences (ACE) Questionnaire (see Appendix E), and the Multidimensional Cultural Humility Scale (MCHS) (see Appendix F). All instrumentations are described further below, beginning with the Adapted Elementary School Counselor Play Therapy Survey, which includes questions from Van Horne's (2014) original assessment and additional questions that identify amount and quality of play therapy training.

Adapted Elementary School Counselor Survey

The Adapted Elementary School Counselor Play Therapy Survey consists of 16 questions. In the first section, "Your Work as a School Counselor," of the Elementary School Counselor Play Therapy Survey, participants were asked about their work as a school counselor. The use of play therapy, ethnic distribution of students, and theoretical orientation are also addressed in the "Personal Information" section. In the next section, data regarding personal information including counselor demographics, such as age, race, gender, employment state, work setting (rural, suburban, or urban), and whether they were currently practicing as a school counselor was collected.

The next section, “Education and Training” included two variables in the data analysis, amount of training and quality of training. The first variable asked participants to identify the amount of training received specific to play therapy. The response options were: no training, minimal training (e.g., one workshop, seminar, and/or in-service training), moderate training (e.g., a couple of workshops), or substantial training (e.g., multiple workshops, semester-long course, certificate, other extensive formal training). The second variable asked participants to rate their perception of the quality of the play therapy training they received by rating on 4 bipolar adjectives (bad - good, weak - strong, partial - thorough, and shallow - deep) using a 6-point Likert rating scale. The perception of play therapy training was identified through semantic differential items (Osgood et al., 1957).

ACEs Questionnaire

The ACE-Q is widely used in clinical settings to assist with addressing the impact of childhood trauma on a person’s health and well-being (Craig et al., 2023). Felitti et al.’s (1998) Adverse Childhood Experience study created a 10-item, self-report questionnaire surveying potentially traumatic events and experiences in participants’ lives before the age of 18. These events and experiences include the following: (a) physical abuse, (b) physical neglect, (c) emotional abuse, (d) emotional neglect, (e) sexual abuse, 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. Examples of questions include, “Did a parent or other adult in the household often push, grab, slap, or throw something at you?”, “Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?”, and “Was a household member depressed or mentally ill or did a household member attempt suicide?”

The original Felitti et al. (1998) study reported the Cohen's kappa coefficient measuring test-retest reliability 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., 2004). Four or more ACEs were generally observed as the threshold for high ACE exposure, indicating a significantly increased likelihood of negative health outcomes as an adult (Dube et al., 2003). Subsequent to the original study, there have been other recent studies that reported the reliability of the ACE-Q. Zanotti et al. (2018) reported the overall ACE-Q measure yielded a modest test–retest coefficient, $r = .71$, $p < .001$. Craig et al. (2023) reported the Cronbach's alpha reliability coefficient of 0.73, signifying a relatively high reliability.

For this study, participants were not asked to identify which events; rather they were asked to add the total number of ACEs they experienced and provided the total number. Participants' ACE score was the total number of "yes" responses to each of the 10 experiences.

Multidimensional Cultural Humility Scale

The Multidimensional Cultural Humility Scale (MCHS; Gonzalez et al., 2020) measures interpersonal dimensions of humility as it relates to individuals' cultural backgrounds and experiences. Cultural humility was measured by the Multidimensional Cultural Humility Scale (MCHS; Gonzalez et al., 2020). The scale consists of 15 items on a 6-point Likert-type scale (1 = strongly disagree; 6 = strongly agree). The five dimensions of cultural humility identified on the MCHS scale include: (a) Openness (b) Self-awareness (c) Ego-less, (d) Supportive Interactions, and (e) Self-reflection and Critique. The Supportive Interactions subscale is reverse scored. Sample items are "I seek to learn more about my clients' cultural background," "I seek feedback from my supervisors when working with diverse clients," and "I ask my clients about their

cultural perspective on topics discussed in session." The total scores from the scale range from 15 to 90. Higher scores indicate higher cultural humility. Internal reliability coefficients revealed convergent and discriminant validity and internal reliability evidence of scores on the scale (Gonzalez et al., 2020). The Cronbach's alpha coefficients values for the MCHS were .76, .66, .77, .56, and .53 respectively in regard to internal consistency reliability. The Cronbach's alpha for the entire 15-item scale is .79 (Gonzalez et al., 2020). The researcher used the mean scores on the MCHS to assess PSC's cultural humility.

Research Design

This study used a non-experimental correlational research design to examine the proposed research questions. To answer research questions 1-3, a logistic regression was utilized to determine how the predictor variables of amount and quality of play therapy training, adverse childhood experiences of school counselors, and attitudes toward cultural humility are related to the dichotomous outcome variable of use of play therapy/CCPT. In addition, ACEs was also utilized as a moderator between the quality of play therapy training and use of play therapy/CCPT and as a moderator between the relationship between attitudes toward cultural humility and use of play therapy/CCPT. To answer research question 4, a Chi-Square analysis was utilized.

Research Questions

1. How are the amount of play therapy training, quality of play therapy training, adverse childhood experiences, and attitudes toward cultural humility related to the probability to the use of play therapy/CCPT among elementary school counselors?
2. How does ACEs moderate the relationship between the quality of play therapy training and the probability of using CCPT?

3. How does ACEs moderate the relationship between attitudes toward cultural humility and the probability of using CCPT?
4. How is the use or non-use of CCPT different among PSCs who are in schools with 50% racially/ethnically minoritized versus 50% non-racially/ethnically minoritized student populations?

Data Analysis

To address the research question, participants who indicated that the play therapy theoretical orientation they most frequently use was selected for inclusion in the data analysis.

Screening Data

The data was screened using SPSS before running regression analyses. The purpose of screening data is to identify any issues within the data, such as missing data, outliers, accuracy, normality, homoscedasticity, linearity, and collinearity.

Since the survey did not collect email addresses and also involved an incentive, it was important that the data were screened thoroughly to identify if there were any discrepancies, including interference of any bots. During the tail end of data collection, an increase in survey responses occurred and the researcher closely monitored and looked through the data. The survey was closed immediately to avoid any potential bot interference and due to the target sample size being met. During both collection and screening of the data, the researcher consulted and worked with the methodologist to ensure the survey responses were cleared and approved to be included in the regression and chi-square analyses. The researcher suggests adding additional safeguards when utilizing surveys and incentives, such as adding passwords, collecting emails, or captcha.

Descriptive Statistics

Descriptive statistics was utilized to summarize participants in the study. Descriptors included information about participants' age, gender, race, years of experience, region, work

setting, and racial/ethnic distribution of students at their school setting. Descriptive analyses presented was based on the frequencies and percentages for categorical variables and means, standard deviations, and central tendency measures for continuous variables.

Logistic Regression

Logistic regression analysis was utilized due to there being three predictor variables and a dichotomous outcome variable (Hahs-Vaughn, 2017). Regressions are often used to predict; therefore, this method was chosen to examine how each predictor variable relates to use of play therapy/CCPT. The analysis determined the amount of variance in play therapy/CCPT use by the predictor variables: amount and perception of play therapy training, PSCs adverse childhood experiences, and attitudes toward cultural humility. In addition, the second and third research questions were addressed by checking if the interaction effect between the two predictors. The data was entered and analyzed in SPSS.

Chi-Square

A chi-square analysis was utilized to answer research question 4. Nonparametric statistics are used when the assumption of normality cannot be met, with ordinal or nominal data, and when sample sizes are small. The chi-square statistics is a nonparametric statistical technique that is used with nominal-level data to test the statistical independence of two variables (Mertens, 2020). In other words, a Chi-square test is used for hypothesis testing and confirms whether the research data is as expected. The test compares the observed values in the data to the expected values to see if the null hypothesis is true.

Summary

This chapter outlined the methodology, including participants, data collection procedures, and instrumentation. In addition, the research design, research questions, and data analyses have been described to explain the process by which the predictor variables were examined for their

predictive relationship to the dependent variable, use of child-centered play therapy among elementary school counselors. Additionally, data analyses have been described to explain the process of exploring how ACEs may moderate the relationship between the quality of play therapy training and use of CCPT, as well, how ACEs may moderate the relationship between attitudes toward cultural humility and use of CCPT. Lastly, the data analysis also described the process of exploring how the use or non-use of CCPT may be different among PSCs who are in schools with 50% racially/ethnically minoritized versus 50% non-racially/ethnically minoritized student populations.

CHAPTER 4: RESULTS

The purpose of this study was to explore how the amount and quality of play therapy training, adverse childhood experiences (ACEs) of the PSCs, and attitudes toward cultural humility are related to the use of child-centered play therapy (CCPT) in addressing student's mental health needs among elementary school counselors. The first research question explored how the amount of play therapy training, quality of play therapy training, adverse childhood experiences, and attitudes toward cultural humility were related to the probability of using play therapy/CCPT among elementary school counselors. The second research question examined how ACEs moderates the relationship between the quality of play therapy training and the probability of using CCPT. The third research question examined how ACEs moderates the relationship between attitudes toward cultural humility and the probability of using CCPT. The fourth research question explored how the use or non-use of CCPT is different among PSCs who are in schools with 50% racially/ethnically minoritized versus 50% non-racially/ethnically minoritized student populations. The first section of this chapter presents a discussion of the research questions. This includes the results of the analyses that answer the first, second, third, and fourth research questions. The final section of this chapter outlines the summary of the chapter.

Discussion of Research Questions

Research Question 1

The first research question explored how the amount of play therapy training, quality of play therapy training, adverse childhood experiences, and attitudes toward cultural humility are related to the use of play therapy/CCPT among elementary school counselors. Logistic regression was used to explore the relationship between the independent and dependent

variables. The use of play therapy and the use of CCPT was dichotomized into two levels (use and nonuse). Results of both analyses are provided below. All assumptions were met, including noncollinearity, linearity, and independence. No violations of multicollinearity were noted, with variance inflation factors ranging from 1.06 to 2.08, and tolerances ranging from .48 to .95. Missing data and outliers were screened using IBM SPSS Statistics software version 28.0.1.0. Missing data were around 5.9%, and Little's MCAR test suggested the data could be treated as missing completely at random due to the p-value being above .05.

The responses indicated that of the 241 participants included in the analysis, 95.4% (n = 230) reported using play therapy, while 11 (4.6%) reported not using play therapy in the elementary school setting. The responses also indicated that 33.2% (n = 80) of the 241 participants reported using CCPT as their play therapy orientation most frequently used, while 161 (66.8%) reported utilizing other play therapy orientations more frequently and not using CCPT.

Use of Play Therapy

The model for use of play therapy was statistically significant, χ^2 (4) = 51.43, p < .001, which provides support to the model. The Hosmer and Lemeshow test, χ^2 (8) = 4.428, p = .817, indicated that there is no significant difference between the observed frequencies and expected frequencies. Therefore, the model is a good fit.

There was a significant prediction of use of play therapy by all predictors, χ^2 (4, N = 241) = 51.43, p < .001, Negelkerke R^2 = .620. The likelihood of using play therapy increased by a factor of 4.77 for each unit increase in extent or amount of play therapy training score, B = 1.56, χ^2 (1) = 3.709, p = .054, exp(B) = 4.771. The likelihood of using play therapy increased by a factor of 2.53 for each unit increase in quality of play therapy training score, B = .930, χ^2 (1) =

3.900, $p = .048$, exp(B) = 2.534. The likelihood of using play therapy increased by a factor of .03 for each unit increase in cultural humility score, $B = -3.520$, χ^2 (1) = 13.287, $p < .001$, exp(B) = .030. There was no significant prediction of ACE scores, $B = -.095$, χ^2 (1) = .203, $p = .652$, exp(B) = -.095. There was no significant difference between observed and predicted group membership in the use of play therapy model, Hosmer and Lemeshow χ^2 (8) = 4.428, $p = .817$. The overall classification rate was good. About 97.5% of participants were correctly classified (63.6% for nonuse of play therapy and 99.1% use of play therapy).

Use of CCPT

The model for use of CCPT was not statistically significant, χ^2 (4) = 1.562, $p = .816$, which may not lend support to the model. The Hosmer and Lemeshow test, χ^2 (8) = 11.042, $p = .199$, indicated that there is no significant difference between the observed frequencies and expected frequencies. However, in reviewing the contingency table, there are some significant differences in the observed versus expected values. Therefore, the model may not be a good fit.

There was not a significant prediction of use of CCPT by all predictors, χ^2 (4, N=241) = 1.56, $p = .816$, Negelkerke $R^2 = .009$. There was no significant prediction of amount of play therapy training $B = .196$, χ^2 (1) = .625, $p = .429$, exp(B) = 1.216, quality of play therapy training $B = .026$, χ^2 (1) = .021, $p = .886$, exp(B) = 1.026, ACE scores $B = .013$, χ^2 (1) = .047, $p = .828$, exp(B) = 1.013, or cultural humility $B = -.004$, χ^2 (1) = .000, $p = .988$, exp(B) = .996. There was a significant difference between observed and predicted group membership in the use of CCPT model, Hosmer and Lemeshow χ^2 (8) = 11.042, $p = .199$. The overall classification rate was not good. About 66.8% of participants were correctly classified (100% for nonuse of CCPT and 0% use of CCPT).

The frequency, mean, and standard deviation of the predictor variables in the first research question are reported below in Table 2.

Table 2

Predictor Variables for Logistic Regression, Number, Frequency, Mean, Standard Deviation, Range

Variable	*n*	%	Mean	SD	Min	Max
Training Amount	248	96.9	3.18	.805	1	4
Training Quality	248	96.9	5.39	1.15	0	6
ACE	244	95.3	4.09	2.31	1	10
MCHS	243	94.9	4.44	.58	1	6

Research Question 2

The second research question how ACEs moderates the relationship between the quality of play therapy training and the probability of using CCPT, a moderator analysis was performed using PROCESS. The outcome variable for analysis was use of CCPT. The predictor variable for the analysis was the quality of play therapy training. The moderator variable evaluated for the analysis was ACEs. The interaction between the variables were found to not be statistically significant. Pseudo R^2 values for the model ranged from .006% (Cox and Snell R^2) to .008% (Nagelkerke R^2), $p = .717$. The results indicated that ACEs does not moderate the relationship between quality of play therapy training and use of CCPT. In other words, ACEs does not strengthen the relationship between quality of play therapy training and use of CCPT.

Research Question 3

The third research question explored how ACEs moderates the relationship between attitudes toward cultural humility and the probability of using CCPT, a moderator analysis was

performed using PROCESS. The outcome variable for analysis was use of CCPT. The predictor variable for the analysis was attitudes toward cultural humility. The moderator variable evaluated for the analysis was ACEs. The interaction between the variables were found to not be statistically significant. Pseudo R^2 values for the model ranged from .007% (Cox and Snell R^2) to .010% (Nagelkerke R^2), $p = .628$. The results indicated that ACEs does not moderate the relationship between attitudes toward cultural humility and use of CCPT. In other words, ACEs does not strengthen the relationship between attitudes toward cultural humility and use of CCPT.

Research Question 4

The fourth research question examined whether there was a difference in use or non-use of CCPT in schools with 50% racially/ethnically minoritized student populations versus 50% non-racially/ethnically minoritized student populations. There was no significant difference between use and non-use of CCPT in schools with 50% racially/ethnically minoritized versus 50% non-racially/ethnically minoritized student populations, X^2 (1, $N = 256$) = .38, $p = .539$.

Of the 155 participant responses, 51 (33%) of 50% racially/ethnically minoritized schools used CCPT, while 104 (67%) did not use CCPT. Of the remaining 101 responses, 37 (37%) of 50% non-racially/ethnically minoritized schools used CCPT, while 64 (63%) did not use CCPT. A total of 88 of participants reported using CCPT across both types of school populations, 50% racially/ethnically minoritized students and non. A total of 168 of participants reported not using CCPT across both types of school populations, 50% racially/ethnically minoritized students and non.

Summary

The first goal of this study was to explore how the relationship between the amount and quality of play therapy training, adverse childhood experiences (ACEs) of the PSCs, and attitudes toward cultural humility are related to the use of play therapy and child-centered play therapy (CCPT) in addressing student's mental health needs among elementary school counselors. The second and third goals were to determine whether ACEs moderates the relationship between the amount and quality of play therapy training and the use of CCPT, as well as, to determine whether ACEs moderates the relationship between attitudes toward cultural humility and the use of CCPT. The fourth and final goal was to explore how the use or non-use of CCPT is different among PSCs who are in schools with 50% racially/ethnically minoritized versus 50% non-racially/ethnically minoritized student populations. Most participants identified as White or Caucasian (78.9%; *n* = 202) and female (66%; *n* = 169). Participants highlighted their use of play therapy (94.9%; n = 243), with child-centered play therapy (*n* = 88) identified as the play therapy orientation most frequently utilized.

The results indicated that there was a significant relationship among the amount and quality of play therapy training, attitudes toward cultural humility, and the use of play therapy, but not ACEs. The results also indicated that there was not a significant relationship among the amount and quality of play therapy training, ACEs, attitudes toward cultural humility, and the use of CCPT. ACEs was not found to moderate the relationships between quality of play therapy training and the use of CCPT, as well as the relationship between attitudes toward cultural humility and the use of CCPT. Lastly, there was no significant difference between use and non-use of CCPT in schools with 50% racially/ethnically minoritized versus 50% non-racially/ethnically minoritized student populations.

CHAPTER V: DISCUSSION

The purpose of this study was to explore how the amount and quality of play therapy training, adverse childhood experiences (ACEs) of the PSCs, and attitudes toward cultural humility are related to the use of child-centered play therapy (CCPT) in addressing student's mental health needs among elementary school counselors. This chapter will provide discussion and conclusions, contributions of the study, limitations of the study, implications of the findings, recommendations for future research and concluding remarks.

Discussion

The discussion section of this study highlights the results of the demographics and each research question. All results are discussed in relation to previous literature and research, followed by implications, limitations, recommendations, and concluding remarks.

Demographics

The data revealed that the participants in this study were predominantly Caucasian or White (78.9%; *n* = 202) females (66%; *n* = 169). The findings show a lack of diversity in the sample, which is consistent with prior studies that also used a sample of elementary school counselors who were majority Caucasian (85.4%) females (91.7%) (Van Horne, 2014). These findings were consistent with the trend found in previous research of elementary school counselors identifying as Caucasian females (Ebrahim et al, 2012; Ray et al., 2005; Shen, 2008; Van Horne, 2014). Most of the participants worked in the urban school setting (53.1%), followed by rural (30.9%). In comparison to Van Horne (2014)'s study, which indicated that most participants worked in the rural school setting (40.1%) followed by suburban (39.1%).

The majority of participants worked in public schools (62.9%; *n* = 161). Though limited to the state of Texas, Shen (2008)'s study explored the reasons that influenced school

counselors' use or nonuse of play therapy in public schools (*n* = 239). Both studies reiterated the prevalence of play therapy use among school counselors in the public-school setting; furthermore, this study extends upon prior research by exploring school types (i.e., public, private, or charter). Most respondents worked in the South region (41.5%; n = 106), similar to previous research by Van Horne (2014) outlining similar findings (53.1%; *n* = 102). Participants' ACE scores in this study ranged from 0 to 10, with a mean score of 4.09 (*SD* = 2.31). In comparison, Chase (2021)'s mean ACE score of 2.76 (*SD* = 2.44) and Felitti et al. (1998)'s original ACE study findings that 25% of participants reported at least two (Felitti et al., 1998). This study provides new findings that outline the occurrence of higher ACE scores among professional elementary school counselors. The results further highlight the need for continued examination of PSCs' ACE scores since this is the first study to examine PSCs' ACE scores and to confirm their prevalence. Participants' scores on the Multidimensional Cultural Humility Scale (MCHS) had a mean score of 4.44 (*SD* = .58), with each question ranging from 1-6. Chase (2021) reported an overall mean score of 74.36 (*SD* = 6.83). The findings from both studies showed that participants had moderately high culturally humble attitudes.

Of the 256 participants, 54.7% identified as being in the age range of 29-39 (*n* = 140), with most of the participants falling in the 4-8 years of experience range (57%; *n* = 148). In comparison with Van Horne (2014), whose average age of respondents were slightly higher at 42.6 years and had a slightly higher average of 10.7 years of experience. The results indicate that more elementary school counselors who use play therapy in schools are a younger age and have had less years of experience. This study defined the amount of play therapy training through a scale to include graduate courses, workshops, etc. versus participants only identifying the number of graduate courses completed. Of the 248 participants who responded, the majority

(39.8%; *n* = 102) reported that they had received substantial training in play therapy, followed by moderate play therapy training (35.9%; *n* = 92), minimal training (19.5%; *n* = 50), and no training (1.6%; *n* = 4). As compared to prior research, Ray et al. (2005) found that 33% of participants had taken at least one course in play therapy, Ebrahim et al. (2012) highlighted that 52% had taken a graduate course in play therapy, and Van Horne (2014) found that 28.6% had taken a graduate course in play therapy. In this study, the majority of participants reported that they currently receive play therapy supervision (62%; *n* = 186), which is a significant difference compared to past research outlining only 2.6% (*n* = 5) who reported receiving play therapy supervision (Van Horne, 2014). The results provide new findings and imply that play therapy supervision has increased over the past decade. This may be due to play therapy supervision having a considerable impact on professional development and clinical practice (Mullen, 2015). This may also be due to the younger age group of PSCs in this study compared to Van Horne (2014) and that younger PSCs may be more inclined to seek play therapy supervision.

The vast majority of respondents indicated that they used play therapy (94.9%; *n* = 243), while only 5.1%, or 13 elementary school counselors reported that they do not use play therapy. These are similar to Van Horne (2014)'s findings that majority of elementary school counselors used play therapy (57.3%; *n* = 110). The results not only support prior research that play therapy is being utilized in the elementary school setting by school counselors, but it also extends the findings by showing the substantial increase in the amount of elementary school counselors who use play therapy.

Of the 256 participants, child-centered play therapy was identified as the play therapy orientation most frequently utilized (34.4%; *n* = 88), followed by cognitive/cognitive behavioral (34.4%; *n* = 88). Lambert et al. (2007) also found that the majority of participants (67%)

identified their primary theoretical orientation as child-centered play therapy. Although one-third of Van Horne (2014)'s sample did not respond to the question of theoretical orientation, the findings showed a predominance of the child-centered approach (53%), followed by solution-focused (34%). These results support and also extend prior findings, suggesting that CCPT is not only used in the school setting by elementary school counselors, but CCPT is more likely to be used compared to other play therapy theoretical orientations. This could be due to the multitude of research that supports CCPT and foundational trainings focusing on CCPT as the foundation of play therapy.

This study utilized the theoretical framework of person-centered/client-centered therapy and play therapy/CCPT. Client-centered therapy has an existential-humanistic lens and focuses on clients as the experts of determining the issues important to them and having the ability to solve their own problems (Kirschenbaum, 1979). There are six necessary conditions outlined as requirements for therapeutic change to occur: client-therapist relationship, congruence, genuineness, unconditional positive regard, empathic understanding, and client perception (Rogers 1957; 1959). This theoretical framework and six conditions align with play therapy and the construct of cultural humility, which both variables (use of play therapy and attitudes towards cultural humility) were found to be correlated in this study. As previously noted, play therapy uses "the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (The Association for Play Therapy, 1997, p. 4). Play therapy relies on the individual and their experiences as they work within the playroom, which is what cultural humility allows PSCs to do, follow the lead of the child and respect their unique cultural background and lived experiences. The results of this study further substantiates and contributes to the importance of PSCs working through these theoretical lenses as it equips

them with culturally humble mindsets and culturally responsive tools to better serve and support all students' social, emotional, and mental health needs in the elementary school setting.

Research Questions

Research Question 1

With regard to the first research question that explored the amount of play therapy training, quality of play therapy training, adverse childhood experiences, and attitudes toward cultural humility and their relationship between the use of play therapy/CCPT among elementary school counselors, two analyses were conducted. The model for use of play therapy was statistically significant, χ^2 (4) = 51.43, $p < .001$, indicating that there were statistically significant correlations among the predictor variables of amount and quality of play therapy training, attitudes toward cultural humility, and use of play therapy among elementary school counselors. In other words, the amount and quality of play therapy training and cultural humility were predictors of play therapy use in elementary schools, while ACEs were not a significant predictor of play therapy use. While ACEs of PSCs were not a significant predictor, this is the first study that has explored PSCs' overall ACE scores and use of play therapy/CCPT. While the literature has outlined increasing rates of ACEs and their detrimental effects on individuals across the lifespan (Metzler et al., 2017; Parker et al., 2021), ACEs were found to not be statistically significant in this study. Some reasons for this may be due to the changing landscape in school counselors being younger in age and may be inclined to implement self-care practices and seek mental health services for themselves. PSCs who have an ACEs background may have an increased sense of empathy and therefore have the ability to create a compassionate culture among the students they serve. The lack of significance could also be due to increased resiliency and protective factors, such as positive childhood experiences (Brown et al., 2022), that combat

potential negative effects of ACEs such as burnout, compassion satisfaction, and secondary traumatic stress. Similar to Chase (2021), the results further highlight the prevalence of ACEs and the importance of ongoing assessment of the impact of childhood trauma on professional school counselors and their work.

This is the first study to date that explored the aforementioned variables and outlined the significant relationship between play therapy training, cultural humility, and use of play therapy. The findings align with research that has outlined play therapy training as an important factor that contributed to school counselor's play therapy use (Ebrahim et al., 2012; Ray et al., 2005; Van Horne, 2014). Van Horne (2014) explored the impact of self-efficacy and effectiveness on using play therapy, the findings indicated that the perceived effectiveness of one's play therapy was the only predictor of play therapy use in elementary schools. This study adds to Van Horne (2014)'s findings of additional predictors (play therapy training and cultural humility) that are related to the use of play therapy among elementary school counselors.

Although Chase (2021) explored different variables (ACEs, attitudes toward trauma-informed care, and cultural humility), cultural humility was a significant predictor of social justice advocacy attitudes among play therapists. This study is the first of its kind to explore elementary PSCs' attitudes toward cultural humility and to find a correlation between the use of play therapy in schools. The findings align with the notion that cultural humility is a beneficial tool in developing PSC's cultural sensitivity and cultural responsiveness. PSCs who have higher cultural humility mindsets may engage in more self-reflection, have increased awareness of biases and openness to diverse cultures. PSCs may be learning and increasing their understanding of the racially/ethnically diverse student populations and families they serve and tailoring their support to meet those unique needs. The use of play therapy with culturally diverse

students has been substantiated; therefore, this study's results of there being a connection between cultural humility and use of play therapy reiterates its appropriateness in the school setting.

Although this study had high rates of PSCs utilizing play therapy and most utilized CCPT, there are barriers to implementing play therapy/CCPT in the school setting by PSCs. A few examples of barriers include a lack of time, budget, space, support from administration, and supervision. While there has been a progression of play therapy training offered over the years, there are still a lack of opportunities and a limited amount of approved centers of play therapy education and universities that offer play therapy instruction according to the Association for Play Therapy's directory (The Association for Play Therapy, n.d.). Additional barriers may include burnout and being stretched thin, especially after the mental health crisis among youth that has ensued due to the pandemic and its aftermath.

The model for use of CCPT was not statistically significant, χ^2 (4) = 1.562, p = .816, indicating that there were no statistically significant correlations among the predictor variables of amount and quality of play therapy training, attitudes toward cultural humility, and use of CCPT among elementary school counselors. In other words, the amount and quality of play therapy training, ACEs, and cultural humility were not significant predictors of CCPT use in elementary schools. The researcher urges caution when interpreting the results of these findings due to the small sample size of those who used CCPT (34.4%; n = 88). As previous research has shown, CCPT is a widely recognized and empirically supported intervention (Bratton et al., 2005; Davis & Pereira, 2014; Landreth et al., 2009; Ray et al., 2015).

Research Question 2

With regard to the second research question that explored how ACEs moderates the relationship between the quality of play therapy training and the probability of using CCPT, the results of the moderator analysis indicated that ACEs does not moderate the relationship between quality of play therapy training and use of CCPT. In other words, ACEs does not impact the relationship between quality of play therapy training and use of CCPT. A reason for this may be due to ACEs not having a significant correlation between use of play therapy and CCPT in this study. Further, ACEs also did not predict the use of play therapy or CCPT among elementary school counselors in this study. The lack of significance of ACEs may again be due to PSCs' utilization of self-care strategies and mental health resources, as well as resilience, and protective factors. There has been no examination of ways in which a counselor's or school counselor's own experience of ACEs may affect their work (Brown et al., 2022; Wheeler et al., 2021; Zyromski et al., 2020). This is significant based on reported information that ACE scores of mental health workers are among the highest in the helping profession (Brown et al., 2022), as well as this study's findings. Brown et al. (2022) suggested that counselors increase their awareness of their own experiences of ACEs, in which this study allowed PSCs to do.

Research Question 3

In terms of the third research question that explored how ACEs moderates the relationship between attitudes toward cultural humility and the probability of using CCPT, the results of the moderator analysis indicated ACEs does not moderate the relationship between attitudes toward cultural humility and use of CCPT. In other words, ACEs does not determine the relationship between attitudes toward cultural humility and use of CCPT. The findings of both the second and third research questions were not surprising since ACEs was found to not be a

significant predictor variable to the use of play therapy and CCPT. The findings could signify ACEs not impacting PSCs' work due to reasons already outlined; however, further research is needed since this is the first study of its kind to examine PSCs' own ACE scores. Since this is the first study to examine PSCs' ACE scores, it begins the conversation around whether ACEs impacts the work and support they provide to students in the school setting.

Research Question 4

The fourth and final research question examined whether there was a difference in use or non-use of CCPT in schools with 50% racially/ethnically minoritized student populations versus 50% non-racially/ethnically minoritized student populations. The results indicated that there was no significant difference between use and non-use of CCPT in schools with 50% racially/ethnically minoritized versus 50% non-racially/ethnically minoritized student populations, X^2 (1, N = 256) = .38, p = .539. The researcher again urges caution when interpreting the results of these findings as the non-significance may be due to the smaller sample size of those who used CCPT, and there being eight other play therapy theoretical orientations to choose from in addition to CCPT. Another reason for these results could be due to some missing data for this particular question on the survey. Some participants did not complete the racial/ethnic distribution of their student population due to not knowing and not providing that information in which could have impacted the results. These results could also mean that if PSCs are trained in play therapy, then they are more likely to use play therapy, regardless to the background, culture, racial/ethnic make-up of the student population. Play therapy/CCPT can be used across cultures and various backgrounds to meet the academic, social/emotional, and mental health needs of all students in the school setting. As previous research has shown, schools with over 50% racially/ethnically minoritized populations utilized child–teacher relationship training

(CTRT) interventions (CCPT skills used by teachers) with these populations (Post et al., 2020; Post et al., 2020; Post et al., 2022).

Implications of the Findings

The findings from this study make several contributions to the existing play therapy literature and highlight implications for professional school counselors, counselor preparation programs, counselor educators, the American School Counselor Association (ASCA), the American Counseling Association (ACA), and the Council for the Accreditation of Counseling and Related Educational Programs (CACREP). While researchers have examined the use of elementary professional school counselor's play therapy use, no research has examined play therapy training (amount and quality) of elementary school counselors, their total ACE scores, and their attitudes toward cultural humility as it relates to play therapy use in schools. Through a logistic regression analysis, a relationship between play therapy training (amount and quality), attitudes towards cultural humility, and use of play therapy emerged.

For PSCs, there are implications regarding training, supervision, and continuing education. Results from this study suggest that it would behoove PSCs to take part in play therapy training courses, workshops, etc. to obtain the training and supervision needed to implement play therapy in the school setting. Additionally, PSCs could seek out education and training focusing on cultural humility to become not only more culturally aware and responsive counselors, but also to increase the probability of using play therapy. Play therapy training can be obtained through university coursework, institute/professional conference trainings, or workshop trainings (Anderson, 2022).

In terms of coursework, PSC could complete an Introduction to Play Therapy course in which they implement play therapy with children and receive peer feedback through

observations of weekly play sessions (Juang et al., 2023). By completing coursework in play therapy, PSCs can gain a deeper understanding of children's social/emotional and behavioral needs, advance their developmentally appropriate skills in working with children, and demonstrate both personal and professional growth (Juang et al., 2023). PSCs could also engage in intensive play therapy workshops that include experiential learning opportunities, similar to Maddox et al. (2023). Play therapy workshops can include lectures, discussions, and brief role-plays focusing on basic play therapy/CCPT skills. Through play therapy training and/or professional development workshops, PSCs' attitudes, knowledge, and skills in play therapy can strengthen. Play therapy training can increase PSCs' confidence and feelings of being better equipped to address and support students' mental health needs in the elementary school setting. The researcher recommends using the Play Therapy Attitudes, Knowledge, and Skills Survey Revised (PTAKSS-R) as a pre and post assessment for child-centered play therapy trainings and workshops.

In terms of counselor preparation programs, this study informs and also reiterates the need to increase the number of play therapy courses and training opportunities provided. As previously noted, there is a scarcity in play therapy training that is provided at universities and within counseling preparation programs (Anderson, 2022; Ebrahim et al., 2012; Jones & Rubin, 2005; Shin & Gonzalez, 2018). Given the results of this study found play therapy training as not only prevalent among participants, but it was also a significant predictor of the use of play therapy, counselor preparation programs could be intentional with offering and allowing play therapy courses to be an elective, as well as a requirement for PSCs who will work with children. Play therapy skills can be taught, encouraged, and supervised during practicum and internship courses and field placement. Play therapy skills will equip PSCs with developmentally

appropriate and culturally responsive practices in supporting student's holistic needs in the school setting (Haas & Ray, 2020; Landreth, 1993; Ray et al., 2015; Ray et al., 2021; Shen, 2016).

Counselor educators can be intentional with incorporating or integrating play therapy training and skill development as they teach and supervise school counselors-in-training. Similar to Landreth (1991), the researcher suggests that adequate training in play therapy include having a master's degree in an area of a helping profession and knowledge of relevant content areas including child development, counseling/psychotherapy, and group counseling. Additionally, they should also (1) experience personal counseling, (2) attain the equivalent of 45 clock hours of instruction in play therapy, (3) apply knowledge/skills in observation and case analysis of typical and maladjusted children, (4) critique sessions of experienced play therapists, and (5) receive supervision by a professional skilled in play therapy (Landreth, 1991). Counselor educators and PSCs can also review the Credentialing Guide for The School Based-Registered Play Therapist™ (SB-RPT; The Association for Play Therapy, n.d.) credential to further understand the recommended amount of adequate play therapy education, training, and experience needed to implement play therapy in the school setting. In this study, PSCs reported having received substantial training in play therapy (39.8%), followed by moderate play therapy training (35.9%), and minimal training (19.5%). The researcher suggests PSCs receive training by completing a couple of workshops, a semester-long course, a certificate, or other extensive formal training.

Since this study provides greater understanding of play therapy/CCPT utilization in elementary schools, it can be used to further advocate for appropriate roles and resources for school counselors, including courses and training in play therapy, as well as Tier 2 and 3

interventions through the Multi-tiered Systems of Support (MTSS). The results of this study did not identify CCPT as statistically significant among the study's variables, which could be due to regardless of the background and racial/ethnic make-up of the student population, if PSCs are trained in play therapy/CCPT, then they are likely to utilize in the elementary school setting. To reiterate, CCPT was identified as the play therapy orientation most frequently utilized among participants, signifying the prevalence of CCPT use across all school types, settings, regions, and types of student populations in the elementary school setting. Furthermore, there is still evidence highlighting CCPT is an appropriate, relevant, and culturally sensitive intervention in addressing elementary aged children's diverse background, behavioral issues, and presenting concerns (Haas & Ray, 2020; Landreth, 1993; Ray et al., 2015; Ray et al., 2021; Shen, 2016). Additionally, the implementation of CCPT in the school setting is an effective way to address barriers to mental health needs for racially diverse children (Ray et al., 2021). As noted by Landreth (1993), CCPT can aid in addressing children experiencing abuse, depression, divorce, dependency, learning disabilities, lack of self-control, socially inappropriate behavior, regressive behavior, physical disabilities, and many other issues. Through the use of CCPT, culturally inclusive principles can be effectively implemented (Ray et al., 2021). In addition, the use of CCPT can be utilized as an intervention for academic achievement (Blanco et al., 2019b; Post et. al, 2019; Ray et al., 2005; Ray et al., 2015) and it is a significant tool for PSCs to implement through a comprehensive school counseling program (Blanco et al., 2019b).

The results of this study highlight the need for professional organizations such as ASCA, ACA, and CACREP to be intentional in supporting and providing training in play therapy/CCPT. In doing so, school counselors will be equipped with developmentally appropriate and culturally responsive practices in meeting racially/ethnically minoritized student's holistic needs in the

school setting. An actionable step is to make play therapy courses or training a requirement for school counselors who work with children or incorporate play therapy modules for in-house trainings. Also, play therapy training can be added within CACREP standards, and more training opportunities can be made available through ASCA and ACA.

Limitations of the Study

There are several limitations of this study to acknowledge, including social desirability, generalizability, lack of sample diversity, ACE-Q reliability, small sample size of CCPT users, and response rate. The data collected in this study was self-reported, therefore, social desirability is a limitation in that participants have provided more socially desirable answers that reflect them more positively. In terms of generalizability, the study's results cannot be generalized to all professional school counselors, such as PSCs who are not on the APT mailing list, Facebook, LinkedIn, CESNET-L listserv, and non-elementary school counselors. To add, generalizability is limited based on the convenience, volunteer sampling that could create a biased sample where only professional elementary school counselors who worked in schools and used play therapy/CCPT were pursued.

The researcher disseminated the survey through various methods previously noted, however, the participants' demographics were not diverse, which is similar to prior play therapy studies (Ebrahim et al, 2012; Chase, 2021; Ray et al., 2005; Shen, 2008; Van Horne, 2014). This limitation highlights the limited diversity among PSCs who work in elementary schools and use play therapy, signifying further efforts should be made to increase the diversity among professional elementary school counselors.

A limitation of the ACE-Q survey is that the overall reliability is moderate and not high. The ACE-Q was employed because it derives from seminal research on trauma and traumatic

experiences. The ACE-Q is typically used as a screening tool, and not an assessment tool; further, it is used to identify the prevalence of trauma and traumatic experiences, not the degree of trauma. Future research could continue to use ACE-Q to further assist with reliability and validity of the instrument. There was a small sample size of participants who used CCPT, which could have impacted the results of there not being a statistically significant relationship between use of CCPT, play therapy training, and attitudes toward cultural humility.

The final limitation of this study was the overall response rate. While over 47.3k recruitment messages were sent by various means, only 256 participants consented and responded to the survey, and 243 participants fully completed the survey. One reason for this could be data collection occurred during the summertime, which school counselors are on summer break from working and may not be inclined to check emails or complete surveys. Though the study had several notable limitations, the results provide a foundation for future research studies on PSCs and play therapy/CCPT use.

Recommendations for Future Research

The results of this study provide a starting point and raises inquiry for future research on factors related to the use of play therapy/CCPT among PSCs. Researchers could conduct more studies focused in these areas due to the prevalence of play therapy use in schools and the limited research on PSCs. One suggestion is to examine other dependent variables such as perception of effectiveness and use of play therapy, similar to Van Horne (2014)'s study, or including the Play Therapy Attitudes, Knowledge, and Skills Survey Revised (PTAKSS-R) as Anderson (2022)'s study did to examine the relationships between professional development and attitudes, knowledge, and skills in play therapy among professional elementary school counselors. Similar to Shen (2016), the researcher suggests implementing more empirical studies that examine the

cross-cultural use of play therapy by school counselors to better serve the rapidly growing racially/ethnically minoritized student populations in schools.

Further research could continue to explore play therapy training and also play therapy supervision as these were highlighted in the literature as being important factors related to the use of play therapy/CCPT. Similar to Placeres et al. (2022)'s recommendation, the researcher suggests addressing school counselor's training needs at each level of P-12 with developmentally responsive approaches, including the use of play therapy/CCPT. Though ACEs were not found to be statistically significant in this study, the results still highlight the presence and prevalence of adverse childhood experiences and the essentialness of assessing their impacts on PSCs. It is recommended that future research continue to explore ACE scores and use of play therapy/CCPT among PSCs since this is the first study of its kind to do so.

In addition to play therapy training, attitudes toward cultural humility and the use of play therapy among elementary school counselors should be explored further since this is the first study to date that examines these areas. Researchers could also focus on qualitative studies to examine PSCs' lived experiences of play therapy utilization in the school setting. Additional research could explore how counselor preparation programs are addressing and incorporating play therapy training and cultural humility with school counselors-in-training. Researchers could implement more intentional strategies to recruit diverse participants by collaborating with entities such as the Black Play Therapy Symposium or Black Mental Health Symposium. Lastly, future research could include other mental health professionals who provide play therapy in schools (i.e., CMHC, social workers, psychologists, LMFT, school-based clinicians, etc.) to increase overall sample size and compare the findings among the different professionals, including PSCs.

Concluding Remarks

With the continued increase in cultural diversity in the United States' population and the increase in overall diversity of students in school setting, it is imperative that student's mental health needs are addressed. Many of the urgent and intensive mental health, academic, and behavioral needs of children are first recognized and addressed in the school setting. PSCs in the elementary setting are charged with addressing and supporting the ongoing social/emotional, behavioral, academic, and mental well-being of students. PSCs can approach these needs through play therapy/CCPT. Child-centered play therapy (CCPT) is a widely recognized, empirically supported, and a promising evidenced-based mental health intervention (Bratton et al., 2005; Davis & Pereira, 2014; Landreth et al., 2009; Ray et al., 2015; The Title IV-E Prevention Services Clearinghouse, 2022; Trice-Black et al.; 2013). Further, CCPT is a culturally sensitive and developmentally appropriate approach (Bratton, 2010; Landreth et al., 2009; Post et al., 2019; Ray et al., 2015; Van Horne et al., 2018) in treating racially/ethnically minoritized student populations.

The benefits and effectiveness of play therapy in elementary schools are widely known, therefore, it is essential that factors related to using play therapy/CCPT in schools are further explored and understood. When PSCs are provided with play therapy training, as well as training in culturally humility, they are better equipped with culturally responsive skills and tools to effectively serve and support all students in the school setting, including racially/ethnically minoritized student populations and young students; additionally, play therapy training and cultural humility increases the probability of their implementation of play therapy. The aim of this study was to add to the gaps and existing literature on PSCs, their play therapy training, ACEs, cultural humility, and use of play therapy/CCPT. This study and future research provides

greater understanding of ways that professional school counselors can best serve student's mental health and overall needs in the elementary school setting.

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APPENDIX A: MENTAL HEALTH RESOURCES FOR PARTICIPANTS

MentalHealth.gov

https://www.mentalhealth.gov/

Mental Health America

https://mhanational.org/

988 Suicide & Crisis Lifeline

https://988lifeline.org/

Dial 988 for immediate assistance

The Jed Foundation

https://jedfoundation.org/resource/how-to-cope-with-psychological-trauma/

Veterans Crisis Line

https://www.veteranscrisisline.net/

National Alliance on Mental Illness (NAMI)

https://nami.org

1- 800-950-6264

Substance Abuse and Mental Health Services Administration (SAMHSA)

https://www.samhsa.gov

1-800-662-4357

Samaritans

1-877-870-HOPE (4673)

APPENDIX B: INTRODUCTORY LETTER

Dear Professional School Counselor,

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. Sejal Parikh Foxx.

My dissertation study is on factors related to the use of child-centered play therapy among professional elementary school counselors. Specifically, this study aims to explore how play therapy training (amount and quality), adverse childhood experiences, and attitudes toward cultural humility among elementary school counselors are related to the use of child-centered play therapy in addressing the mental health needs of elementary-aged children.

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

- You are a licensed/certified or provisionally licensed/certified Professional School Counselor, and
- You work in an elementary school

If you meet these criteria, I invite you to complete a 15-minute online survey. The survey will ask questions about your work as a school counselor and play therapy training, self-report (total score only) of potentially adverse events and experiences in participants' lives, and interpersonal dimensions of cultural humility. Your participation is entirely voluntary, and your responses will be confidential. You may choose to leave the survey at any time with no explanation.

We also ask you to pass this email to someone you think is eligible to participate in this study.

If you decide to participate in this study, please read the electronic informed consent (attached), and proceed by clicking the link below to access the online survey. Proceeding to the survey (choosing Agree), indicates consent to participate.

Survey Link: https://surveys.qualtrics.charlotte.edu/jfe/form/SV_e9RD1t4Jl2VxdxI

Thank you in advance for your participation. The results may increase attention to the need for more play therapy/child-centered play therapy training within counselor preparation programs to equip school counselors with effective, developmentally appropriate, and culturally responsive practices in meeting elementary student's needs. If you have any questions, please contact me or my dissertation chair.

Warmly and with Gratitude,

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APPENDIX C: INFORMED CONSENT

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

Consent to Participate in a Research Study

Title of Project: *Exploring Factors Related to the Use of Child-Centered Play Therapy among Elementary School Counselors*
Principal Investigator: Sheree Harper, Doctoral Candidate, Dept of Counseling, UNC Charlotte
Dissertation Chair: Dr. Sejal Parikh Foxx, PhD, Professor, Dept of Counseling, 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 to participate. If you have any questions, please ask.

Important Information You Need to Know

- The purpose of this study is to explore factors related to the use of child-centered play therapy among professional elementary school counselors.
- You may withdraw from the study at any time.
- There will be no personal identifying data collected such name and email addresses in order to complete the survey. Your answers are completely confidential and cannot be identified to you specifically.
- We will be collecting demographic information.
- We ask participants to complete a brief survey assessing their background as a school counselor, play therapy use and training, history of adverse childhood experiences, and their attitudes related to cultural humility. The survey can be completed in approximately 15 minutes and can be done on any device with access to the internet.

Why are we doing this study?

The purpose of this study is to explore how play therapy training, adverse childhood experiences, and attitudes toward cultural humility are related to the use of child-centered play therapy among school counselors who support the mental health needs of students in elementary schools. Results may inform participants of their training needs. They may inform counselor preparation programs to provide play therapy courses, as well as highlight the need for professional organizations (i.e., ASCA, ACA, CACREP, etc.) to support and provide training in play therapy/CCPT to meet the needs of students in the elementary setting.

Why are you being asked to be in this research study?

You are being asked to be in this study because you are a licensed/certified or provisionally licensed/certified Professional School Counselor, and work in an elementary school.

What will happen if I take part in this study?

If you choose to participate, you will complete an online survey. There are no other requirements. We will collect your demographic information. You will take the one survey. Participants will be asked about their work as a school counselor and their play therapy training. Questions will also include self-report (total score only) of potentially adverse/traumatic events and experiences in participants' lives before the age of 18. There will also be questions measuring interpersonal dimensions of humility as it relates to individuals' cultural backgrounds and experiences. Your total time commitment if you participate in this study will be approximately 15 minutes.

What benefits might I experience?

You may develop deeper awareness of factors (i.e., play therapy training, ACEs, and cultural humility) influencing your use of play therapy as an elementary school counselor. Research will inform the counseling field and hopefully lead to more play therapy training within counselor preparation programs to equip school counselors with effective, developmentally appropriate, and culturally responsive practices in supporting student's holistic needs. A greater understanding of play therapy/CCPT utilization in elementary schools can be used to further advocate for appropriate roles and resources for school counselors.

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 have had as a child that includes household dysfunction, abuse, or neglect. Should you feel discomfort, resources have been made available to you on a separate page at the end of the survey. Participants can stop and close the survey at any point.

How will my information be protected?

There will be no personal identifying data collected such as name and email addresses in order to complete the survey. When you access the survey, we will not collect any information that can identify you as the survey taker. Emails of participants who wish to be included in the drawing for an Amazon gift card will be obtained through a Google form and will be separate from the survey data. Email addresses will be deleted once the drawing is complete.

How will my information be used after the study is over?

After this study is complete, study data may be shared with other researchers for use in other studies without asking for your consent again or as needed for other studies from this data set. The data will NOT include information that could identify you.

Will I receive an incentive for taking part in this study?

Participants who complete the surveys who have decided to be included in the drawing will be entered into a drawing for a $20.00 Amazon gift card. Ten gift cards will be given away.

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.

Who can answer my questions about this study and my rights as a participant?

For questions about this research, you may contact Sheree Harper, sharpe15@charlotte.edu or Sejal Parikh Foxx at sbparikh@charlotte.edu. 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 704-687-1871 or uncc-irb@charlotte.edu.

Electronic Consent to Participate

By Clicking the arrow below, you acknowledge that you: (1) are a licensed/certified or provisionally licensed/certified Professional School Counselor, and (2) work in an elementary school, have read this consent form, have understood the above information, and agree to voluntarily participate in this research.

"I Agree"

Begin Survey

APPENDIX D: ADAPTED QUESTIONNAIRE ELEMENTARY SCHOOL COUNSELOR PLAY THERAPY SURVEY (Van Horne, 2014)

Instructions: Please complete the survey as completely as possible. There are no right or wrong answers.

YOUR WORK AS A SCHOOL COUNSELOR

1. How many years of paid school counseling experience do you have? _____ years

2. Do you use play therapy in your work at your school? Yes or No

a. If yes, **have you conducted at least 4 play therapy sessions in the past year?** Yes or No

3. How many hours per week do you use individual counseling, other than play therapy, at your school? _____hours/week

4. What is the percentage racial/ethnic distribution of students at this school setting? (The total for all categories combined should equal 100%)

African American/Black ____%

American Indian or Alaska Native or Indigenous _____%

Asian or Pacific Islander _____%

Biracial or Multiracial _____%

Caucasian/White _____%

Hispanic/Latinx _____%

Other _____% [_____]

5. Identify the play therapy theoretical orientation you *most frequently* use (select one)?

Child-centered

Jungian

Eco-systemic

Theraplay

Cognitive

Solution Focused

Other [_____]

PERSONAL INFORMATION

6. Are you a currently a practicing Elementary School Counselor? Yes or No

7. Indicate the state you work in: _____ (Dropdown list)

8. Indicate what setting you work in: Urban, Rural, or Suburban

9. Indicate what type of school you work in: Public Private Charter

10. What is your age: _____ (Dropdown of age ranges)

11. What is your gender?

Male

Female

Non-binary

Transgender Female

Transgender Male

Other [_____]

12. What is your race/ethnicity?

African American/Black
American Indian or Alaska Native or Indigenous
Asian or Pacific Islander
Biracial or Multiracial
Caucasian/White
Hispanic/Latinx
Other [_____]

PLAY THERAPY EDUCATION/TRAINING INFORMATION

13. Please indicate the extent of training you have received specific to play therapy.

- o No training
- o Minimal training (e.g., one workshop, seminar, and/or in-service training)
- o Moderate training (e.g., a couple of workshops)
- o Substantial training (e.g., multiple workshops, semester-long course, certificate, other extensive formal training)

14. Please indicate the quality of your overall play therapy training.

Rate the quality of training from bad to good.

Bad Good

0 1 2 3 4 5 6

Rate the quality of training from weak to strong.

Weak Strong

0 1 2 3 4 5 6

Rate the quality of training from partial to thorough.

Partial Thorough

0 1 2 3 4 5 6

Rate the quality of training from shallow to deep.

Shallow Deep

0 1 2 3 4 5 6

15. Do you currently receive play therapy specific supervision?

Yes No

16. With regard to receiving play therapy supervision, what is/was your experience?

Bad Good
0 1 2 3 4 5 6

Negative Positive
0 1 2 3 4 5 6

Weak Strong
0 1 2 3 4 5 6

Hard Easy
0 1 2 3 4 5 6

Passive Active
0 1 2 3 4 5 6

Tense Relaxed
0 1 2 3 4 5 6

APPENDIX E: ADVERSE CHILDHOOD EXPERIENCES QUSETIONNAIRE

Total ACEs score (possible 0-10) from the following page.

Read the following questions. Count the **total number** of "**Yes**" **responses** and enter that number at the end of this assessment.

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**… **Yes** **No**

   - 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?

2. Did a parent or other adult in the household **often**… **Yes** **No**

   - Push, grab, slap, or throw something at you? **OR**
   - **Ever** hit you so hard that you had marks or were hurt?

3. Did an adult or person at least 5 years older than you **ever**… **Yes** **No**

   - 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?

4. Did you **often** feel that… **Yes** **No**

   - 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?

5. Did you **often** feel that… **Yes** **No**

- 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?

6. Were your parents **ever** separated or divorced? **Yes** **No**

7. Was you mother or stepmother: **Yes** **No**

- **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**
- **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 here: _____.**

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: 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 has 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.