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How Play Therapists Integrate Knowledge of Attachment Theory Into Clinical Practice:

A Grounded Theory

A Dissertation

Submitted to the Graduate Faculty of the
University of New Orleans
in partial fulfillment of the
requirements for the degree of

Doctor of Philosophy
in
Counselor Education

By

Karen Swanson Taheri

B.J., University of Texas at Austin, 2006
M.A., University of Texas at San Antonio, 2009

March 2015

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To Kevin, thank you for your consistent love, friendship, and support. Thank you for making sure you were available to care for baby George while I was driving long distance to campus or spending hours upon hours on various projects! Thank you for emboldening me to take risks. Your belief in my ability to achieve my dreams is a true gift.

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Dedication

I dedicate this dissertation to the Georges in my life... my father, my brother, and especially my son. Dad ("Paw"), I am so grateful that you were my father. You shaped me and inspired me more than I am capable of describing. You taught me firsthand the excitement and power of learning through exploration. Thank you for being a secure base and for encouraging me to adventure. Chuck (George Charles, Jr.), I maintain that some of the most interesting conversations in my life have been with you. You are patient, kind, intelligent, and have inspired me to have courage in relationships. To my baby George Ocean, I love you forever. I look forward to watching you grow and am elated to be a secure base and safe haven for you. I can't wait to see how our adventures in life unfold! Every day I wake up and think it is impossible to love you more, and each night I am surprised that by the time I fall asleep I've grown to love you even more. I believe you are making my heart expand! You are my sun, my moon, my stars, my everything.

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Abstract

The quality of the dynamics within individuals' early relationships with their caregivers can impact the overall mental health, functioning, and quality of future relationships for those individuals (Aguilar, Sroufe, Egeland, & Carlson, 2000; Bowlby, 1988; Carlson, 1998; Cassidy & Shaver, 2008; Deklyen & Greenberg, 2008; Johnson & Whiffen, 2003; Levy & Orlans, 1998; Ogawa et al., 1997; Renken et al., 1989; Warren, Huston, Egeland, & Sroufe, 1997). Attachment Theory describes the nature, characteristics, and dynamics of the relationship between a child and caregiver, and delineates how an internal concept of self and self and others is created via those relationships (Bowlby, 1988; Brisch, 2011; Levy & Orlans, 1998; Solomon & George, 1999). Assessing for and addressing attachment issues early in life, and helping to establish a secure base for a child, can serve as a preventative measure for thwarting a variety of interpersonal and self-concept issues (Bowlby, 1988; Martin, 2005; Morisset et al., 1990; Rutter, 1987). Several play therapy interventions for addressing attachment issues exist, yet no framework existed to describe how theoretical knowledge of Attachment Theory may be integrated into clinical practice from initial contact through termination. The purpose of this research was to generate a framework that explored and described how play therapists integrated knowledge of Attachment Theory within their treatment planning. The constructed framework may be used by educators, play therapists and families to conceptualize the play therapy process from an attachment-based perspective.

Key words: attachment theory, play therapy, treatment planning, clinical practice

CHAPTER ONE

INTRODUCTION

Background

All mammals play (Brown & Vaughan, 2009). The importance of human play has been deliberated for centuries. Plato stated, “You can discover more about a person in an hour of play than in a year of conversation” (Association for Play Therapy, APT, 2014a). Engaging in play behaviors contributes to the overall development of the brain, as well as cognitive and social abilities, across many animal species (Brown & Vaughan, 2009). In humans, play offers a variety of therapeutic benefits. Schaefer (2013) referred to those benefits as the “therapeutic powers of play,” which include self-expression, access to the unconscious, direct and indirect teaching, catharsis, abreaction, counter-conditioning of fears, positive emotions, stress inoculation and management, therapeutic relationship, attachment, empathy, social competence, resiliency, creative problem solving, moral development, psychological development, self-regulation, and self-esteem (p. xiv). Play has been used in mental health professions for several decades and has evolved into a specialized form of therapeutic intervention referred to as play therapy (Kottman, 2013; Landreth, 2012; Ray, 2011; Schaefer, 2013). According to the APT (2014b), play therapy is defined 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. (p.1)

Play therapy is a therapeutic modality through which a variety of presenting issues may be addressed (Kottman, 2001; Landreth, 2012; Schaefer, 2003a, 2003b). Although some children and adolescents may choose to verbally communicate their concerns, play is considered to be

“the natural medium of communication” of the child (Landreth, 2012, p.9). Play therapy, whether the child or adolescent decides to speak or not, is considered a developmentally appropriate approach (Drewes, 2006; Landreth, 2012; Ray, 2011). Play therapy is primarily utilized with children and adolescents, but may also be used with adults (Kottman, 2001; Landreth, 2012; Schaefer, 2003b; Suri, 2012; Turner, 2005). There are also several existing techniques and methods within play therapy to enhance familial relationships, such as theraplay, filial therapy, and family play therapy (Kottman, 2001; Landreth, 2012; Parker, 2012; Schaefer, 2003a).

Children are influenced by their environments and their primary relationships; therefore, it is beneficial to work with a child’s caregivers when providing services to that child (Dugan, Swanson, & Short, 2011; Landreth & Bratton, 2006; Ray, 2011). Play therapists work with caregivers to strengthen the child-caregiver relationship, which in turn enhances therapeutic outcomes (Bratton, Ray, Rhine, & Jones, 2005). Some play therapists choose to engage the caregivers through ongoing consultation sessions or directly within the play therapy sessions. Other play therapists believe the therapeutic relationship can serve as the foundation for repairing and rebuilding an individual’s patterns of relating with others, thereby changing the dynamics within existing relationships for that child without directly engaging the caregiver in sessions. The importance of working with caregivers, when working with children, is further illuminated through an Attachment Theory lens.

Human infants are extremely vulnerable and are completely dependent on their caregivers for survival. A newborn cannot hold its head up without assistance and certainly cannot feed itself, create a warm environment for itself, or protect itself from predators. The infant relies on the caregiver to provide for all basic needs, including emotional needs.

Attachment Theory, developed by Bowlby (1969), describes the importance of, and the dynamics within, the child-caregiver relationship. Based on the consistency and quality of the caregiver's responses to the child, as well as internal factors within the child, the early child-caregiver relationship primes the child for future relationships. In general, Attachment Theory describes two potential styles for the child's development of concept of self and self and others: secure and insecure. A secure child is more likely to perform well in school, trust others, and engage in satisfying relationships in the future (Levy & Orlans, 1998).

Statement of the Problem

The quality within the dynamics of individuals' early relationships with their caregivers can impact the overall mental health, functioning, and quality of future relationships for those individuals (Aguilar, Sroufe, Egeland, & Carlson, 2000; Carlson, 1998; Cassidy & Shaver, 2008; Deklyen & Greenberg, 2008; Johnson & Whiffen, 2003; Levy & Orlans, 1998; Ogawa et al., 1997; Renken et al., 1989; Warren, Huston, Egeland, & Sroufe, 1997). Attachment theory describes the nature, characteristics, and dynamics of the relationship between a child and his or her caregiver, and delineates how an internal concept of self and self and others is created via those relationships (Bowlby, 1988; Brisch, 2011; Levy & Orlans, 1998; Solomon & George, 1999). Assessing for and addressing attachment issues early on, and helping to establish a secure base for a child, can serve as a preventative measure for thwarting a variety of interpersonal and self-concept issues (Bowlby, 1988; Martin, 2005; Morisset et al., 1990; Rutter, 1987). Researchers have demonstrated that engaging caregivers within the play therapy process enhances therapeutic outcomes (Bratton, Ray, Rhine, & Jones, 2005). Ryan and Bratton (2008) stated, "Attachment Theory and research is a well established framework for understanding children's normal and atypical social/emotional development. It is used extensively by clinicians

to design interventions, understand interactions, and assess clinical progress" (p. 28). Haslam and Harris (2011) reported a deficit in knowledge "about what beliefs and attitudes drive the practice decisions of play therapists around their work with families" (p.52). Play therapists reported a perceived lack of training and competency in family systems based play therapy interventions and claimed what is missing from current play therapy research is an understanding of the "concrete application of Attachment Theory from assessment to treatment" (Parker, 2012, p. 114).

Significance of the Study

Establishing a secure base for a child early in life can serve as a preventative measure and can decrease mental health and social issues later in life (Aguilar, Sroufe, Egeland, & Carlson, 2000; Carlson, 1998; Cassidy & Shaver, 2008; Deklyen & Greenberg, 2008; Johnson & Whiffen, 2003; Levy & Orlans, 1998; Ogawa et al., 1997; Renken et al., 1989; Warren, Huston, Egeland, & Sroufe, 1997). Play therapists primarily provide services to children and their families, yet little is known about the beliefs that motivate and drive their practices of including family members within treatment (Haslam & Harris, 2011). The APT (2012) Best Practices guidelines for play therapists encourage the use of treatment plans, and updating clients and their families according to those treatment plans, for play therapy services rendered. Ray (2011) discussed the importance of tracking progress within and across sessions to provide timely updates to caregivers throughout the play therapy process.

Purpose

The purpose of this research study was to explore and describe how play therapists integrated Attachment Theory within their clinical practice. I developed a framework grounded in data obtained that may serve as a guide for play therapists interested in integrating Attachment

Theory within their clinical practice. I co-constructed this framework with data obtained from participants. This framework can also be used to conceptualize the process of change for the play therapist, as well as the caregivers involved in treatment. Potential barriers to integrating Attachment Theory within clinical work were identified. The final framework, or grounded theory, that was developed may serve as a guide for play therapists and caregivers to conceptualize the change process from an Attachment Theory perspective.

Conceptual Framework

According to Charmaz (2014), the “literature review and theoretical framework are ideological sites in which you claim, locate, evaluate, and defend your position” (p. 305). For the purpose of studying the process of how play therapists with knowledge of Attachment Theory integrate such knowledge into their clinical practice, the study was ideologically situated within a conceptual framework that combined aspects of Attachment Theory, Social Constructivist Theory, and the Play Therapy Dimensions Model.

Attachment Theory

Attachment Theory, formulated by Bowlby (1969), posits that the quality of early childhood relationships between a child and her or his caregivers effects that child’s development of a self-concept, quality of future relationships across the lifespan, and several other areas of functioning (Cassidy & Shaver, 2008; Johnson & Whiffen, 2003; Levy & Orlans, 1998). An individual’s attachment style may be categorized as falling on a continuum ranging from secure to insecure. Enhancing the child-caregiver relationship, thus establishing a more secure attachment style early in life, can provide a secure base from which the child can develop a positive sense of self and others.

Attachment Theory was utilized in data gathering and data analysis for this research study to inform me regarding the content of questions to ask during semi-structured interviews, as well as to determine which portions of the data obtained from the participants were Attachment Theory based. I paid attention to any disclosures about engaging caregivers within the play therapy process, signs that Play Therapists looked for to determine whether or not a child is presenting with a more secure or insecure attachment style, and how Play Therapists chose to approach children and their families through clinical intervention based on their attachment style. To generate the practice-based theory of the decision-making process that Play Therapists used to incorporate Attachment Theory into their practice, it was necessary to understand and clearly delineate which portions of the data were attachment-based. To my knowledge, no theory existed prior to this research that provided information on how Attachment Theory may be integrated from initial contact through termination within the play therapy process. Thus, I hoped the results of this study might enhance the applicability of Attachment Theory within play therapy clinical practice.

Social Constructivist Theory

Social constructivist theory, particularly the frameworks ideologically associated with the theoretical concepts of Vygotsky (1978), purports that reality is individually constructed within the context of social relationships, one's environment, and one's experiences. No single reality is thought to exist from this perspective, as all realities are created within each individual in relation to the person's context. Reality is not viewed as static; rather, it is continuously and collaboratively constructed through "collective subjectivity" (Hua Liu & Matthews, 2005, p.392).

The process of treatment planning, broadly defined as the incorporation of knowledge into clinical practice, involves the therapist's perception of reality, as well as the client's perceptions of reality. A treatment plan, or plan for the therapy process, involves social co-construction between the therapist and the client. Both provide information to one another and together they determine mutually set goals for the therapeutic process. In other words, they co-construct their reality for the play therapy process and this plan is re-assessed, updated, and re-constructed periodically as change occurs across the entire play therapy process. In this study, attention was paid to the therapist's knowledge gained through previous education as well as social interaction with the client, or "collective subjectivity," (Hua Liu & Matthews, 2005, p.392) and how such knowledge informed the play therapists' clinical practice from an Attachment Theory perspective.

Play Therapy Dimensions Model

Yasenik and Gardner (2012) developed the Play Therapy Dimensions Model (PTDM), based on their clinical practice, to serve as a treatment planning and decision-making guide for integrative play therapists. The PTDM can be broken down into two primary dimensions: consciousness and directiveness. Yasenik and Gardner (2012) described four quadrants that are created when the continuums of consciousness and directiveness are intersected perpendicular to one another. Those four quadrants are labeled as "active utilization," "open discussion and exploration," "non-intrusive responding," and "co-facilitation." A play therapist utilizing the PTDM conceptualizes the process of integration based on the quadrant within which the client's needs and the therapists' orientation exist. The model may be used across all theoretical orientations and allows the play therapist to monitor treatment progress and changes. Movement across the quadrants is not considered necessary to indicate progress and therapeutic change.

Yasenik and Gardner (2012) also consider the play therapist's primary theoretical orientation, the client's needs and presenting issues, and the therapeutic powers of play that might be engaged to best address the client's concerns. For the purposes of this study, I focused on understanding the play therapists' primary theoretical orientation and how this orientation shaped and drove play therapists' clinical practice and choices for integration of Attachment Theory, how and when the therapeutic power of attachment was incorporated into practice, and the play therapists' conceptualization of the clients' needs and presenting issues within and across the play therapy treatment process. I used portions of the PTDM as a conceptual guide to describe and monitor the process of change reported within and across play therapy sessions by participants. Specifically, I focused on Yasenik and Gardner's (2012) questions of what (which quadrant the play therapist is practicing within), how (the "therapeutic roles and activities," p. 100), who ("clinical applications," p. 108), and when "considerations for the play therapy process," p. 106) in conceptualizing participants' reports to better understand their treatment planning and decision-making processes.

Research Questions

To discover the process of how play therapists are integrating their knowledge of Attachment Theory within their clinical practice, it was important to understand their decision-making process firsthand. Without an understanding of how a play therapist moved from thinking about Attachment Theory to using it in clinical practice, there was no understanding of how the theoretical knowledge was applied. Understanding the decision-making process helped link thinking to the application of knowledge. A qualitative methodology allows for individual participants to share their experiences. The hope was that from that sharing, patterns and themes would emerge in how those participants integrated their knowledge of Attachment Theory.

Those themes were linked and described to show the overall process of integration, as it occurred among participants. Thus, the primary research question was: How do play therapists who have knowledge of Attachment Theory integrate that knowledge into their clinical practice?

Several sub-questions were also explored. These sub-questions were: What is the decision-making process behind integrating Attachment Theory into play therapy clinical practice from initial contact through termination? How do play therapists define and describe the stages of integration of Attachment Theory in their clinical practice? What barriers, if any, do play therapists perceive as hindering integration of Attachment Theory into clinical practice? Gaining insight into potential barriers that play therapists face in incorporating an attachment theoretical approach to practice is essential to understanding why some play therapists may choose not to, or be unable to, integrate Attachment Theory into their clinical work.

Overview of Methodology

Grounded theory is a methodology that may be used to explore and describe a process. (Creswell, 2013). According to Creswell (2013), “participants in the study would all have experienced the process, and the development of the theory might help explain practice or provide a framework for further research” (p. 83). Although several schools of thought exist regarding how grounded theory research is best conducted, Charmaz (2014) described constructivist grounded theory as providing an opportunity for the theoretical framework to emerge from data and as ultimately co-constructed by the researcher and participants. The notion that the researcher is completely free from bias is considered a falsity, as the researcher is entering the research process with previously gained knowledge, values, and life experiences that can and do shape the researcher’s perspective. The researcher’s previous knowledge and experiences, or bias, is not viewed in a negative light. Rather, it is considered a valuable tool that

can assist in informing the researcher's approach to co-constructing the grounded theory in conjunction with participants (Charmaz, 2014). In chapter three of this document, I discuss my bias and how it informed my approach to this research. "The researcher focuses on a process or an action that has distinct steps or phases that occur over time" (Creswell, 2013, p.85). The process is further illuminated through the development of the theoretical explanation for the movement within that process. Thus, identifying a gap in the literature includes deciphering a process, or action, that is in need of further explanation. In this study, I sought to explore and describe the process of how play therapists with knowledge of Attachment Theory integrated such knowledge within their treatment planning. The use of grounded theory methodology allowed for the exploration of play therapists' beliefs and thoughts behind incorporating an Attachment Theory perspective into their clinical work.

A screening survey was used to determine which participants met the following requirements for research participation: had knowledge of Attachment Theory, perceived self as integrating Attachment Theory within clinical practice, and held the Registered Play Therapist or Registered Play Therapist Supervisor credential. The use of these requirements ensured the participants had the knowledge and experience to contribute to the development of the grounded theory. The initial round of semi-structured interviews was completed with seven participants via videoconferencing technology and telephone. Each participant was notified that there may be several rounds of interviews. Participants were asked to participate in follow-up interviews, as needed, to fill in any gaps within the emergent categories and theoretical framework. The sample size was determined by the number of participants and interviews needed for data saturation to occur. The stages of data analysis consisted of initial coding, focused coding, deciphering of categories, and construction of the theoretical framework or grounded theory through linking

categories. A framework grounded in data was co-constructed; that framework described how participants integrated Attachment Theory within their treatment planning.

Assumptions of the Study

I assumed that all participants in the study were honest and forthcoming in their reports. There were no incentives provided, no attempts were made to sway participants to answer in any specific manner, and I assumed participants were trustworthy in their responses to interview questions. I also assumed that participants who reported they had education in Attachment Theory and perceived themselves as integrating Attachment Theory within their clinical work were knowledgeable enough to provide insightful responses for participating in co-construction of the grounded theory.

Limitations and Delimitations

Limitations of this research study were the sole qualitative focus in data gathering, the subjectivity of data obtained, and the researcher's bias. The use of only qualitative data within the study limited the generalize ability of findings and may have limited the applicability of findings across diverse practitioners and clientele. The use of semi-structured interviews and a small number of practitioner perspectives in construction of the grounded theory led to subjectivity in data obtained. A limitation in using only highly subjective data to generate the theory was that perspectives used may not apply beyond the participants of this study. Further research of the theoretical framework constructed will need to occur to determine the applicability of the framework across diverse practitioners and clientele. The researcher's own experiences and bias shaped the manner in which the research was conducted. While I will attempted to openly disclose my own assumptions and experiences that may have shaped the research process, it was impossible to disclose every single experience and subjectivity that

informed my perceptions. Thus, researcher subjectivity was a limitation of this study and also hindered the ability of the research to be precisely replicated.

Delimitations of this study included the small sample size, the exclusive inclusion of credentialed play therapists, and the use of technology for data gathering. The sample size consisted of seven participants. This sample size was small and therefore limited the number of perspectives that were used in constructing the grounded theory. The inclusion of only credentialed play therapists also limited the number of perspectives that were utilized in the study. There may be professionals studying or training to become credentialed as play therapists with knowledge, training, and clinical experience implementing Attachment Theory. Their voices were not heard within this study. The use of videoconferencing technology may have deterred participants who were less familiar with such technology. Their perspectives were also lost in this study.

Definition of Terms

Attachment Theory- A bio-psycho-social, evolutionary theory that describes the quality of the dynamics within early dyadic relationships between children and their primary caregivers; based on those relationships the child develops a concept of self and self and others (Bowlby 1969/1988; Levy & Orlans, 1998). These concepts of self and others can influence the individual's development of future relationships (Bowlby, 1988).

Initial contact- The first contact the play therapist makes with the client. Some play therapists may view this as the initial phone conversation; others may perceive initial contact to be the first face-to-face appointment with the client.

Play Therapy- "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” (Association for Play Therapy, 2012).

Termination- Landreth (2012) defined termination as the “discontinuing of the [therapeutic] relationship” and noted that the termination process varies in length from practitioner to practitioner (p. 361). Some consider the final session to be the termination of the therapeutic relationship, whereas others view a series of final sessions to comprise the termination process. Ray (2011) recommended a minimum of three termination sessions, and possibly more depending on the length of time the child has been in play therapy.

Treatment Planning- The definition of treatment planning was broadened for the purposes of this study to include all clinical practice, not solely the treatment plan that was written down on paper or saved using electronic means.

Organization of Manuscript

This document is comprised of five chapters. Chapter One serves to introduce the research topic, pertinent background information, purpose of the research study, research questions, chosen methodology, assumptions, limitations and delimitations, and definition of relevant terms. Chapter Two, the literature review, provides an overview of existing literature relevant to the research topic. This chapter contains three major sub-sections: play therapy, Attachment Theory, and Attachment Theory in play therapy. Chapter Three describes in detail the chosen methodology and research process. Chapter Four provides results of the study and provides direct quotations from participant transcripts in support of findings. Chapter Five provides a summary and discussion of the findings of the study, relates the results back to pertinent literature, describes implications for educators and play therapists, suggests areas for future research and provides a reflection of the researcher.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter provides an overview of literature on play therapy, Attachment Theory, and Attachment Theory within play therapy. A brief history of play therapy is provided, along with a description of play therapists and their practices, existing theoretical orientations, the process of treatment planning, and stages of the play therapy process. Attachment Theory is described along with its seminal tenets, modifications, current perspectives, and research related to the importance of addressing attachment issues early in life. Finally, literature surrounding the integration of Attachment Theory within play therapy clinical practice is provided with a focus on extant attachment-based individual and family systems play therapy interventions.

Play Therapy

Historical Development

The origins of the use of play in mental health counseling can be traced back to Freud and his work with a young boy named Hans (Freud, 1909). Freud corresponded with Hans' father; he encouraged the father to observe Hans' play and then to report his observations back to him. Freud interpreted the psychological conflicts Hans was experiencing through analyzing Hans' father's play reports and then suggested ways the father could respond to Hans to facilitate psychological change (Kottman, 2011; Landreth, 2012). Anna Freud and Melanie Klein are credited as the first mental health professionals to have utilized play directly with child clients (Bratton, Ray, Rhine, & Jones, 2005). Anna Freud focused on using play to establish rapport

with the child and then moved to verbal processing once rapport was established, whereas Klein perceived play to be the child's primary means of expression (Kottman, 2011).

A variety of directive, non-directive, and integrative play therapy theoretical orientations have evolved over more recent decades. The most commonly reported forms of play therapy used are non-directive and integrative approaches to play therapy (Bratton, Ray, Rhine, & Jones, 2005; Lambert et al., 2007; Phillips & Landreth, 1995). Virginia Axline, a student of Carl Rogers, created a form of non-directive play therapy by integrating Rogers' person-centered concepts with relationship-focused play therapy principles (Kottman, 2011; Landreth, 2012; Ray, 2011). Axline (1969) recognized that play was a form of communication for children and chose to work with children through use of play instead of verbalization. Axline focused on building a solid foundational relationship, or therapeutic rapport (Ray, 2011). Landreth (2012) expanded on Axline's work and further established Child-Centered Play Therapy (CCPT). Landreth (2012) and Axline (1969) focused on the importance of creating a unique relationship in the playroom to establish a safe, accepting, and permissive environment where the child could experience freedom of expression without judgment. Through this therapeutic environment, in conjunction with the therapeutic relationship, change and self-actualization occur for the child. Several other play therapy theoretical orientations, based on theories typically used with adults, have been developed (Kottman, 2011; Schaefer, 2003a).

A Developmentally Sensitive Approach

Play therapy is a developmentally appropriate form of therapeutic intervention (Kottman, 2011; Landreth, 2012; Ray, 2011). Although play therapy may be utilized across the lifespan, the average age of clients is age seven (Bratton, Ray, Rhine, & Jones, 2005). According to Piaget's (1962) theory of cognitive development, children do not acquire the ability to think abstractly

until approximately age 12. Play provides a concrete medium for expression; it allows children to communicate symbolically through use of toys rather than through verbal self-expression, which requires abstract cognitive abilities. Landreth (2012) stated that the “toys are used like words by children, and play is their language” (p. 16). Play therapy, in addition to being a cognitively appropriate intervention, allows children to experience control over external situations and experiences, within which they may otherwise feel powerless. In play therapy, children can convey desires, wishes, fears, and needs; be understood; and experience acceptance by a trained professional (Landreth, 2012).

Play Therapy Credentialing and Practices

The two primary credentials that play therapists earn are Registered Play Therapist (RPT) and Registered Play Therapist Supervisor (RPT-S). These two credentials are bestowed upon qualified professionals by the Association for Play Therapy (APT), the national professional association for play therapists. Education and training guidelines exist and must be met to fulfill the qualifications of either of these designations. To become an RPT, individuals must be licensed in the state of practice, hold a master’s degree in a mental health discipline with specific core education requirements and have a minimum of two years and 2,000 hours of clinical practice. They must have completed 150 hours of play therapy specific education from approved providers, 500 hours of play therapy clinical practice, and 50 hours of play therapy supervision (APT, 2014c). The application for becoming an RPT-S requires the same qualifications as the application for becoming an RPT and has an additional three years and 3,000 hours of clinical experience, an additional 500 hours of play therapy clinical practice (for a total of 1,000 hours), and requires the applicant to be a licensed supervisor within the state of practice or have completed six hours of play therapy supervisor training (APT, 2014c). Membership within the

APT is open to any individual studying or working to become a play therapist as well as those who are already credentialed as play therapists and play therapist supervisors. The APT currently has 5,100 members, of whom 1,236 hold the RPT credential and 1,222 hold the RPT-S credential (C. Guerrero, personal communication, September 30, 2014).

Phillips and Landreth (1995), in a survey of 1166 play therapy professionals, found that the majority of play therapists are female, master's-level degree holders, ranging from age 30 to 50, who have received most of their training in play therapy and child development from workshops. Male participants in the study were more likely to be doctoral level practitioners; there was no difference between female and male play therapists' hours per week devoted to practicing play therapy or number of average sessions per week (Phillips & Landreth, 1995). Most play therapists worked with children on an individual basis once a week; the typical number of sessions needed to complete therapy was 11 to 20, and most play therapists completed work with clients within 30 sessions. The two most common theoretical orientations employed were eclectic, or integrative, and client-centered play therapy (Phillips & Landreth, 1995). In a more recent study, Lambert et al. (2007) found the majority of practitioners utilizing play therapy operated from the child-centered perspective. One group of researchers found that play therapists receive the most training in the child-centered orientation to play therapy (Ryan, Gomery, & Lacasse, 2002). Play therapists believe play therapy is most appropriately utilized with children ages three to 11 (Phillips & Landreth, 1998). The most commonly reported presenting issues that play therapists reported to be effectively addressed through play therapy were physical and sexual abuse, depression or withdrawal, acting out or impulse-control difficulties, and academic difficulties (Phillips & Landreth, 1998).

Theoretical Orientations to Play Therapy

Several theoretical orientations to play therapy exist. Play therapists' choice of theoretical orientation drives conceptualization of the therapeutic relationship, change process, and methods of intervening. In general, play therapy orientations may be divided into directive, non-directive, mixed directive and non-directive, and integrative. Directive and non-directive refer to the level of leadership the therapist takes within the play therapy sessions; higher levels of the therapist deciding the direction of the therapeutic session are indicative of a directive therapist stance and higher levels of the child leading the direction of the session are indicative of a more non-directive therapist stance. Integrative approaches allow the play therapist to follow the child's needs and to intervene from a directive, non-directive, or mixed approach in response to the child's changing presentation (Schaefer, 2003b).

Non-Directive Play Therapy Approaches. In non-directive play therapy approaches the play therapist allows the child to lead the direction and content of play sessions. Non-directive theoretical orientations to play therapy include Jungian Analytical Play Therapy and Child-Centered Play Therapy.

Jungian analytical play therapy. This approach, originally utilized in adult therapy, was adapted for use with children based on the principles of Jung's Analytical Psychology. Traditionally, this play therapy approach was used with sand tray (Kottman, 2011). Lowenfeld (1950) created a technique called "The World" wherein clients constructed their world in the sand and each object symbolically represented a piece of their existence. Kalff, a friend of Jung, expanded on Lowenfeld's work and the use of symbolism to include use of narrative to illuminate the scenes in the sand (Kottman, 2011). Several theorists further developed this theoretical orientation through the use of play and art with clients to "explore the ego, the self,

and the collective unconscious” (Kottman, 2011, p. 36). Jungian analytical play therapy is considered to be a non-directive approach to play therapy, as the counselor does not lead the client to complete certain tasks within the session or provide interpretation of the process to the client (Kottman, 2011).

Child-centered play therapy. Virginia Axline applied Carl Rogers’ fundamental concepts of client-centered therapy for adults to the process of play therapy. The therapeutic relationship is the key focus within this orientation and is viewed as the primary vehicle for change (Axline, 1969; Kottman, 2011; Landreth, 2012). The therapist does not interpret the child’s play or provide direction; rather, the focus is on trusting the child’s inherent tendency toward growth and therefore allowing the child to lead the therapeutic process (Landreth, 2012). It is only when the child feels free to continue without changing the self that the process of change begins (Landreth, 2012).

Directive Play Therapy Approaches. In directive approaches to play therapy the play therapist provides the direction of play sessions. Cognitive-Behavioral Play Therapy is a directive theoretical orientation to play therapy.

Cognitive-behavioral play therapy. Cognitive-behavioral play therapy is “structured, directive, and goal-oriented” (Kottman, 2011, p. 35). Knell integrated traditional cognitive-behavioral techniques into the play therapy process to increase children’s awareness of thoughts, behaviors, and relationships. The therapist sets up specific play situations to mimic real life concerns the child has experienced. The child is then able to practice new approaches to those dilemmas and develop new behaviors for future implementation (Kottman, 2011).

Mixed Directive and Non-directive Approaches. The play therapist in mixed directive and non-directive approaches to play therapy switches back and forth between directing the play

sessions and allowing the child to lead in the direction of the play sessions. Mixed approaches include Adlerian Play Therapy and Gestalt Play Therapy.

Adlerian play therapy. Adlerian play therapy involves the use of a wide variety of creative interventions such as music, sand tray, play, dance, storytelling, and art (Kottman, 2011). The purpose of the use of creative interventions and expression through play is to enhance the therapeutic relationship and to allow the therapist “to explore the child’s intrapersonal and interpersonal dynamics, to help the child gain insight, and provide a context for the child to learn and practice more constructive ways of thinking, feeling, and behaving” (Kottman, 2011, p. 35). The play therapist also works with the child’s caregivers, such as parents or teachers, to facilitate change in the child’s environments (Kottman, 2011). The Adlerian play therapist utilizes both directive and non-directive techniques. The play therapist often begins with a more non-directive approach. Once the therapist’s understanding of the child’s perceptions and experiences and the therapeutic relationship are well established, the therapist may choose to take a more directive stance to address presenting concerns (Kottman, 2011).

Gestalt play therapy. Oaklander (1978) developed Gestalt play therapy based on the primary concepts of Perls’ Gestalt Therapy. The relationship between the play therapist and the child fluctuates between directive and non-directive approaches. At times the play therapist directs the child to participate in experiments, or activities, intended to facilitate growth. At other times the therapist allows the child to take the lead in session (Kottman, 2011). Oaklander “focused on the relationship between the therapist and children, the concept of organismic self-regulation, children’s boundaries and sense of self, and the therapeutic role of awareness, experience, and resistance” (Kottman, 2011, p. 35).

Integrative Play Therapy Approaches. Integrative approaches to play therapy allow for the play therapist to choose from a wide variety of interventions and assessments to address the child's, or family's, presenting issues. Integrative approaches include Ecosystemic Play Therapy and Prescriptive Play Therapy.

Ecosystemic play therapy. O'Connor (2000, 2009) developed ecosystemic play therapy. This approach takes into consideration each of the child's systems, as understanding the child's contexts is essential in comprehending experiences and facilitating change. The play therapist assesses the child using a variety of evaluative tools in the following areas: "cognitive, physical, social, emotional, and processing of life experiences" (Connor 2000; 2009 as cited in Kottman, 2011, p. 36). Based on the results of those assessments, the play therapist provides directive experiences for the child within the play sessions to facilitate development and change (Kottman, 2011).

Prescriptive play therapy. The prescriptive approach to play therapy developed from a discerned need to tailor therapeutic interventions to an individual's presenting concerns and needs. There was a focus on utilizing techniques and theory directly in response to the client's "presenting problems, specific personality traits, and particular situation" (Kottman, 2011, p. 38). Play therapists working from this perspective need to have acquired a wealth of knowledge and training in a variety of theoretical orientations and techniques to aptly apply tailored interventions to clients' needs.

Stages of the Play Therapy Process

The literature surrounding understanding stages of the play therapy process focuses heavily on child-centered play therapy. A model describing the stages of engaging caregivers in the play therapy process also exists and may be useful in understanding the potential stages

involved in play therapists' work with caregivers from an attachment perspective. Understanding the stages of the play therapy process can assist play therapists in treatment planning as well as provide caregivers with information regarding the process and progress in play therapy treatment (Cochran et al., 2010; Fall, 1997; Nordling & Guerney, 1999; Ray, 2011).

Child-centered play therapy stages. The therapeutic relationship is the key element within the child-centered play therapy process. It is through establishment of an accepting, genuine, empathic relationship that change is facilitated (Landreth, 2012). Moustakas (1955, as cited in O'Connor and Braverman, 1997), stated that once such a relationship is established, children progress through the following stages of the therapeutic process:

1. Diffuse negative feelings, expressed everywhere in the child's play
2. Ambivalent feelings, generally anxious or hostile
3. Direct negative feelings, expressed toward parents, siblings, and others, or in specific forms of regression
4. Ambivalent feelings, positive and negative, toward parents, siblings, and others
5. Clear, distinct, separate, usually realistic positive and negative attitudes, with positive attitudes predominating in the child's play (p. 84).

Nordling and Guerney (1999) proposed four stages of the child-centered play therapy process. These stages were called "warm up," "aggressive," "regressive," and "mastery" (Nordling & Guerney, 1999, p. 18). Certain types of behaviors occur within each stage of the process, and the therapeutic relationship is said to strengthen throughout completion of each stage (Nordling & Guerney, 1999). The authors noted that each child passes through the stages of the play therapy process at a unique pace. During the warm up stage, the child orients to the play therapist and the new play therapy environment. The child becomes accustomed to taking the lead within the sessions, a theory-specific aspect of the child-centered play therapy process. Children enter the "aggressive" stage of the process once trust and therapeutic rapport have been established within the therapeutic relationship. During this phase, the child tends to exhibit more aggressive play

behaviors or practice self-assertion. The “regressive” stage is marked by the child’s display of and engagement in regressive behaviors to “work on issues related to nurturance, attachment, dependence/independence, identity and self-image, and other issues related to the relationships with others” (Nordling & Guerney, 1999, p. 20). Such play behaviors may include “cooking meals, giving a tea party, telling a bedtime story,” “putting a bottle in the mouth,” “taking a nap,” or “engaging in babbling/baby talk” (Nordling & Guerney, 1999, p. 20-21). The final stage, referred to as mastery, is marked by the child’s increased expressed competence, mastery, and creativity. Some children exhibit these qualities through independent play, while others express them through “creation of their own games” or “interactive role-play” (Nordling & Guerney, 1999, p. 21). Transitioning between stages is not considered to occur without overlap between the stages, at times across several sessions (Nordling & Guerney, 1999). Cochran et al. (2010) tracked two boys’ progress through the stages of child-centered play therapy defined by Nordling and Guerney (1999) and confirmed the existence and utility of the stages to track client progress.

Engaging caregivers and beyond. Steen (2010) outlined four stages of engaging caregivers in the play therapy consultation process. Those four stages were: engagement, cooperation, incorporation, and termination. The stages describe the developmental process caregivers venture through while their children are in treatment. During the engagement phase, or first phase, caregivers may feel reluctance about the play therapy treatment process. The therapist’s focus in this stage is providing appropriate education to the caregiver regarding play therapy, offering empathic responses, and establishing rapport and trust with the caregiver while remaining focused on the child client (Steen, 2010). In the cooperation phase, the caregiver begins to become “a more active participant” in the consultation process (Steen, 2010, p. 1). The caregiver is more likely to seek out advice, which illustrates progression past the engagement

phase and signifies growing trust in the play therapist. Next, caregivers enter the incorporation phase wherein they begin to implement the advice, or skills, they have acquired throughout consultation with the play therapist. As caregivers integrate new practices into their relationship with their child, caregivers experience increased empathy with their child and they grow increasingly aware of their responsibility and ability to facilitate change (Steen, 2010). The final stage of the caregivers' process is termination. At this point the caregiver "appears relaxed, maybe relieved; the parent and child have both made significant changes, and furthermore, the dynamics in the family have changed substantially" (Steen, 2010, p. 2). Steen (2010) stated that understanding these stages allows the play therapist to tailor responses and skills offered to caregivers in a developmentally appropriate fashion.

Treatment Planning and Decision-Making

Caregivers and treatment planning. As caregivers are the primary decision-makers for their child's engagement in play therapy services, their inclusion in the treatment planning and decision-making processes is crucial (Ray, 2011). Ray (2011) recommended providing caregiver consultations every three to five play therapy sessions to inform caregivers, obtain information and updates from caregivers on changes in other environments, and to provide skills for caregivers' use. APT (2012) advocated that play therapists "explain the developmentally appropriate treatment plan in an understandable manner to the client and/or his/her legal guardian, if applicable" (p. 2). Caregiver consultations provide an appropriate time to accomplish collaborating with caregivers in development of the treatment plan, as well as to explain the treatment plan. According to Play Therapy Best Practices (APT, 2012), a treatment plan "should contain measurable outcome goals" and be "reviewed regularly to ensure viability, effectiveness, and the continued support of the client and the involvement of the others in achieving the

therapeutic goals” (p. 2). According to Ray (2011), a treatment plan should include “a diagnosis, prediction of therapy length, reported symptoms, and objectives for the client” (p. 234). In addition, the play therapist “report[s] parental concerns,” “set[s] objectives that are assumed to be easily attainable by the child, and provid[es] a rationale for [the chosen theoretical orientation] as the most appropriate intervention” (Ray, 2011, p. 234). Ray (2011) developed a treatment planning form for play therapists’ use, adapted from a form provided in Wiger (2009), which focused on presenting problem, caregivers’ concerns, goals and objectives, and interventions used. The treatment plan may be updated as change occurs, new information is obtained through caregiver consultations, and new or different goals or objectives become the focus. Throughout the caregiver consultations, the play therapist provides the caregivers with feedback regarding progress, changes, skills for use, and prepares the caregivers for the eventual termination (Ray, 2011).

Diagnosing disorders of attachment. Treatment plans are part of a medical model approach to play therapy and generally involve diagnosis, intervention, assessing for progress, and plans for termination (Ray, 2011). Some play therapists who ascribe to certain theoretical orientations, such as child-centered play therapy, may be less inclined to diagnose. However, with insurance companies dictating reimbursement for client services, diagnosis is often a necessity for clients to receive play therapy services (Ray, 2011). The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V, 2013), is the primary guide used by mental health professionals in deciphering a mental health diagnosis for a client. Several disorders (typically presenting in children) specifically mentioned the word attachment within the criteria for diagnostic assessment, including Separation Anxiety, Reactive Attachment Disorder, and Disinhibited Social Engagement Disorder (DSM-V, 2013). Whereas these are some of the

disorders that refer directly to attachment, research has shown that a wide variety of disorders may present in childhood, adolescence, or adulthood in correlation with the quality of an individual's early attachment relationships, among other risk factors (Rutter, 1985). These other disorders include anxiety, depression, bipolar disorder, borderline personality disorder, antisocial behaviors, dissociative disorders, feeding and eating disorders, and conduct disorder (Aguilar, Sroufe, Egeland, & Carlson, 2000; Carlson, 1998; Deklyen & Greenberg, 2008; Ogawa et al., 1997; Renken et al., 1989; Warren, Huston, Egeland, & Sroufe, 1997). The National Institute of Child Health and Human Development (NICHD) Study of Early Child Care found that children's insecure attachment tended to significantly predict future problem behaviors in children who lived in at-risk environments (Belsky & Fearon, 2002). Gender was also a significant factor in prediction of future behavioral issues. In a longitudinal study conducted by the Minnesota Parent-Child Project, researchers found that "infant avoidance predicted teacher-rated aggressiveness in middle childhood and ambivalence predicted passive withdrawal; however, these associations were significant only for boys" (Renken et al., 1989 as cited in Deklyen & Greenberg, 2008). Several other studies, with smaller sample sizes and fewer insecure children included, found no significant effect between insecure attachment in children living in low-risk environments and behavioral issues later in life (Bates, Bayles, Bennett, Ridge, & Brown, 1991; Bates, Maslin, & Frankel, 1985; Deklyen & Greenberg, 2008; Fagot & Kavanaugh, 1990; Goldberg, Lojkasek, Minde, & Corter, 1990; Lewis, Feiring, McGuffog, & Jaskir, 1984). The presence of a secure attachment early in life was considered to be a protective factor against future behavioral issues and psychopathology, particularly for those children in high-risk environments (Morisset et al., 1990; Rutter, 1987).

Assessing for progress. Play therapists assess for progress within and across play therapy sessions. One method for assessing progress is to look for a change in themes exhibited within the child's play and expressions (Landreth, 2012; Ray, 2011). Ray (2011) also provided a list of play behaviors that can be tracked within and across sessions to assess for progress. Each of those behaviors, such as destructive and constructive, was displayed in the format of a continuum without a preference for either continuum representing increased health. "The play therapist assesses growth according to movement in the direction that is helpful to the child" (Ray, 2011, p. 126). Assessing progress may be conceptualized in terms of what stage of the play therapy process the client is in (Cochran et al., 2010; Fall, 1997; Landreth, 2012; Nordling & Guerney, 1999; Ray, 2011). In general, a play therapist can assess a child's overall progress in terms of moving from maladjusted behaviors to adjusted behaviors (Moustakas, 1955; 1973).

Termination. Termination signifies the ending of the therapeutic process and relationship. Assessing for and deciding whether a child is ready for termination can be challenging (Landreth, 2012; Ray, 2011). At times termination occurs without warning, when a caregiver decides to end play therapy. "In ideal cases, the child has come to a natural end of therapy wherein he is expressive and constructive in session; maintains warm relationships with some adults and children, including the therapist; and engages in self-enhancing behaviors" (Ray, 2011, p. 134). The therapist takes an encouraging stance during this final phase of therapy and reflects the strengths and growth that have occurred across the play therapy process to both the caregivers and the child (Ray, 2011). Landreth (2012) focused on the importance of allowing time for the child to process the ending of the therapeutic relationship, as it is significant, and suggested offering a minimum of two to three sessions as part of the termination process.

A framework for decision-making and treatment planning. Yassenik and Gardner (2012) developed the Play Therapy Dimensions Model to provide a decision-making and treatment-planning framework for use across theoretical orientations within the play therapy process. This model is based on three primary assumptions: “first, each child is unique regarding his/her skills and abilities; second, all children follow a common developmental pathway; and third, the play therapist has a central role in facilitating change and optimizing growth” (Yassenik & Gardner, 2012, p. 45). Two dimensions make up the primary components of the model: directiveness and consciousness. Directiveness refers to the amount of direction and interpretation the play therapist elicits. Consciousness refers to the amount of the child’s awareness regarding verbal expressions, behaviors, and play. Each of these dimensions exists on a continuum from less to more; the intersections of directiveness and consciousness in perpendicular form create a four-quadrant diagram illustrating four potential combinations of these two dimensions. Yassenik and Gardner (2012) labeled each potential combination, or quadrant, as follows: “active utilization” (high consciousness and non-directiveness), “open discussion and exploration” (high consciousness and high directiveness), “non-intrusive responding” (non-directiveness and low consciousness), and “co-facilitation” (directiveness and low consciousness) (p. 14). The model is flexible enough to be utilized across all theoretical orientations to play therapy and may be used to address concerns in individual or family systems interventions (Yassenik & Gardner, 2012).

Attachment Theory

Development of Attachment Theory

Bowlby (1969), the originator of Attachment Theory, was inspired by the work of clinicians and scientists from various disciplines. Bowlby discerned the need for a new theory

that provided further explanation of certain behaviors children displayed upon separation from caregivers. In particular, the works of Harlow and Lorenz were highly influential on Bowlby. Obtaining food was considered the primary motivation for an infant seeking proximity to a caregiver before Harlow's (1960) experiment displayed macaques monkeys' preferences for a soft mother over a mother that provided food (Bowlby, 1988). Lorenz (1935) showed the existence of an inherent behavioral system that encouraged ducklings to seek out closeness to a primary caregiver. Bowlby was curious about the purpose this intrinsically motivated behavior served in humans, and concluded it is a survival instinct that elicits the desire for the child to seek out physical and emotional safety from the caregiver (Bowlby, 1988). Bowlby (1988) theorized that this built-in behavioral system is left over from a time when the infant may have been vulnerable to wild predators. After World War II ended, Bowlby was asked to initiate a child psychotherapy program at the Tavistock Clinic. Two students who would become influential in the future joined his research team: Ainsworth and Robertson (Brisch, 2011). Robertson had been a student of Anna Freud's and utilized intense observational techniques to analyze behaviors and relationships; these skills proved highly beneficial in the work he completed as a researcher under Bowlby's tutelage. Robertson created a documentary called "A Two Year Old Goes to the Hospital," which portrayed a young girl's experiences of having to go to the hospital without access to her mother. At that time children were not allowed to have caregivers present during treatment at a hospital. The documentary displayed the attachment stages of behaviors associated with separation: "protest, despair, detachment" (Brisch, 2011, p. 9). The documentary was later used to update hospital policies to allow children to have access to caregivers. It was also used to display the stages of attachment behaviors children elicit and experience when separated from a primary attachment figure for prolonged periods of time

(Brisch, 2011). Initial attachment behaviors displayed upon departure of a caregiver typically involve intense protest (e.g., crying, wailing) by the child to instigate the caregiver's instinct to return and provide safety to the child. If the child's first attempts are to no avail, the secondary set of attachment behaviors are usually withdrawn, quiet behaviors. These categories of attachment behaviors were derived from theories of evolution and are thought to be by-products of the basic drive for survival (Bowlby, 1988; Brisch, 2011; Johnson & Whiffen, 2003). Those infants and children who did not seek proximity by demonstrating attachment behaviors did not survive as long as those who did (Bowlby, 1988).

Attachment theory assessments. Ainsworth, another researcher who studied under Bowlby at the Tavistock Clinic, provided the necessary research to establish Attachment Theory as credible in the professional community (Bowlby, 1988). Ainsworth conducted research in Uganda, where she observed the relationships between children and their mothers. Ainsworth (1967) made "2- hour visits in their homes every 2 weeks accompanied by an interpreter" during which she made "very detailed records both of the mother's caregiving behavior and the child's attachment and separation behavior" (Brisch, 2011, p. 11). From her research in Uganda, in conjunction with further research upon return to the United States, Ainsworth developed the Strange Situation test (Ainsworth & Wittig, 1969). The Strange Situation test is an observational assessment wherein the behaviors elicited by the child and caregiver are evaluated during several episodes of the child's departure from and return to the caregiver. The child's attachment style is evaluated through deciphering the patterns of the child's responses to departure from and reunion with the caregiver. Specific focus is applied to the reunion between the child and the caregiver and the child's ability or inability to be soothed and emotionally regulated through proximity to the caregiver.

George is credited as the primary creator of the Adult Attachment Interview (AAI) (George, Kaplan, & Main, 1985). The AAI is a semi-structured interview that is used to assess adult attachment styles. Although George did not find any significant patterns among individual responses made by the adults in her research interviews, Main and Goldwyn (1985) “discovered that how mothers processed and discussed their childhood experiences [in response to the AAI] was related to their infants’ behavior in the Strange Situation” (Brisch, 2011, p. 12). This correlation initiated a new way of perceiving adult attachment and allowed for insight into adult memories of childhood attachment relationships (Brisch, 2011).

Basic Tenets of Attachment Theory

Attachment Theory is comprised of ten essential tenets. Attention is paid to internal working models, or attachment styles. Comprehension of the development of an internal working model is vital to understanding the clinical application of Attachment Theory. Additional tenets include intrinsic motivation, security equals autonomy, security offers a safe haven, attachment offers a secure base, accessibility and responsiveness build bonds, fear and uncertainty activate attachment needs, separation distress is predictable, insecure forms of engagement can be identified, and separation and loss are traumatizing (Johnson & Whiffen, 2003).

Intrinsic motivation. The drive for attachment is an innate motivating force. It is instinctual and is present across the lifespan. The instinct to attach is observed in the human drive to connect through relationships (Johnson & Whiffen, 2003).

Security equals autonomy. Attachment Theory does not consider all forms of dependency as being negative. Instead, dependency is differentiated into two types: effective or ineffective. Interdependence is viewed as a necessary construct for human development. Thus, interdependence, or effective dependence, is positive (Johnson & Whiffen, 2003).

Security offers a safe haven. Proximity to a secure attachment figure soothes the central nervous system and reduces stress hormones. Decreased stress leads to a greater sense of satisfaction and promotes healthy development (Johnson & Whiffen, 2003). A relaxed, secure individual is able to use mental faculties for exploration of the environment.

Attachment offers a secure base. The more secure an individual's attachment style, the more autonomous the individual (Bowlby, 1988; Johnson & Whiffen, 2003). Bowlby (1988) discussed the importance of the child's ability to explore the environment to learn survival skills. The more secure a child was, the more likely that child was to explore, adapt, and survive.

Accessibility and responsiveness build bonds. The more accessible the caregiver is, and the better the caregiver is able to respond to the child's expressed needs, the more secure the child will be. The role of emotion is key in Attachment Theory. Emotional accessibility and responsiveness by the caregiver provide the base for the child to develop a sense of self-worth and empathy with others (Johnson & Whiffen, 2003).

Fear and uncertainty activate attachment needs. The caregiver's inability or unwillingness to respond to the child's needs facilitates insecurity. A lack of consistent care as an infant develops the infant's distrust in others. Attachment behaviors are activated in times of stress, and a child whose attachment system is activated is experiencing distress (Bowlby, 1988). The insecurity and inability to trust can lead to a decreased sense of self-worth (Johnson & Whiffen, 2003).

Separation distress is predictable. Due to the nature of the attachment bond, when the caregiver leaves the child, the child becomes distressed. This is a predictable outcome. Attachment behaviors are elicited during those moments of distress to encourage the caregiver to return (Johnson & Whiffen, 2003).

Insecure forms of engagement can be identified. A limited number of insecure forms of engagement are identified. Insecure reactions are described as being primarily anxious or avoidant. Insecure children, whether anxious or avoidant, are not soothed upon return of the caregiver (Johnson & Whiffen, 2003). A history of inconsistent responses or a complete lack of responses by the caregiver train the child not to trust in the caregiver's efforts.

Separation and loss are traumatizing. Bowlby (1988) described the trauma that occurs from neglect, isolation, and loss. Deprivation of emotional responsiveness is traumatizing. Isolation and separation lead to insecurity and a decreased sense of self-worth (Johnson & Whiffen, 2003).

Attachment involves working models of self and others. The attachment bond is mutually established through the caregiver's responsiveness to the child's needs and the child's perceptions of whether or not those needs have been satisfied (Levy & Orlans, 1998). Attachment behaviors, such as crying, sucking, and smiling, are exhibited by the child to communicate a need to the caregiver. An individual's attachment model is activated during times of increased stress. Once the model is activated, the individual displays attachment behaviors, and seeks out proximity to the primary attachment figure to gain a sense of increased security (Bowlby 1988). Depending on the primary caregiver's availability and response to the child's attachment behaviors, the child builds a concept of self and others. This concept is referred to as the internal working model. The individual's patterns of attachment behaviors demonstrated are indicative of that individual's internal working model. An individual's internal working model differs from the person's attachment style because the internal working model can change from individual to individual. The attachment style describes the overall tendencies within the individual and can range from secure to insecure; along the insecure continuum, an attachment

style is further described as ranging from anxious (hyperactivated) to avoidant (deactivated). Attachment styles categorized as secure, anxious, avoidant, and mixed (Johnson & Whiffen, 2003). The anxious, avoidant, and mixed classifications are indicative of an insecure working model. An insecurely attached child has a diminished sense of self, lower self-esteem, and is not trusting of others. A securely attached child has a more positive self-concept and is more trusting of others. Security equates to feeling worthy of receiving love, whereas insecurity equates to not feeling worthy of receiving love (Johnson & Whiffen, 2003).

Internal Representation, Internal Working Models, and Attachment Styles

The dynamics of the caregiver-child relationship shape the way a child perceives self, and self and others (Bowlby, 1988). Based on the sensitivity level of a caregiver's responses to a child, as well as the response rate and consistency in the caregiver's responsiveness, the child develops an internalized sense of self in relation to that caregiver, which is considered to be an internal representation. Throughout the course of the first year of life, that internal representation becomes further solidified through continued interactions with the primary caregiver(s) and the child develops Internal Working Models (IWM) of self and self and others (Bowlby, 1973). "These models reflect the child's appraisal of, and confidence in, the self as acceptable and worthy of care and protection, and the attachment figure's desire, ability, and availability to provide protection and care" (Solomon & George, 1999, p. 5). "These models, in turn, organize appraisal processes, thought, memory, and feelings with regard to the attachment figure and serve to guide future behavior" (Bowlby, Main, et al., as cited in Solomon & George, 1999, p. 5). An individual's attachment style develops through multiple relationship experiences in conjunction with the quality of the early life relationships that shaped the development of the IWM (Cassidy & Shaver, 2008). Bowlby (1988) believed that once a child's IWM is

internalized, it remains stable across the lifespan; research has shown that an individual's attachment style may change throughout life depending on future relationships and life experiences (Cassidy & Shaver, 2008). Attachment styles, as originally defined by Ainsworth et al. (1978), were categorized as secure, avoidant, and ambivalent. Main and Solomon (1990), through conducting the Strange Situation test with a larger sample than Ainsworth et al. (1978) utilized, found an additional classification of attachment style which they called the disorganized type. The child with the disorganized type of attachment style perceives "the caregiver as scary and scared; therefore the infant needs to be comforted, but is afraid to seek comfort from the caregiver" (Zilberstein & Messer, 2010 as cited in Parker, 2012, pp. 40-41). Snow, Sullivan, Martin, and Helm (in submission) provided a summary of Attachment Theory, describing the cycle of development and influence of an individual's representational model, IWM, and attachment style:

The parent-child relationship is influenced by the parent's representational model. Through the interaction of parent-child, the child develops an internal working model (IWM) based on the representational model of the parent. The IWM contributes to the development of a sense of self and self and others. It is from this sense of self and self and others the child develops patterns of relating which come together to form an attachment style. The attachment style becomes the adult's representational model which then influences the parent-child relationship (p.6).

Attachment Across the Lifespan

Bowlby (1944) completed a mixed-methods study wherein he compared several factors between 44 thieves and 44 children who were not thieves (control group). In addition to

gathering quantitative information such as age and intelligence level, Bowlby interviewed the juvenile participants first, then their mothers. Bowlby sought, throughout the qualitative portion of the study, to investigate whether or not distinguishable patterns of relating existed within the relationship between primary caregivers (mothers) and their child in the juvenile participants (thieves) versus the control group (non-thieves). Bowlby's (1944) seminal research with the 44 thieves provided a link between maternal deprivation (particularly within the first two years of life) and a lack of the development of empathy. This research supported Bowlby's suspicion that the quality of the primary caregiver-child relationship early in life affects that child's ability to relate in future relationships. A plethora of research has since been conducted to try to establish a clear connection between the quality of a child's early relationships and the child's later social functioning and development of psychopathology into adolescence and adulthood (Deklyan & Greenberg, 2008). To summarize that literature, insecure children, particularly boys, living in at-risk environments, are most likely to be adversely effected; they tend to develop psychopathology and unstable relationships as they age (Aguilar, Sroufe, Egeland, & Carlson, 2000; Belsky & Fearon, 2002; Carlson, 1998; Deklyen & Greenberg, 2008; Ogawa et al., 1997; Renken et al., 1989; Rutter, 1985; Warren, Huston, Egeland, & Sroufe, 1997). The presence of a secure attachment early in life served as a protective factor against future behavioral issues and psychopathology, particularly for children living in high-risk environments (Morisset et al., 1990; Rutter, 1987).

Intergenerational attachment patterns. The quality of the attachment relationship is signified by the caregivers' responsiveness and sensitivity to the signals children present in an attempt to have needs met (Brisch, 2011). When an adult has an insecure attachment style, he or she is less likely to respond in a consistent, sensitive, and caring manner to a child's presenting

bids for care. This inconsistency in responsiveness may lead the child to develop an unstable sense of self and self and others and can lead to development of an insecure attachment style. Research has shown “there is a connection between the quality of the attachment representations in the parental generation and the attachment quality that develops in infancy” (Brisch, 2002, p.20; Fonagy, Steele, & Steele, 1991; Main et al., 1985; Steele & Steele, 1994). Benoit and Parker (1994) stated that “Working models have a propensity for stability within individuals and across generations” (p.322). “Studies show that there are correlations between the attachment representation of the parents, observable behavior in caregiving and interaction with their infants, and the later development of attachment quality in their children” (Grossman, Grossman, & Zimmermann, 1999, p. 760-786). Martin (2005) tracked attachment styles across three generations using the Marschack Interaction Method (MIM) and the Adult Scale of Parental Attachment (ASPA). Martin’s (2005) findings supported the notion that a grandmother’s attachment style effected her ways of relating to her daughter, which in turn effected the daughter’s development of an attachment style and patterns of relating to her child. Patterns and influence among attachment styles were found across the three generations, but did not indicate a definite passing down of the same attachment style from generation to generation (Martin, 2005). Similarly, Main and Goldwyn (1985) “discovered that how mothers processed and discussed their childhood experiences was related to their infants’ behavior in the Strange Situation” assessment (Brisch, 2011, p. 12). In short, the attachment style of the caregiver influences the ways the caregiver relates to the child, which influences the development of an IWM and attachment style within the child. Internal and external factors shape the child’s development of an IWM and attachment style (Cassidy & Shaver, 2008). The caregivers’ responsiveness and

patterns of relating with the child serve as examples of external factors that contribute to the development of the child's IWM and attachment style.

Current Perspectives on Attachment Theory

Application of Attachment Theory is being investigated across a wide variety of disciplines. Current research topics include the relationship between attachment style and physical health, whether animal-human bonds are indicative of an attachment relationship, attachment in animal-assisted therapy, and models of clinical supervision that discuss the effects of attachment styles on the supervisor-supervisee relationship (Neswald-McCalip, 2001; Petromonaco, Uchino, & Schetter, 2013; Sable, 2013; Zilcha-Mano, Mikulincer, & Shaver, 2011). In addition, increased attention has been paid to the effects of attachment style on development. Researchers have shown that children with a secure attachment style are more socially adept, have enhanced cognitive abilities, are more competent in problem-solving, are more independent, and have a more positive self-concept than children with insecure attachment styles (Johnson & Whiffen, 2003; Levy & Orlans, 1998).

Conclusion

Bowlby (1988) was interested in expanding the application of his theory into clinical practice. "He felt [incorporation of his theory into practice] is particularly important to prevent the development of psychopathological patterns of attachment in the early adult-child relationship, as well as in psychotherapeutic work generally" (Brisch, 2011, p. 14). Research supports the notion that addressing attachment issues within the caregiver-child dyad early in life may enhance the social abilities, cognitive well-being, and the caregiving practices of that individual in the future (Martin, 2005; Levy & Orlans, 1998).

Attachment Theory in Play Therapy

Attachment Theory is not considered a primary theoretical orientation for providing play therapy services. Rather, it is a secondary theory that may be integrated into providing services across the play therapy process. For the purposes of this study, play therapists from a variety of theoretical orientations were interviewed to ground the emerging theory in multiple perspectives. This diverse background in theoretical orientations allowed the theoretical framework to be applied across theoretical orientations to play therapy. In this section, existing attachment-based clinical interventions and their effectiveness are described. Basic play therapy skills that exist across all theoretical orientations are discussed and attention is paid to the importance of establishing the therapeutic relationship. These skills facilitate the development of therapeutic rapport between client and play therapist.

Play Therapy Skills and the Therapeutic Relationship

The importance of the therapeutic relationship in facilitating the creation of an accepting and facilitative therapeutic environment has been acknowledged in the field of play therapy (Axline, 1969; Kottman, 2011; Landreth, 2012; Moustakas, 1955; Ray, 2011). The play therapist utilizes specific skills and techniques to establish the therapeutic relationship and facilitate change. Although precise skills and techniques may differ according to the theoretical orientation of the play therapist, basic verbal and non-verbal skills are common among all theoretical orientations. Those skills are also the core techniques used from a child-centered theoretical perspective and include tracking behavior, reflecting content, reflecting feeling, returning responsibility, facilitating creativity and spontaneity, esteem building, facilitating relationship, reflecting larger meaning, and limit setting (Ray, 2011).

Tracking. When a play therapist uses the skill of tracking behavior, the play therapist states exactly what the child is doing, without labeling the toys or items used until the child labels the items. Naming an item before the child labels it conveys an assumption on the part of the play therapist and can disrupt or direct the child's play. The purpose and rationale for using tracking is to let the child know the therapist is engaged and interested in what the child is doing, without leading or directing the child's play (Landreth, 2012; Ray, 2011).

Reflecting content. Reflecting content is a verbal skill that allows the play therapist to convey understanding of both verbal and non-verbal expressions of the child. Just as a counselor reflects the content of adult verbalizations, so does the play therapist paraphrase and give back to the child the content of exactly what the child is expressing. In play therapy, reflecting content is possible even when the child is not verbal. For instance, the play therapist may summarize the content of an interaction the child is playing out with toys (Landreth, 2012; Ray, 2011).

Reflecting feeling. Reflecting feeling is a verbal skill that can increase the child's emotional awareness. The play therapist provides a statement wherein the child's emotional expressions are reflected back to the child. This skill also allows the play therapist to demonstrate understanding and acceptance of the child's feelings, whatever they may be. For instance, if a child is angry about attending play therapy and verbalizes that anger, the therapist may respond, "You are angry about being here and you'd rather be [somewhere else]" (Ray, 2011, p.86).

Returning responsibility. Returning responsibility encourages children to realize their own capability. The play therapist does not complete any task in the playroom that the child is able to accomplish without assistance. Instead, the therapist encourages the child to work on

carrying out the task with which he or she is seeking help. These types of responses “help children experience themselves as able and empowered” (Ray, 2011, p. 87).

Facilitating creativity. Facilitating creativity fosters the child’s ability to make creative decisions. For instance, if a child is wondering what the characters in a story he or she has created should do, the play therapist may respond, “In here you can decide what happens next.” Allowing children to utilize creativity in self-expression encourages “them to develop flexibility in thought and action” (Ray, 2011, p. 87).

Esteem building. Esteem building is a skill that is used to enhance the child’s positive self-perception. The play therapist notices when the child has worked to accomplish a task or an activity and communicates that realization to the child. The therapist may say, “You worked really hard on that and were able to do it!” The play therapist does not praise the child by evaluating what the child creates; rather, the therapist encourages and acknowledges the effort the child puts into an activity, thereby building esteem (Landreth, 2012; Ray, 2011).

Facilitating relationship. Verbal responses that bring awareness and insight to the child about the therapeutic relationship between the child and therapist are referred to as facilitating relationship. The purpose of this skill is to “help the child learn effective communication patterns and express the therapist’s care for the child” (Ray, 2011, p. 88). The child gains a further understanding of the nature of the therapeutic relationship and can practice communication skills in a non-threatening environment.

Reflecting meaning. Reflecting the larger meaning is used by the play therapist to augment meaning for the child. This skill begins with the therapist noticing themes and patterns in the child’s play and then those patterns are communicated back to the child. The use of reflecting the larger meaning can enhance the child’s insight into play behaviors. Ray (2011)

provided the example of a child who consistently chose to keep the playroom organized; the therapist responded, “You like to keep things clean and organized” (p. 88).

Limit setting. Limit setting provides necessary structure and safety for the child. According to Landreth and Bratton (2004), limits are not to be set until they are absolutely needed. For instance, a limit is needed if the therapist does not allow people to get hurt in the playroom and the child is forcefully hitting the therapist. In this situation the therapist might say, “I’m not for hitting. You can choose to pretend the doll is me and hit the doll, or you can choose to pretend the bop bag is me and hit the bop bag.” This skill allows for redirection of the child’s behavior in an accepting manner without disregarding the child’s need for catharsis and expression (Landreth, 2012).

Basic play therapy skills are present across all theoretical orientations and are purposeful. The trained play therapist understands that it is not necessary for all of the basic skills to be utilized in each session. Every skill has a specific rationale for use and the trained play therapist is adept at choosing the most appropriate skill, or set of skills, for use in any given context. The establishment of the therapeutic relationship is essential to the process of change across all theoretical orientations to play therapy. Basic play therapy skills assist in establishing a secure therapeutic relationship. It is through the therapeutic relationship that the child experiences acceptance, validation, increased awareness, and the freedom to utilize inherent capacity to move toward growth (Landreth, 2012).

Attachment-Based Play Therapy Clinical Interventions

Individual play therapy interventions. Although the majority of attachment-based play therapy clinical interventions involve direct engagement of the caregiver in the play therapy treatment process, individual attachment-based interventions do exist. In these individual

interventions the therapist is perceived to be the secure base for the child. Goodyear-Brown (2014) stated that any positive relationship interaction is viewed as beneficial for the child because it allows for new neural pathways to be created. The idea is that the more positive relationships the child is engaged in, the better able the child is to establish trust in future relationships.

Object relations play therapy. The theoretical underpinnings of this approach to play therapy are a combination of Bowlby's (1988) Attachment Theory and object relations theories of Winnicott (1965) and Mahler (Mahler & Furur, 1968). Object Relations Play Therapy is based on three core assumptions: striving to connect with others through relationships drives an individual's development; individuals develop concepts of self and others through their relational experiences; and the therapeutic relationship becomes the secure platform from which previous unstable concepts of self and others may be reconfigured to healthier, more stable concepts (Benedict, 2006). The primary focus in object relations play therapy is developing an essential, secure, therapeutic relationship through emotional attunement to the child (Benedict, 2006). Object relations play therapists believe that establishing the relationship is therapeutic in and of itself, as many of the clients benefiting from this type of intervention have experienced interpersonal trauma and have a difficult time learning to trust others. Once the relationship is developed, the therapist then begins to challenge the child's maladaptive internal working model through the established therapeutic relationship and the use of play (Benedict, 2006). Certain play techniques, such as thematic play, are utilized to facilitate the child's ability to progress towards a more secure sense of self and others (Benedict, 2006).

Circle of security. The Circle of Security model provides play therapists with a way to conceptualize and respond to the child client's needs and foster the development of a secure

relationship with the play therapist (Stewart, Whelan, & Pendelton, 2014). A diagram outlining the circle of security displays two primary functions of the therapist: to be a secure base, and to be a safe haven for the child (Cooper, Hoffman, Marvin, & Powell, 1998). The play therapist responds to underlying needs of the child within the therapeutic environment. When a child is in need of exploration and venturing away, independent from the play therapist, the play therapist serves as a secure base for the child to return to whenever he or she desires. When a child is in need of nurturance, or ‘coming to you,’ then the play therapist serves as the safe haven for the child. The play therapist is constantly assessing and re-assessing the needs of the child as they change across the play sessions and responds accordingly to these two basic needs.

Developmental play therapy. Developmental play therapy, created by Brody (1978), focuses on utilizing touch in the play therapy process to foster development. Brody suggested that human touch is a necessity to forming an attachment bond early in life and that without exposure to affectionate, healthy touch, the child does not develop a sense of trust in others (Brody, 1992). This approach differs from other individual approaches as it may also be applied within a group format, as well as with primary or temporary caregivers. The play therapist works with the child and the caregiver to develop healthy touch patterns and to establish, or re-establish, trust within their relationship. Examples of the types of touch activities utilized in this approach are holding, stroking, and rocking (Kottman, 2011). Brody (1978) also focused on introducing the child to temporary caregivers from the community, as well as teachers, to continue establishing trust with other adults. Each child played individually with an assigned adult before joining the other children in a group format. The children’s group time was referred to as “Circle Time” and was intended to allow the children to practice separation from their temporary caregivers and to focus on relating with peers (Brody, 1978).

Attachment security intervention. Whelan and Stewart (2015) proposed a new method, based on clinical experience, for addressing attachment issues in play therapy clinical practice wherein the play therapist responds to the child and caregiver separately. The clinician is attuned to attachment insecurity in the caregiver-child dyad and works to assist in forming a more secure attachment between the child and the caregiver through use of the therapeutic relationship. The play therapist responds to the caregiver's frustrations, concerns, and confusion regarding mixed or "noisy attachment signals" (Whelan & Stewart, 2015, p. 119) from the child in caregiver consultation sessions. The intent is to help the caregiver "not to feel personally disrespected, rejected, or emotionally injured by the child's emotions and actions" (Whelan & Stewart, 2015, p. 119) and to help the caregiver reframe the child's behaviors into expressed needs. The play therapist also strives to create a secure environment for the child wherein attachment issues may be explored and addressed through attuned responsiveness by the play therapist in individual sessions (Whelan & Stewart, 2015).

Family systems play therapy interventions. Research has shown that engaging caregivers while working with children enhances therapeutic treatment outcomes (Bratton & Landreth, 2005; Bratton, Ray, Rhine, & Jones, 2005; Leblanc & Ritchie, 2001). Several play therapy clinical interventions are used to address the relationship between children and their caregivers. The techniques of the interventions may differ, but the end goal is the same: to create or enhance a secure attachment bond between the child and at least one primary caregiver.

Theraplay. Theraplay was established by Jernberg in 1967. According to Booth and Jernberg (2010), Theraplay is "based on attachment research that demonstrates that sensitive, responsive caregiving and playful interactions nourish a child's brain, form positive internal representations of self and others, and have a lifelong impact on behavior and feelings" (p.4).

The structured sequence to providing Theraplay is assessment, treatment, and then follow up sessions. The Marschak Interaction Method (MIM), an observational technique, is used in conjunction with several questionnaires and an intake interview to evaluate the quality of the child-caregiver relationship (Booth & Jernberg, 2010; Marschak, 1960). The therapist then develops a treatment plan. The four Theraplay dimensions utilized throughout treatment are structure, engagement, nurture, and challenge. Activities are used during sessions to engage the caregiver with the child and to mimic early interactions of a secure relationship between an infant and a caregiver. The purpose is to allow the child, whose needs as an infant may not have been met or may have been met inconsistently, to have a corrective experience that facilitates development (Booth & Jernberg, 2010). Follow-up sessions are scheduled as needed.

Parent-child interaction therapy. Parent-Child Interaction Therapy (PCIT) was originally created to address a variety of psychological and behavioral concerns in children. Enhancing the caregiver-child relationship and teaching caregivers how to implement effective consequences for undesired behaviors were emphasized. PCIT is a two-phase intervention. The first phase, termed Child-Directed Interaction (CDI; Urquiza & Timmer, 2012), focuses on allowing the child to lead during sessions with the caregiver. The end phase of therapy, Parent-Directed Interaction (PDI), focuses on “improving child compliance” as the caregiver implements consequences with the child (Urquiza & Timmer, 2012, p.146). Urquiza and Timmer (2012) estimated the typical number of sessions ranges from 14 to 20. In short, the caregiver learns how to respond to the child’s needs for empathy and structure.

Filial therapy. Filial Therapy (FT) was created by Louise and Bernard Guerney in the 1960s in response to a shortage of mental health counselors to provide services to children (Bratton & Landreth, 1995). In FT, caregivers become the primary therapeutic change agent for

their child. The therapist teaches the caregiver how to provide Child-Centered Play Therapy (CCPT). Once the caregiver has a strong grasp of the necessary therapeutic skills, the caregiver begins to perform at-home play sessions. Regularly scheduled meetings continue to take place between the therapist and the caregiver to discuss skills and progress. VanFleet (2014) estimated that the goals of filial therapy are achieved in approximately “15-20 one-hour sessions for families experiencing moderately challenging problems” (p.3).

Child-parent relationship therapy. Child-Parent Relationship Therapy (CPRT) is a condensed version of FT. CPRT is a ten-session model wherein caregivers meet in a group format to learn how to provide at-home CCPT sessions. CPRT is a highly structured format. The manual for the CPRT group format provides worksheets for caregivers, essential key points for the therapist to remember to stress in each session, helpful tools and lists for caregivers, and homework assignments for caregivers to complete between sessions (Bratton, Landreth, Kellam, & Blackard, 2006). Caregivers are required to bring in a video example each week of an at-home session. The videotapes are reviewed in the group format. Feedback is provided to the caregiver regarding the caregiver’s skills by peer group members and the therapist (Landreth & Bratton, 2006).

Conclusion

Play therapy is purposeful. A discussion of the historical development of play therapy provides an overview of the perspectives and approaches that have been used by mental health practitioners and play therapists. The use of play in therapy evolved into the use of play therapy. Play therapy is a developmentally appropriate intervention that allows children to express themselves in a natural format. Rather than encouraging the child to come to the therapist’s level of cognitive ability through use of verbal expression, the therapist enters the child’s

developmental level of communication, or play (Landreth, 2012). Play therapists deliberately choose to use specific skills to harness the therapeutic powers of play and attend to the expressions and needs of the child, or client. The use of basic play therapy skills facilitates the establishment of a secure, therapeutic relationship, through which the child experiences acceptance and the freedom to experience and move toward growth (Landreth, 2012).

The therapeutic relationship is viewed by some play therapy professionals, from an attachment perspective, as serving as a secure-base and safety-haven from which the child is free to explore or retreat for nurturance as needed (Benedict, 2006; Stewart, Whelan, & Pendelton, 2014). Other Attachment Theory play therapy clinical interventions are family-based and focus on directly engaging the caregiver in the process of play therapy to enhance the attachment relationship between caregiver and child and also to reduce maladaptive behaviors within the family system (Booth & Jernberg, 2010; Landreth & Bratton, 2006; Urquiza & Timmer, 2012; Van Fleet, 2014). Knowledge of Attachment Theory is necessary to fully grasp the concept of healthy childhood development. The caregiver-child relationship plays an integral part in a child's ability to accept nurturance from others, establish relationships, develop a positive self-concept, and explore the world (Bowlby, 1988; Johnson & Whiffen, 2003; Levy & Orlans, 1998). Play is a child's most natural form of communication (Landreth, 2012). Enhancing the child-caregiver relationship through use of play-based interventions assists the caregiver to empathize with the child's perspective (Landreth & Bratton, 2006). Addressing attachment concerns early in life can lead to increased empathy and interpersonal skills across the lifespan (Bowlby, 1988; Levy & Orlans, 1998). Individual play therapy interventions may be used to address attachment concerns; however, enhancing the child-caregiver bond directly is essential in providing effective treatment within the family (Lieberman, 2003). Schaefer (2003) and Schaefer

and Drewes (2011) cited several research studies providing validation that PCIT, Theraplay, and FT are effective in addressing attachment-related issues. Ryan and Bratton (2008) stated, “Attachment theory and research is a well established framework for understanding children's normal and atypical social/emotional development. It is used extensively by clinicians to design interventions, understand interactions, and assess clinical progress” (p. 28). However, Parker (2012) found that play therapists indicated “low levels of adequate training and self-reported competency in Filial Therapy, Parent-Child Interaction Therapy, and Theraplay” (p. 95). Parker (2012) also claimed that what is missing from current play therapy research is an understanding of the “concrete application of Attachment Theory from assessment to treatment” (p. 114). “Results garnered from studying the process through with Attachment Theory is applied during intake, how it informs treatment, and how the treatment is implemented would be useful” (Parker, 2012, p. 114). Some play therapists reported barriers to implementing attachment-oriented family-based play therapy interventions, such as “limit[ed] access to caregivers” (Parker, 2012, p. 114).

CHAPTER THREE

METHODOLOGY

Introduction

In this chapter, the overall methodology used to conduct the study is described. The purpose of the study is reiterated and is followed by an explanation of the rationale for choosing a qualitative approach to the research topic. The specific use of grounded theory methods is further described in relation to the purpose of the study and research topic. The primary research questions are discussed in depth, including the rationale for their foci. Ethical considerations, participant selection and demographic information, data gathering procedures, and measures taken to establish credibility and trustworthiness are expounded.

Purpose of the Study

The quality of an individual's early relationships can impact the overall mental health, functioning, and quality of future relationships for that individual (Cassidy & Shaver, 2008; Johnson & Whiffen, 2003; Levy & Orlans, 1998). Assessing for and addressing attachment issues early on, through helping to establish a secure base for a child, can serve as a preventative measure for thwarting a variety of interpersonal and self-concept issues. What is lacking from current play therapy research is “a concrete understanding of the application of Attachment Theory from assessment to treatment” (Parker, 2012, p. 104). The purpose of this study was to construct a framework for play therapists to use that describes how to incorporate Attachment Theory within their clinical practice, as well as to discern any perceived barriers to implementing an Attachment Theory perspective within play therapy clinical practice. The framework that was

constructed described the incorporation of knowledge of Attachment Theory from intake through termination, was grounded in data, and provides play therapists with a guide for how to incorporate Attachment Theory into their clinical practice.

Rationale for Use of a Qualitative Approach

Qualitative research allows the researcher to explore and describe in rich detail individual participants' experiences and reports (Creswell, 2013). A qualitative perspective is "a natural extension of the therapeutic process" and allows the researcher to approach research with "the basic conditions of genuineness, empathy, and positive regard" (Glazer & Stein, 2010, p.55). Exploring play therapists' thought processes behind their incorporation of Attachment Theory into their clinical practice could have been obtained through several forms of data, such as verbal discourse, a survey, or written documents. I chose to utilize verbal discourse, through semi-structured interviews, as the primary method of data gathering. I chose to use a qualitative approach to allow for individual nuances and experiences to remain present in participants' reports. For instance, a quantitative survey involves forcing participants to subscribe to predetermined possible answers. I wanted the participants to fully express their perceptions and experiences without having to subscribe to predetermined answers.

Grounded theory, one approach to qualitative research, is typically used to explore and describe a process (Creswell, 2013). Exploring how play therapists are incorporating Attachment Theory in their play therapy clinical practice, from initial contact through termination, involved uncovering a time-sensitive decision-making process. Grounded theory methodology enabled this process to be explored and described. In using a grounded theory approach to qualitative research, I was able to construct a theory directly from data obtained. The theory constructed in this research was grounded in play therapists' perceptions and clinical experiences. Grounded

theory is a method in contrast to a quantitative approach, which often involves the researcher individually constructing a theory and then testing its validity, reliability, and applicability. Using grounded theory methodology allowed me to understand how Attachment Theory was integrated by several play therapists. In other words, the theory was generated from the ground up rather than from the researcher down. “In qualitative research, knowledge is not passively observed, but actively constructed and evolved from an exploration of people’s internal construction” (Yeh & Inman, 2007, p. 370). Using the grounded theory methodology enabled me to co-construct, through Charmaz’s (2014) constructivist grounded theory approach to analysis, the theoretical framework with participants through their reports. The conceptual framework employed to inform research methods and data analysis was a combination of Attachment Theory, Social Constructivist Theory, and the Play Therapy Dimensions Model.

Research Questions

The primary research question of the study was: “How do play therapists with knowledge of Attachment Theory integrate that knowledge into their clinical practice?” To fully address this primary research question, several sub-questions were necessary. The primary research question, in conjunction with the sub-questions further described in this section, were used to create the interview guide (see Appendix A) for conducting in-depth, semi-structured interviews with participants.

The answers to the sub-questions explored in this research contributed to the deciphering of data obtained in regards to the primary research question of the study. Together, the answers obtained to sub-questions provided information specifically regarding the decision-making process behind theoretical integration of Attachment Theory, perceived importance of the use of

Attachment Theory, and perceptions of barriers to incorporating Attachment Theory within clinical practice.

To understand how play therapists integrated theoretical knowledge into practice, it was essential to understand their decision-making process. Thus, one sub-question was: “What is the decision-making process behind play therapists’ integration of their knowledge of attachment theory into their clinical practice?” For the purposes of this study, the decision-making process was defined from a broad perspective to avoid assuming that all decision-making processes were alike. The focus was on understanding play therapists’ use of particular bits of knowledge of Attachment Theory at certain junctures, or critical decision moments, within the therapy process. Part of how this was discerned was through inquiry concerning cues that play therapists used, either from the client or from the therapist’s previously acquired knowledge of Attachment Theory, to decide on the course of treatment for a particular client or family. In accordance with the Play Therapy Dimensions Model (Yasenik & Gardner, 2012), attention was paid to the therapists’ primary chosen theoretical orientation, each therapist’s level of directiveness, and the client’s presenting concern. Such data was used to clarify the purposeful connection of theory to practice. Participants were asked to provide a specific case example of a client with whom they had integrated their knowledge of Attachment Theory; descriptions were sought from initial contact through termination. I realized before conducting the research that play therapists may not have integrated Attachment Theory from initial contact through termination, so data was not forced to fit within this time frame. Rather, participants’ reports regarding their perceptions of the stages of the integration process, as well as implicit use of Attachment Theory within their case example reports, were used to construct the stages of the integration process.

Within any process, there is a flow. At times the flow may be linear, and at times it may be cyclical or another type of non-linear flow. Parker (2012) pinpointed the need for a more thorough understanding of the ways that play therapists integrate their knowledge of Attachment Theory into their practice. Rather than the researcher deciding how to label the stages of the process of integration for the participants, a social constructivist approach was employed. The constructivist perspective allowed participants to share their experiences of integration, name the stages of their integration process, and describe what occurred in each stage. Thus, a second sub-question that was used to establish the theoretical framework describing the integration process was: “How do play therapists with knowledge of Attachment Theory define and describe the stages of their process of integration of this knowledge?” Once this information was gleaned, the stages of the integration process emerged through cross-interview coding. Follow-up interviews were utilized to fill in any gaps within the process.

Haslam and Harris (2011) recognized a lack of understanding regarding the “beliefs and attitudes [that] drive the practice decisions of play therapists around their work with families” (p.52). Parker (2012) showed that play therapists have an interest in utilizing an Attachment Theory perspective and that some may not have the competence gleaned from attachment-based training to provide services from an Attachment Theory perspective. Understanding how play therapists’ perceptions of Attachment Theory drive their use of Attachment Theory in their practice may further enlighten others as to the perceived importance of the use of such interventions. Answers to this question may also serve to describe the impetus for inclusion or non-inclusion of attachment-based interventions in play therapists’ work. Thus, a third sub-question was: “What perceived importance do play therapists’ place on utilizing an Attachment

Theory perspective and how, if at all, does this importance motivate their inclusion of knowledge of Attachment Theory into their clinical practice?”

Parker (2012) found that some play therapists experienced barriers to providing family-based play therapy interventions, although those barriers were not fully described. Rather, the barriers were discovered as an unexpected emergent theme from responses to an open-ended qualitative question. The fourth sub-question, intended to gain clarification regarding barriers, was: “What barriers, if any, have play therapists encountered, or imagine others might encounter, to integrating their knowledge of Attachment Theory into their clinical practice?” The intention of this sub-question was to discover any barriers or hindrances that exist that may keep play therapists from implementing an Attachment Theory perspective.

Grounded Theory

Grounded theory, developed by Glaser and Strauss in 1967, is a qualitative approach to research that may be used to generate a theory that describes a process (Creswell, 2013). According to Creswell (2013), “participants in the study would all have experienced the process, and the development of the theory might help explain practice or provide a framework for further research” (p. 83). Several schools of thought exist within the grounded theory approach. Glaser and Strauss created the approach to streamline the development of theory. Rather than creating a theory based on inferences, the intent of this new methodology was to allow the theory to be “grounded in data from the field, especially in the actions, interactions, and social processes of people” (Creswell, 2013, p. 84). The two creators developed a highly structured approach to analyzing the data obtained. Eventually, Glaser and Strauss no longer agreed upon the structured approach, called axial coding, and they each created their own frameworks for grounded theory analysis. Constructivist grounded theory, a more recent approach to grounded theory, was

established by Charmaz (1995, 2000, 2014). Charmaz focused on allowing the theory to emerge from the data rather than following a highly structured format (Creswell, 2013).

The first step in conducting grounded theory research is to identify a gap in the current literature. “The researcher focuses on a process or an action that has distinct steps or phases that occur over time” (Creswell, 2013, p.85). The process is further illuminated through the development of the theoretical explanation for the movement within that process. Thus, identifying a gap in the literature includes deciphering a process, or action, that is in need of further explanation. To my knowledge, no description existed of the process of integration of Attachment Theory knowledge into play therapy treatment planning from intake through termination. Parker (2012) asserted that more information was needed on how clinical application of the theoretical knowledge of Attachment Theory occurs in the play therapy treatment planning process.

Next, the researcher deciphers what types of participants are necessary to study the process in question. Grounded theory relies predominantly on interviewing as the means for gathering data, but other forms of materials such as documents and audiovisual materials may be used as well (Creswell, 2013). The researcher then decides what types of questions will be asked. The focus is “on understanding how individuals experience the process and identify the steps in the process” (Creswell, 2013, p. 88). There were two phases of interviewing within the data collection process. As certain patterns, or categories, emerged from the data, I returned to interview participants, and acquired more specific details about the process. The categories were linked through movement from a time-sensitive perspective to create the theory. The data collection phase did not end until each category identified became saturated and solidified as a component within the generated theory.

Next, the researcher embarks on the data analysis stage of research. The data analysis process is either detailed and structured, or involves a more flexible approach that allows the end theory to emerge from the data (Creswell, 2013). Throughout the analysis process, a technique called memoing was utilized. Through memoing the researcher “writes down ideas about the evolving theory throughout the process of open, axial, and selective coding” (Creswell, 2013, p. 89). The final step was for the researcher to report the “substantive-level theory” that was grounded within the data collected and to compare the theoretical product to similar existing theories (Creswell, 2013, p. 89). I discussed research findings and related them to pertinent literature in Chapter Five.

Selection of Participants

The participants for this research study were selected by a combination of purposeful and theoretical sampling. According to Creswell (2013), purposeful sampling is defined as “select[ing] individuals and sites for study because they can purposefully inform an understanding of the research problem and central phenomenon in the study” (p. 156). Purposeful sampling involves three primary considerations: the participants, the sampling method, and the number of participants or sample size (Creswell, 2013).

Sampling Procedures and Criteria

All participants for this study were members of the Association for Play Therapy (APT), which is the national professional association for play therapists. A screening survey was sent by e-mail to 5,707 APT members. Of those e-mailed APT members, 262 responded to the screening survey (see Appendix B for the e-mail and Appendix C for the screening survey). The gender breakdown of those responses was 242 females and 20 males. Within that same e-mail, potential participants were notified of possible benefits and consequences of participating, their right to

withdraw their participation at any time, and they were informed that participating in the anonymous screening survey comprised informed consent. Those who were willing to participate in initial interviews were asked to provide their e-mail address at the end of the screening survey for me to contact them if they met criteria for further participation. To reduce any potential bias in answering the questions truthfully, the researcher did not divulge the criteria required for further participation. In response to the final question of the screening survey, 90 participants provided their e-mail addresses and indicated they were interested in participating in the interview portion of the research. Of those 90 participants, 34 participants met the criteria for participation in the study. Seven participants were selected based on their RPT or RPT-S credential, ethnicity, geographical location, ability and willingness to participate, perceived frequency of incorporating knowledge of Attachment Theory within their treatment planning process, and exposure to a minimum of 18 clock hours of education in Attachment Theory. It was anticipated that play therapy professionals who were educated in Attachment Theory, who also integrated such knowledge into their clinical practice, would be able to contribute to the development of a theoretical framework that described the overall process of incorporation of Attachment Theory into practice. These criteria for purposeful sampling ensured that participants had the ability and knowledge to contribute to the overall development of the target theoretical framework of the study. Of interested participants, individuals with the most education and experience in Attachment Theory were selected for the first round of interviews.

Theoretical Sampling

In the grounded theory approach to qualitative research, the researcher utilizes theoretical sampling (Charmaz, 2014). When using theoretical sampling, the researcher “chooses participants who can contribute to the development of the theory” (Creswell, 2013, p. 155).

Charmaz (2014) described the process of theoretical sampling as occurring once “a tentative theoretical category from the data” has been developed and the “researcher seeks people, events, or information to illuminate and define the properties, boundaries, and relevance of this category or set of categories” (p. 345). Thus theoretical sampling occurred during and throughout the data collection and data analysis phases of research and differed from initial sampling. Using theoretical sampling, I requested additional interviews from participants whose reports needed further clarification in to further flesh out a category or to obtain additional information as to how certain categories related, or did not relate, to one another. Once saturation of categories was reached, and there was no longer any question about the relationship of the categories to one another within the developed theory, I ceased to gather data.

Participant Demographic Information

In an attempt to diversify the sample, several additional criteria were utilized in selection of participants. Demographic information such as gender, race, and age were used along with information regarding practice settings of participants to gain as much variety as possible within the sample. Attention was also paid to obtaining participants from differing geographical locations, as well as to the recruitment of participants with varied theoretical orientations to play therapy. The hope was that, by recruiting participants in different geographical locations with differing theoretical orientations, a less homogenous sample would be obtained. The attempt to reduce homogeneity of the participants in the sample allowed for richer data to be obtained in constructing the intended grounded theoretical framework of the study.

Sample Size

Differing viewpoints exist concerning what constitutes an appropriate sample size for grounded theory methodology. Creswell (2013) recommended that a range of “20 to 30

individuals” (p. 157) may be necessary to meet saturation. Charmaz (2014) agreed with a similar range of participants, yet acknowledged that certain criteria diminish the need for larger sample sizes. Criteria such as homogeneity of participants in the sample, researching a topic that has a “shared language,” the use of more structured interviews, rich data gathering, having a clearly focused area of research, and diversifying the types of data gathered tend to decrease the need for larger sample sizes (Charmaz, 2014). The concept of saturation, or the point at which obtained data are no longer generating new themes or categories within the research, and at which existing categories are fleshed out and supported by multiple perspectives, is prevalent across the literature regarding grounded theory research. The sample size is indicated once the researcher reaches saturation (Charmaz, 2014; Creswell, 2013; Glaser & Strauss, 1967; Guest, Bunce, & Johnson, 2006; Strauss & Corbin, 1998; Thomson, 2011). The difficulty lies in estimating the number of participants it will take to reach saturation before the data are actually obtained. Thomson (2011) suggested that the sample size will most likely continue increasing until the process of theoretical saturation is completed. Guest, Bunce, and Johnson (2006) attempted to discover the point at which the majority of themes, categories, and saturation are reached in qualitative research in terms of sample size. Although the researchers acknowledged that several factors play a role in increasing or diminishing the sample size, they reported that 94 percent of codes and themes “had been identified within the first six interviews” and that 97 percent “were identified after twelve” (Guest, Bunce, & Johnson, 2006, p. 73). The researchers concluded “data saturation had for the most part occurred by the time we had analyzed twelve interviews” (Guest, Bunce, & Johnson, 2006, p. 74).

Due to relative homogeneity of the target sample for this research study, the use of semi-structured interviews, and a clearly defined research topic of interest, the first round of

interviews consisted of seven participants. I was prepared to increase the sample size as necessary to reach saturation. Data obtained from seven participants led to the achievement of saturation.

Data Gathering Procedures

Permission and approval were obtained from the University of New Orleans' Institutional Review Board (IRB) before beginning the data gathering process. See Appendix D for the IRB exemption letter. Participants, all of whom were members of the APT, received an e-mail with an informed consent letter describing possible benefits and consequences of partaking in the research study, as well as participants' right to withdraw their participation from the study at any point. Within that same e-mail potential participants were provided with a link to the initial screening survey. Participants who chose to complete the screening survey were prompted on the last question to provide their e-mail address to the researcher if they were interested in participating in interviews. Once participants were selected, I contacted seven participants via e-mail to schedule the initial round of interviews (see Appendix E). Participants were selected according to their demographic information, geographical location, credential level, practice setting, education hours in Attachment Theory, and how often they perceived themselves as integrating their knowledge of Attachment Theory in their clinical practice. Those participants who were not selected for the interviewing process were sent an e-mail thanking them for their participation and notifying them that they were not selected (see Appendix F).

Interviewing

The use of in-depth interviewing to obtain rich data is appropriate to the construction of a grounded theory. The researcher uses this form of data gathering "because it facilitates conducting an open-ended, in-depth exploration of an area in which the interviewee has

substantial experience” (Charmaz, 2014, p. 85). Through verbal discourse the researcher is flexible enough to both glean information from the participant as well as to allow novel data to emerge. The researcher is able to address and inquire further about emerging information throughout the interview discourse process (Charmaz, 2014). I used a semi-structured interview guide to provide a somewhat consistent format across interviews. I acknowledged that the interview was a fluid, dynamic process wherein information may be addressed and further pursued within the moment. Therefore, each interview was unique and generated varied data. The use of the interview guide allowed the focus of the interview to remain primarily on information pertinent to the construction of the grounded theory.

Constructivist approach to interviewing. The constructivist approach to grounded theory involves applying a perspective to the interviewing process that is different from other grounded theory approaches. Special attention is paid to the development of a mutual relationship between the researcher and the participant so that the interview process becomes collaborative. The researcher may begin by asking few, open-ended questions to allow the participant to share any information the participant deems relevant. It is possible that just a couple of open-ended questions may suffice at the beginning of the interview, depending on how much narrative and description the participant provides (Charmaz, 2014). As the data collection process becomes more focused, the researcher’s interview questions also become increasingly focused. The researcher begins in a somewhat non-directive stance to interviewing and ends up being increasingly specific in the types of questions asked to obtain the necessary information required to flesh out the emerging theoretical concepts and categories (Charmaz, 2014). Consistent with Charmaz’s (2014) guidelines for constructivist interviewing, I began the

interviews with open-ended questions and followed up with more specific questions once patterns in the data were observed.

Technology and interviewing. Most qualitative data are acquired through discourse, observations, and documents (Creswell, 2007; Mayan, 2009; Patton, 2002). The use of interviews to obtain data is the most widely used approach to data collection qualitative research (Redlich-Amirav & Higginbottom, 2014). With the advancement of technology, the use of technology to acquire qualitative data for research purposes has increased. Interviewing via the Internet using videoconferencing programs allows the researcher to conduct face-to-face interviews in real time without sacrificing the observational component lost when conducting interviews solely via telephone or through chat rooms (Evans, Elford, & Wiggins, 2008). The use of technology to obtain data through videoconferencing also allows the researcher to gain access to participants over vast geographical terrain, thereby increasing the researcher's ability to diversify the sample. Other benefits to utilizing videoconferencing technology in the data gathering process are that it is inexpensive, the participant may remain in the comfort of one's home or office, and the ability to record visual and audio data simultaneously. Guldberg and Mackness (2009) claimed that one of the primary disadvantages to using technology as a means for data gathering is that participants who are unfamiliar with such technology may have a difficult time participating and may have an aversion to the use of such media as videoconferencing. Also, the potential for time lags if the Internet connection is unstable on one end of the conversation, the possibility of disconnection, or the loss of data acquired may increase participant and researcher frustration with the use of the technology (Redlich-Amirav & Higginbottom, 2014).

In this study, data was gathered through use of semi-structured, in-depth interviews via videoconferencing technology and telephone conversations. The use of videoconferencing and telephone conversations allowed me to reach a more geographically diverse sample of participants. I used videoconferencing technology when possible, especially with initial interviews. My hope was to engage in conversation with participants without sacrificing the value of face-to-face interaction and observation. The videoconferencing and telephone interviews were audio recorded for transcription purposes.

Interview process and member checks. The first round of interviews were approximately 45 minutes to 1 hour in length. Once the first set of interviews were completed and transcribed, member checks ensued. I provided each participant with a synopsis of my perception of the reported data via e-mail and asked whether or not he or she would like to add to or change any information. The purpose was to allow participants to contribute any information they may have but did not think to contribute during the first interview. Performing member checks also allowed me to check my perceptions with each participant and therefore added credibility to the study. A second round of follow-up interviews was conducted, as needed, using theoretical sampling to obtain necessary further data. Those second interviews lasted approximately 10 to 20 minutes and allowed me to acquire novel data that helped to fill in gaps for co-construction of the theoretical framework. Participant consent was obtained verbally with each interview and participants were reminded they could withdraw from the study at any time without penalty.

Role of the Researcher

In qualitative research the researcher is the primary research instrument (Creswell, 2013). All data obtained and analyzed are filtered through the researcher. The researcher's perspective

can color and shape the entire research process, from selection of the topic of study to data analysis and the manner in which outcomes are reported. Therefore, the subjective experiences of the researcher and any previous knowledge regarding the research topic in progress can and do shape the research. Peshkin (1988) described subjectivity as “a garment that cannot be removed” (p. 17). It is not necessary, nor is it realistic, to completely remove the researcher’s perspective from the process (Charmaz, 2014; Creswell, 2013). It is imperative that the researcher share as much of the manner in which perceptions and experiences shape the research so that readers may differentiate potential biases within the study. It is also of utmost importance that the researcher remains as aware as possible of how previous experiences are molding the research and to report such influence throughout the process (Peshkin, 1988). Researchers “are obligated to be reflexive about what we bring to the scene, what we see, and how we see it” (Charmaz, 2014, p. 27).

One method for keeping track of the researcher’s own biases and influence over the research is to memo throughout the entire research process. The purpose of memoing is to record “codes and comparisons and any other ideas about [the] data that occur” to the researcher (Charmaz, 2014, p. 4). Whereas memoing typically begins during the coding phases of research, the subjectivities of the researcher may be documented from the beginning of the research process via memoing. This technique allows the researcher to acknowledge changes in the researcher’s perception of the research, as well as enhances the ability to inform the reader of the researcher’s subjectivities throughout the research process. I used memoing throughout the research to maintain awareness of my own biases. An example memo is provided in Appendix G. Excerpts from other sample memos can be found in the research audit in Appendix H.

Researcher's reflections and biases. I am a full-time doctoral student, Licensed Professional Counselor, and Registered Play Therapist. I have provided services to children and their families for approximately five and a half years. For one of those years I was a counseling student intern under faculty supervision for clinical experiences as part of my master's degree attainment, and for about three of those years I was a post-master's counselor-in-training working toward licensure under supervision while studying and training to become a play therapist. At the onset of this research, I worked in private practice part-time where I focused on providing play therapy services to children and their families. I consider myself to be a new professional in both the counseling and play therapy professions.

I have had a penchant for studying relationships since I was an adolescent. Over the years I have become increasingly interested in Attachment Theory and its application in play therapy, the counseling supervisory relationship, and across varying disciplines of clinical practice. As a play therapist who works with children and families, I value the utility of assessing for and addressing attachment styles within and across all relationships related to the counseling process, from supervisor and counselor, to counselor and client, to client and caregiver.

I have training specifically in providing Filial Therapy and Child-Parent Relationship Therapy interventions to children and their families and provide these services in a private practice setting. I also conceptualize clients from an Attachment Theory perspective, yet I am not always quite sure how to incorporate that information into the development of a comprehensive treatment plan. I see Attachment Theory as a complex, beneficial perspective to implement in clinical practice and have a simultaneous dearth of knowledge as to exactly how to incorporate it from initial contact through termination. Part of my bias as the researcher for this study was that I hoped to generate a theoretical framework that describes integration of Attachment Theory into

clinical practice from initial contact through termination. I remained aware of this hope for such a comprehensive framework to develop so that I did not lead participants to answer questions in a particular manner to fulfill this personal goal.

As a Registered Play Therapist who integrated Attachment Theory within my clinical practice, I realized that my knowledge and background shaped my perceptions of other play therapists' reports during the interview process. I was careful not to assume that other play therapists had perceptions and integrative experiences similar to my own. I perceived myself as integrating Attachment Theory primarily through conceptualization and relationship-enhancement interventions. In my practice, I offered Filial Therapy, Child-Parent Relationship Therapy, and family play therapy to directly address the relationships within the family dynamics. I also offered general relationship enrichment through providing caregivers with relationship-enhancing skills to use at home. I did not utilize any formal attachment-based assessments within my practice, as I had not received the necessary formalized training. It was important for me to memo throughout the data gathering and analysis process to minimize my bias and assumptions as much as possible. I allowed participants to describe their experiences and asked for clarification as necessary to ensure that I did not assume that participants' reports were similar to my own experiences. I also realized that I placed value on utilizing an Attachment Theory perspective within play therapy and remained cognizant throughout the research process that other play therapists may not have valued the utility of Attachment Theory in clinical practice the way that I did.

Bracketing provides an opportunity for the researcher to enhance self-awareness throughout the research process. For bracketing purposes, I have asked myself the same research questions that I asked participants. I think it is very important to assess for and address

attachment issues because I think that attachment is at play anytime there is a relationship involved. This importance reflects the value that I place on working from an attachment perspective. I do not believe there is always an attachment issue; rather, the dynamics within relationships and the manner in which an individual perceives their self-worth and their ability to trust others depends upon their attachment history. Within play therapy I think that establishing a secure, supportive relationship with the child as well as the caregivers is vital to therapeutic success. I try to engage caregivers throughout the entire time I am working with the child, whether it is through family based play therapy interventions or through consultation. I value the caregiver's feedback and try to provide relationship-enhancing skills for the caregiver to use with their child whenever possible, regardless of the presenting issue. I offer this to the clients and families I work with because I do not believe that a 'perfect' attachment relationship exists. I believe that all relationships can be enhanced and therefore provide relationship-enhancing skills whenever I perceive an opportunity to do so. I believe that in strengthening the caregiver-child relationship the child's quality of life is enhanced and that the child can then move more freely in the world to explore self and others. This sense of freedom, or increased confidence, to explore can be useful when facing a variety of presenting issues. I have also witnessed the benefits of caregivers' ability to empathize with their children and to accept them in their struggles. I believe that this type of understanding is the first step for the caregiver to be able to provide support and encouragement to the child whenever the child faces challenges.

Data Analysis

Analysis begins when the researcher starts moving beyond the data obtained and begins creating abstractions of the meaning behind the data. This can begin within the transcription process, or even as early as the initial data collection phase (Charmaz, 2014). I personally

transcribed each participant's interview to fully immerse myself as soon as possible in the data. Constructivist grounded theory approaches data analysis from the perspective that the researcher and participants co-construct the theory through a collaborative process. The researcher's perceptions are viewed as a necessary tool to the construction of the grounded theory, which is an on-going, interactive process among the researcher, the participant, and the data (Charmaz, 2014). Charmaz (2014) described the general process of grounded theory data analysis to be initial coding, focused coding, discovering categories, and then linking those found categories to generate theory.

Initial Coding

Codes are constructed. They are the researcher's interpretations of the data obtained. The researcher re-interacts with participants through the data obtained and works to "understand participants' views and actions from their perspective" (Charmaz, 2014, p. 115). According to Charmaz (2014), initial coding is a detail-oriented process that may take place through word-by-word coding or line-by-line coding. The focus during this stage is on actions occurring within the data. Charmaz (2014; 2012) recommended using gerunds for codes to initiate action-oriented descriptions of the process that is being studied and to avoid type-coding participants rather than the data. I utilized the line-by-line initial coding process and to adhered to Charmaz's (2014) recommendation to focus on noticing the actions that were occurring within the text. I documented those actions using gerunds as codes. This early focus on actions through use of gerunds assisted in the later description of movement within the constructed theory (Charmaz, 2014).

Focused Coding

Focused coding involves the use of initial codes to discern which “make the most analytic sense to categorize your data incisively and completely” and “can involve coding your initial codes” (Charmaz, 2014, p. 138). Essentially, the researcher discerns which codes are most prevalent across the data and discerns whether any of the codes may be combined into fewer codes. Focused coding tends to proceed more quickly than initial coding, involves analyzing larger chunks of data, and allows for categories to begin emerging (Charmaz, 2014). I used Charmaz’s (2014) focused coding once initial line-by-line coding was complete.

Emergence of Categories

Charmaz (2014) compared the process of categories emerging to Strauss and Corbin’s (1998) axial coding. The author purported that the primary difference between the two methods is that the strategies employed to define categories “are emergent, rather [than] procedural applications” (Charmaz, 2014, p. 148). I followed Charmaz’s (2014) process and allowed categories to emerge from the focused codes and initial codes that were constructed. Once categories were created, they were further refined and defined into categories and sub-categories (Charmaz, 2014). Emerging categories proved to be significant within the overall process of the final constructed grounded theory when they were validated across participants.

Generating Theory

Theoretical coding occurred once categories emerged. The general purpose for using theoretical coding is to “help you theorize your data and focused codes” (Charmaz, 2014, p. 150). Theoretical codes convey the relationships between the codes and categories that have already emerged within the data. These relationship codes provide links from category to category to further describe the movement across the process being studied. I used theoretical coding to define the relationships between the categories within the constructed theory to define

the flow of the process of integration of knowledge of Attachment Theory within clinical practice. At any time throughout the data analysis phase, if a hole in the emergent categories or theoretical framework existed, I revisited participants' reports or requested additional interviews to collect data to fill in those gaps. This is a common practice within grounded theory and may prove necessary to reach data saturation. Once saturation occurs, the need for collecting additional data ceases. The final step is for the researcher to report the "substantive-level theory" that has been grounded within the data collected and to compare the theoretical product to similar existing theories (Creswell, 2013, p. 89). Once the grounded theory was generated, I compared aspects of the theory to extant literature. In Chapter Five, I provided a written comparison of the similarities and differences between the grounded theory generated from this research and any pre-existing, similar theory to clarify the novel contributions this study made. Upon completion of the study, participants who provided their e-mail to participate within the study were provided with a copy of the generated theoretical framework via e-mail.

Ethical Considerations

The researcher provided written and verbal consent to each participant. The written consent describing the participants' rights and the potential benefits and consequences of participating in the research study were communicated and obtained via the initial e-mail that provided the link to the screening survey. The second, verbal consent for research participation and audio-taping was acquired through discourse once selected participants had scheduled the first interview. In e-mail discourse while scheduling the first interview, participants were once again informed of their rights and potential benefits and consequences of participating in the study. They were notified that consent for participation included consent to audio recording of the interviews. Participants were given the option to withdraw from the study at any point and

were provided with the option of contacting the researcher prior to the initial round of interviews with any questions or potential concerns. Pseudonyms were assigned to participants to protect their confidentiality.

Establishing Trustworthiness

Creswell (2013) compared the establishment of trustworthiness in qualitative research to the concept of validity in quantitative research. The general idea in establishing trustworthiness is that the researcher is able to clearly communicate how data have been analyzed and how conclusions have been drawn. This allows readers to decide whether they agree with the tactics the researcher used throughout the process. Additionally, Creswell (2013) provided an overview of several researcher stances on what leads to the establishment of credibility of qualitative research. Triangulation is a method often used in qualitative research to establish trustworthiness and involves the researcher backing up data obtained and inferences made through locating evidentiary support through a variety of resources. Creswell (2013) described eight possible forms of conducting triangulation in the research process and recommended that researchers subscribe to a minimum of two of those eight methods to establish trustworthiness. I used four primary forms of triangulation: “clarifying researcher bias” from the beginning, “member checking,” the use of “rich, thick description” in reporting data, and an audit trail (Creswell, 2013, pp. 251-252).

Clarifying Researcher Bias

Researcher bias can impact the entire research process, from the choice of topic, to the analysis methods used, to the reporting of findings. It is vital for readers to be able to separate the researcher’s values, “past experiences, biases, prejudices, and orientations that have likely shaped the interpretation and approach to the study” (Creswell, 2013, p. 251). From a

constructivist perspective the researcher cannot be neutral, as the researcher brings an entire world-view and plethora of experiences into the research process. Grounded theorist researchers must explicate their perceptions and experiences shaping the research to keep the reader as informed as possible (Charmaz, 2014). Again, the intention is that the reader can spot the biases that have shaped the research and understand the manner in which the research was constructed. I bracketed my experiences as a play therapist and clarified my biases as the researcher, as is described under the subheading “researcher’s reflection and biases” under the Role of the Researcher section in Chapter Three.

Member Checking

Lincoln and Guba deemed member checking as “the most critical technique for establishing credibility” (p. 314). Member checking involves the researcher checking in with participants regarding the researcher’s perceptions of participants’ reports. Member checks occurred after each interview was conducted. I provided each participant with a synopsis of his or her reports via e-mail and asked whether he or she would like to add to or change any information. One purpose was to allow participants to contribute any information they may have but did not think to offer during the interview. Once the final theoretical framework had emerged and was established, participants were provided with a synopsis of the framework.

Use of Thick Description

The social constructivist approach to grounded theory focuses on the importance of describing the contexts of research participants as well as the co-construction of reality that occurs between the researcher and participant (Charmaz, 2014). The use of thick description provides a clear understanding of the settings of participants and the information obtained to determine whether such information can be transferred to other contexts (Creswell, 2013).

Descriptions may be physical, or may describe some sort of activity or movement (Creswell, 2013). To portray an accurate understanding of the data and information obtained for this research, I provided rich descriptions of participants' reports. I also provided information regarding their practice settings. Additionally, direct quotations of participants were communicated in appropriate support of findings.

Audit Trail

An audit trail documents the overall process of research so that any outside person may know exactly how the research was completed (Creswell, 2013). I documented each step of the research process and included excerpts of researcher memos that I kept throughout the research journey to further clarify my subjectivities in connection with the research process (see Appendix H). I also made notes regarding the general steps taken, such as obtaining IRB approval.

Summary

This chapter provided an overview of the use of grounded theory research methodology to develop a theoretical framework describing the process of integration of knowledge of Attachment Theory into play therapists' clinical practice. Specific clarification of ethical considerations, participant selection and demographic information, as well as data gathering procedures and measures taken to establish trustworthiness by the researcher were divulged. A step-by-step overview of the process of data analysis was also included. A section airing the researcher's biases, experiences and background information relevant to the research topic was provided.

CHAPTER FOUR

RESULTS

Introduction

Enhancing attachment between a child and his or her caregiver early in life can serve as a protective measure against a variety of mental health concerns and can enhance that individual's ability to engage in future relationships (Aguilar, Sroufe, Egeland, & Carlson, 2000; Carlson, 1998; Cassidy & Shaver, 2008; Deklyen & Greenberg, 2008; Johnson & Whiffen, 2003; Levy & Orlans, 1998; Ogawa et al., 1997; Renken et al., 1989; Warren, Huston, Egeland, & Sroufe, 1997). The purpose of this study was to explore how play therapists with knowledge of Attachment Theory integrate such knowledge into their treatment planning and clinical practice. Although several attachment-based interventions exist, no existing theoretical framework was found to describe the manner in which Attachment Theory is applied across play therapy treatment planning, regardless of the type of intervention(s) employed. The primary research question of this study focused on understanding play therapists' perceptions of their process of integrating Attachment Theory within their treatment planning and clinical practice. Additional research questions focused on discovering the value, if any, participants placed on utilizing an attachment-based perspective, and any perceived barriers that may exist to incorporating knowledge of Attachment Theory into practice.

The intent of this study was to co-construct, with participants, a grounded theory describing the process of integration of Attachment Theory within play therapy treatment planning. The theoretical framework that emerged during data analysis is that integration of Attachment Theory begins at initial contact with the client and ends when play therapy

terminates. The primary focus throughout the integration process is placed on increasing well-being through relationship enhancement. The stages of the theory of integration, as co-constructed by the researcher and participants, are establishing safety, gaining and providing information, facilitating growth through relationship, and saying goodbye. These four stages emerged through the data analysis processes of initial coding, focused coding, theoretical sampling, creation of categories, and linking categories through relationship. The general flow through the stages of the theory was found to be non-linear, due to a cyclical component between the second and third stages. The relationships between the stages of the theory are explicated at the end of this chapter and Figure 3 illustrates the movement through the stages of the final theory.

The formal data analysis portion of the research began with the act of transcribing; interviews were transcribed by the researcher. Memoing and constant comparison methods were utilized throughout data analysis procedures. A research audit was kept, documenting the research steps taken throughout the process. Excerpts from memos serving as examples of the memoing process were included in the research audit. See Appendix G for a memo example and Appendix H for the research audit. Member checks were completed via e-mail following transcription of the initial interviews. The following section introduces the seven participants selected for this research study through descriptions of their practice setting, background information regarding their knowledge of Attachment Theory, and a brief summary of their description of the stages of their integration process. All participants were assigned a pseudonym and specific organization names were omitted to preserve confidentiality.

Participants

All participants held the Registered Play Therapist or Registered Play Therapist-Supervisor credential, reported a minimum of 18 clock hours of education in Attachment Theory, and perceived themselves as integrating Attachment Theory within their clinical practice ‘often’ or ‘almost always.’ During the screening process, attention was paid to selecting participants from varying geographical locations, ethnicities, principal theoretical orientations, primary credentials, and practice settings. To provide an impression of each individual’s responses to interview questions, I have included transcript excerpts in their introductions that exhibit a portion of their perception of integrating Attachment Theory. I also provided each participant’s self-labeled stages of their integration process and remained true to their use of language. In Table 1, participant demographic information is displayed. In Table 2, a concise look is provided at participants’ self-labeled stages of their integration process of Attachment Theory into their clinical treatment planning.

Table 1*Participant Demographic Information*

| Pseudonym | Race | Gender | Theoretical Orientation | Credential | State | Practice Setting | Clock Hours of Education in Attachment Theory |
|------------------|-------------|---------------|--------------------------------|-------------------|--------------|-------------------------|--|
| Raquel | Caucasian | Female | Prescriptive | LPC, RPT | TX | Private Practice | 36 + |
| Kara | Hispanic | Female | Prescriptive | LCSW, RPT | MO | School and Agency | 36+ |
| Ezra | Caucasian | Female | Child-Centered | LMFT, LCSW, RPT-S | UT | Private Practice | 36+ |
| Juanita | Caucasian | Female | Prescriptive | LCPC, NCC, RPT | IL | Agency | 18 to 24 |
| Nikki | Caucasian | Female | Child-Centered | LMFT, RPT | CA | Private Practice | 36+ |
| Simone | Caucasian | Female | Cognitive Behavioral | LCSW, RPT | MI | Private Practice | 18 to 24 |
| Ginger | Caucasian | Female | “Theraplay, Dyadic and others” | Psychiatric Nurse | DC | Private Practice | 36+ |

Raquel

Raquel is a thirty-nine year old, Caucasian female who works in private practice in Texas. She is a Licensed Professional Counselor and Registered Play Therapist, and has approximately five years of clinical experience. She provides services primarily to children, ages six to 10, but also works with teenagers, and utilizes Prescriptive play therapy as her chosen

theoretical orientation. Raquel has received over 36 clock hours of education in Attachment Theory and perceived herself as integrating Attachment Theory within her treatment planning process ‘almost always.’ Raquel’s clinical attachment-based training centered primarily around the use of Theraplay. Raquel believed that the quality of the attachment should be “at least assessed” any time a clinician is working with children and their families. Raquel stated that she believed individuals develop a sense of self within their initial relationships with caregivers and that not assessing or addressing attachment issues leads to a failure on the play therapist’s part to understand a major portion of that child or family’s experiences.

Raquel begins integrating knowledge of Attachment Theory in the initial intake session. She seeks to gain as much knowledge as she can about the child’s presenting issue, developmental history, and family dynamics. Based on the presenting issue, she chooses to integrate her knowledge of Attachment Theory in different ways.

If I’ve got an idea coming from intake that this is truly an attachment problem, like the main issue is an attachment issue, then we’re going to go straight into an attachment assessment during the first session. If it’s more of a, um, say anxiety or depression, or something like that, then I’ve got that in the back of my mind. I’m thinking, ‘Well, how is the attachment environment? How is the attachment style and the whole environment going to support or take away from the problem?’

Raquel either addresses a blatant attachment disruption directly, or uses existing strengths within the caregiver-child attachment relationship to indirectly enhance the play therapy process.

Raquel identified the general phases of her integration process as intake, assessing the attachment itself, feedback, intervention, facilitating change through relationship, and termination. From Raquel’s perspective, intake consisted of gathering information from the

caregivers through asking questions related to attachment, gaining a thorough understanding of the presenting concerns, and establishing goals. She considered intake to be a part of assessment, and described intake as primarily being a time when informal assessment methods, such as verbally asking questions during conversation, were used. When an individual presented with an obvious attachment-related issue, Raquel would proceed from intake into a more formal assessment phase of the integration process, which she referred to as “assessing the attachment itself.” Within this formal phase, she reported she would most likely use the Marschack Interaction Method (MIM) assessment to discover the qualities within the relational dynamics between the caregiver and the child. From there, she would provide feedback and gain information through consultation with the caregiver. It is during this consultation that a course of action, or plan, would be developed in conjunction with feedback from the caregiver. Based on the needs of the caregiver and the child, Raquel stated that she would choose an intervention based on the caregiver’s availability to engage in the therapeutic process. When the caregiver was available to engage directly within therapeutic sessions, Raquel would incorporate the caregiver in sessions. If the caregiver was unable to engage in the process directly but was willing to engage through periodic consultation sessions, then Raquel would engage the caregiver in that manner and work on the caregiver-child relationship in an indirect manner. If the caregiver was unable to engage in either direct sessions or in consultations, and the child was not yet a teenager, Raquel would refer those clients to other practitioners. Raquel spoke about the importance of focusing on encouraging a healthy attachment between the caregiver and child instead of fostering an attachment between the child and the therapist, as the therapeutic relationship is temporary. Raquel stated that harm could occur to the child if the child had attached to the therapist and then the caregivers pulled the child from therapy prematurely.

Raquel spoke about working with teenagers and using the therapeutic relationship as a means from which to “launch them.” She described teenagers as having the insight to be able to cognitively understand and apply the dynamics in the therapeutic relationship to other relationships, whereas a younger child will not likely have the same abilities to cognitively understand and translate the relational dynamics of the therapeutic relationship to other relationships. Raquel focused on using the strengths already existing within the caregiver-child relationship to facilitate growth. The final stage of Raquel’s process, termination, was described as occurring once the initial goals of therapy have been met. Raquel also mentioned that at times termination occurs because a client leaves therapy prematurely and that while she works to avoid this through engaging caregivers within the process, she views it as ultimately beyond her control.

Kara

Kara works in an agency that is also a school. She is a 34 year old, Hispanic female and is a Licensed Clinical Social Worker and Registered Play Therapist in Missouri. She has been practicing for approximately five years. She works primarily with infants and children, infants to age five, and incorporates caregivers and teachers into her interventions. Kara works from a Prescriptive play therapy theoretical orientation. She has completed over 36 clock hours of education in Attachment Theory and perceived herself as integrating this knowledge into her practice ‘almost always.’ She has received training in Theraplay, Child-Parent Relationship Therapy (CPRT), and Didactic Developmental Psychotherapy (DDP).

For Kara, the population she serves is a primary motivator for incorporating her knowledge of Attachment Theory within her clinical practice.

So, the kids that I work with are typically kids that are struggling behaviorally with extreme aggression and violence. The underlying diagnosis tends to be Post-traumatic Stress Disorder (PTSD). So these are families that are in severe places of poverty and with that comes neglect and sometimes abuse. So that attachment piece is so significant!

Kara seeks to incorporate caregivers within her treatment planning and clinical practice whenever possible. She provides individual and group play therapy. She also teaches skills to teachers to incorporate with children in the classroom and holds group therapy sessions within the classroom setting.

Kara perceived herself as integrating Attachment Theory across all the work she does. Kara said, "I feel like everything I do is really attachment-based. I start with that framework essentially." Kara defined the stages of her process of integrating Attachment Theory within her treatment planning as: establishing safety, building trust, regulation and mastery, and termination. Establishing safety was a major emphasis in Kara's interview. Kara described the population she works with as really needing to have that sense of security through safety in the play therapy environment to be able to even begin therapeutic work, particularly from an attachment perspective. Kara said, "You have your safety first and then attachment next." Kara described the establishing safety phase of her work to be overlapping with the entire process, but she also described it as being essential to establish safety before beginning any attachment-based work. Building trust was considered to occur after establishing safety and was described by Kara to be an ongoing process throughout the therapeutic process.

But I think kind of breaking it down, phase two is that building of trust. Consistent responding, consistent responding, which ideally leads to the phase of regulation, which means the child or the adult can have this sensitive, attuned person, that is responding to

them the same way every time, and they learn to build that trust and skill, which...then they can incorporate themselves.

Kara discussed the use of modeling, assessing caregiver's availability, responding to caregiver's needs, responding to child's needs, and encouraging caregiver to respond to child's needs to be part of building trust. Once trust was established and maintained, along with safety, then Kara focused on regulation and mastery of skills.

I'm being very general here, but working on developing skills such as emotional regulation, emotional identification, noticing emotions, validating them, normalizing them for them, then highlighting the resiliency skills that they have and then the last phase is mastery.

The regulation and mastery of skills phase was described as being ongoing until the more secure attachment was established between the child and the caregiver. The regulation and mastery of skills stage is when interventions were used to facilitate growth through relationship. Kara reported using Theraplay interventions to address the needs of the child and the caregiver. Kara also stated that she provides in-classroom groups using Theraplay techniques with the children to foster relationships with their peers in addition to relationships with their caregivers. This generalizing of the relational skills to relationships outside the therapeutic and caregiver-child relationships was viewed as the beginning of the termination process.

Then ideally I'm replacing myself, if I've become the surrogate attachment figure, and replacing myself with a parent that is now ready, or a teacher, or a peer, or someone they can generalize the safe, consistent, validating relationship.

Kara mentioned that she had rarely engaged in a full termination process, as she perceived the attachment issues in the populations she works with to be so great and the work is ongoing.

However, she did mention that her termination process included generalizing skills to outside relationships, first with a caregiver or another adult, and then with peers. Once healthy attachment relationships are formed with peers, she perceived the ending of therapy to be indicated.

Ezra

Ezra, a 58 year old, Caucasian female, is a Licensed Marriage and Family Therapist, Licensed Clinical Social Worker, and Registered Play Therapist Supervisor. She provides services primarily to children age six to 10 and works in private practice in Utah. Ezra operates from a Child-Centered Play Therapy theoretical orientation and has approximately 20 years of clinical experience. She has accomplished over 36 hours of education in Attachment Theory and perceives herself as integrating this knowledge within her treatment planning ‘almost always.’

Ezra believed that working from an attachment perspective with children and their families is vital to the child’s ability to self-actualize. She stated she used her knowledge of Attachment Theory with all of her clients. Throughout the interview she focused on her conceptualization of the therapeutic process from an attachment-perspective, which was facilitating growth through relationship. Ezra described, “I really like what Gary Landreth explains, you know, I don’t treat depression. I make a relationship with the child.”

I’m looking at the attachment as the foundation. Because I connect deeply with that humanistic piece of the child has within them, or the individual has within them, that ability to heal, but it does need to happen in what I’m going to call a safe place, a safe relationship.

Ezra identified the phases of her integration process as intake, assessment, intervention, and tapering off or termination. She also described using modeling from an attachment-perspective,

to show caregivers relational skills, across the entire play therapy process. Ezra viewed the beginning of Attachment Theory integration as occurring in intake through the process of gathering information, getting to know the family dynamics through informal observations, establishing a sense of safety within the therapeutic relationship, modeling healthy attachment qualities to caregivers, and providing education to caregivers regarding Attachment Theory. Ezra focused on gaining trans-generational attachment information in addition to caregiver and child attachment information during her intake process. From intake, Ezra moved into the assessment phase, which she defined as incorporating both formal and informal assessment methods from an attachment-based perspective. Ezra stated she used the MIM in addition to observations of body language cues to assess an individual's attachment style. Ezra reported using an attachment-based perspective with all her clients, and stated that this is "going to be one of the very first places I intervene" when working with clients with "explicit attachment disruption." Ezra assessed the caregiver-child relationship and then decided how to intervene based on the "current status of the relationship." Ezra spoke of incorporating Filial Therapy techniques and Theraplay techniques into her interventions and also of creating "check ins" between the caregiver and the child at home to foster the enhancement of their relationship. Ezra stated that the termination, or tapering off, phase began when the caregiver and child began showing markers of a more secure relationship. Ezra uses the tactics of tapering off the number of sessions and spacing out those sessions farther and farther apart to ease the process of saying goodbye. Throughout the termination, or tapering off, stage Ezra assessed for regression or new presenting concerns and, if no new issues arose, therapy was ended. If a new issue arose, or if there was significant regression, the treatment planning process began again from the beginning, except that the intake stage was replaced by a consultation session with the caregivers.

Juanita

Juanita is a 63 year old, Caucasian female who works in Illinois. She is a Licensed Clinical Professional Counselor, National Certified Counselor, and Registered Play Therapist. She has approximately 15 years of clinical experience and currently provides services within an agency setting. She utilizes a Prescriptive play therapy theoretical orientation and chiefly serves children age three to eight “who are involved with child protective services.” She completed approximately 24 hours of education in Attachment Theory and perceives herself as ‘almost always’ integrating that knowledge within her play therapy treatment planning.

Juanita described the importance of working from an attachment-based perspective as being integral to the child’s development of sense of self and self and others. She also spoke about the importance of establishing safety first to promote a sense of security for accomplishing attachment-based work.

From day one, when they come in, so that we are making this a safe and a predictable environment, and showing them how much we value them and how much we, um, have great esteem for them so that they can start getting that unconditional respect and that they can start to internalize a better sense of themselves.

Juanita outlined the stages of her integration process of Attachment Theory as making the play therapy environment safe and predictable, harder work, integration, and end of therapy. She stated that the children and families she works with typically are overcoming trauma and “attachment is just interwoven through all of that.” Juanita described her process of integration using the metaphor of a sandwich. She stated that the bottom piece of bread was the “basis, your beginning, and the establishment of the foundation of the relationship and the safety and the predictability.” From this initial phase, Juanita described moving into “the meat of the sandwich

and that would be the harder work.” The harder work phase included learning relational skills and raising awareness of negative cognitions about self and self and others and changing those cognitions to reflect a more positive or secure framework from which to view self and self and others. On the other side of the sandwich, or the top piece of bread, is “the turning that into the positive relationship, the ability to practice the good relationship skills with all of that knowledge” and “to be able to integrate and to really use those skills with their families or with their foster families.” Juanita stated that this is the point at which most of her clients are either reunified with their caregivers or adopted, so they are no longer receiving services with her. Juanita clarified that, if she had the opportunity to continue providing longer-term services, she would most likely continue working on the caregiver-child relationship through skills-building and “exploring their self and their feelings of their self and how they’re integrated into society and with their friends and with their families.” Juanita stated that she would know the time had come to terminate “when I would just see that child’s face light up around that adult and then that very same love reflected in the parent’s face.”

Nikki

Nikki is a 45 year old, Caucasian female who is a Licensed Marriage and Family Therapist, Registered Play Therapist, and credentialed teacher. She works from a Child-Centered Play Therapy theoretical orientation in a private practice setting in California. Nikki has approximately seven years of clinical work experience and most of the clients she serves fall within the age range of six to 10 years old. Nikki has completed over 36 clock hours of education in Attachment Theory and perceived herself as ‘almost always’ integrating Attachment Theory within her treatment planning.

According to Nikki, Attachment Theory is “essential. I can’t not incorporate it. It’s always there. It’s something that I’m mindful of the entire session.” Nikki viewed Attachment Theory as a “hopeful” theory for approaching her clinical work and she stated, “It really aligned with just my paradigm of life and therapy.”

Nikki viewed herself as integrating Attachment Theory knowledge with her individual clients through conceptualizing their level of personal security, as well as within family-based play therapy interventions. She stated, in regards to Attachment Theory, “I use the basic concepts in everything that I do.” Nikki defined the stages of her integration process as creating safety, assessing, creating and implementing a plan, and generalizing. Nikki stated, “letting the client or the family know that the first, the only main rule in the room, is to keep everyone safe” is of utmost importance to initiating attachment-based therapy. Nikki clarified that this referred to physical and emotional safety, as well as “knowing that there is nothing that you can do in here that um, can’t be repaired.” While safety was being established and maintained, the assessment phase began. Nikki stated that she used both formal and informal assessments to gain information regarding the attachment style of the individual or the status of the attachment relationship between the caregiver and the child. Nikki reported that she used primarily informal methods of assessing, such as noticing body language cues like “acting out” or “getting big and loud,” to assess the attachment style of an individual or child-caregiver relationship. Nikki also mentioned that she used an attachment assessment that she created based on the Adult Attachment Inventory (AAI) to assess caregivers’ attachment styles in her intake sessions. Following the assessment stage Nikki moved into the creating a plan and implementing the plan stage. It was within this stage that Nikki described tailoring interventions to meet the client’s needs. Nikki described the purpose of this stage as “really, actively helping that family process

and experience that secure attachment.” She mentioned that a lot of the work in this stage with the child is done through the therapeutic relationship and the caregiver-child relationship, without the use of words. Nikki said, “It would all be through play and interaction and relationship.” Once the caregiver and the child are beginning to develop a more secure relationship, or the child and therapist are developing a more secure relationship, then the next step was “to help them generalize that to other relationships.” This is when Nikki would either choose to incorporate the caregiver, if the caregiver was not already directly involved, or another individual who would have a long term presence in the child’s life, within the therapy sessions. Nikki stated that she followed the same signals for ending therapy from an attachment-based perspective as she does with all of her therapy. Nikki said, “when children are done and ready to end our work together, their play becomes less repetitive, less intense.”

Simone

Simone, a 60-year-old Caucasian female, is a Licensed Clinical Social Worker and Registered Play Therapist. She works in private practice in Michigan and has approximately 10 years of clinical experience. She works from a Cognitive-Behavioral play therapy orientation and perceives herself as incorporating Attachment Theory within her treatment planning ‘often.’ Simone has acquired approximately 24 hours of education in Attachment Theory. She typically provides services to children ages six to 10 years old. She utilizes Child-Parent Relationship Therapy, Circle of Security, and Theraplay. Additionally, her attachment-based work is inspired by the writings of Bruce Perry and Daniel Siegel.

Simone spoke to the importance of fostering a secure attachment through integration of Attachment Theory within her play therapy clinical practice. She stated that she was motivated to

learn more about Attachment Theory due to presenting concerns of the population with which she works.

I began to notice that there were many parents who came in too, either adopting parents who are adopting children, or foster parenting, or kinship adoptions, or kinship care, and then parents who had had some kind of separation point with their own children. Or they themselves had experienced separation and destruction in their attachment and it was affecting maybe their parenting or their own life.

Simone expressed a penchant for incorporating animal-assisted therapy from an attachment perspective into her treatment planning. She said, “you establish trust with the animal before, then with the human.”

Simone described the phases of her integration process as assessment, psycho-education and modeling, active therapy, and termination. The assessment phase began during intake, when Simone gathered information through use of intake questionnaires about the child’s and “even beyond that, the family members’ own history” to discern the child’s and the family’s attachment dynamics. Simone stated that she used psycho-education within the intake process and in ongoing consultation sessions with the caregivers, as well as in individual sessions with the child. Simone specifically reported using psycho-education about the brain from an attachment-perspective. Within the psycho-education phase of Attachment Theory integration, Simone also used modeling to enhance the caregiver’s learning about a healthy attachment through experience. Simone said, “You’re actually modeling that sense of safety. Creating a place of safety.” Simone described the next phase as the “active therapy” stage of the integration process. Within this stage, Simone used play, art, and animal-assisted therapy in addition to individual and caregiver-child dyadic sessions to address specific presenting needs of the child and the child

and family. Once the goals of the child and the child and family are reached, the termination phase of therapy begins. Simone emphasized the importance of a proper termination. Simone referred to this phase as “vital.” She addressed the ending of therapy with caregivers from the perspective of wanting to leave the door open for future return. Simone stated that she specifically told caregivers that if any new presenting issues arise, or as new developmental milestones are reached, the child or the child and family may wish to return to continue.

Ginger

Ginger, a 63 year old Caucasian female, is a Psychiatric Nurse and Registered Play Therapist practicing in Washington D.C. She works in private practice and considers her theoretical orientation to play therapy to be “Theraplay, Dyadic, and others.” At the time the interview was completed, she was in the process of completing a Theraplay certification program. Ginger has approximately 15 years of clinical experience and serves primarily children aged six to 10 years old and their families. She has completed over 36 clock hours of education and reported that she integrates Attachment Theory within her treatment planning ‘almost always.’

Ginger discussed the value of integrating Attachment Theory in play therapy clinical practice as being pertinent due to the relationship-focused nature of human beings. She stated, “Everything that we do, healthy, unhealthy, whatever, is within the context of relationships.” Ginger spoke about her use of Attachment Theory across most presenting issues that she addressed in her practice.

Let’s put it this way. It’s easier for me to tell you when I would not do it. When I would not do it would be a parent who has no interest, um, that is not their expressed concern.

I would say half of my work is about med management with things like Attention-Deficit Hyperactivity Disorder (ADHD) and then the other half is a lot of parents work. Parents slash joint kid work.

Ginger labeled the stages of her process of integration of Attachment Theory in her clinical practice as intake, assessment, education and intervention, re-assessment, and tapering off. Ginger stated that her assessment process begins in intake.

I guess I start with intake, and I find out if a parent is calling about a kid, then I insist on seeing the parent first. So, the parent comes in and in my mind, the minute I'm working with them, the minute I'm interviewing them, my mind is sort of going toward the nature of the attachment.

She used both informal and formal methods for assessing attachment styles with her clients and their families. Ginger reported that once she has gathered information from the intake session through questionnaires and conversation, she either continues the assessment process using the formal Marschack Interaction Method or less formal, more observational methods. An example of informal observation she used was described as "looking at behaviors increasing and diminishing and then the parent's attunement to the child." In either case, Ginger also mentioned that assessment is ongoing throughout the entire therapeutic process from an attachment perspective. Using information from the assessment, Ginger stated that she likes to tailor interventions to address the needs of the client. From an attachment-based perspective, this tailoring of interventions included using Theraplay techniques that Ginger had modified, as well as using modified Filial Therapy and Child-Parent Relationship Therapy techniques. Ginger also discussed providing feedback to caregivers in the education and intervention stage. Ginger stated that she rarely terminated permanently with her clients. She mentioned that when she does end

therapy, it tends to be a sort of break in therapy rather than a long-term ending. Ginger stated that two indicators for potential termination included the initial goals of therapy had been met and the caregivers were displaying more confidence in using their caregiving skills. However, Ginger described that when her clients reached a point in therapy where their relationships were reflecting security, then the therapy sessions would occur “less often” and the therapeutic process would essentially be tapered off. Ginger made it clear that she leaves the door open for caregivers and children to return to therapy if any new presenting issues or concerns arise.

The participants’ self-labeled stages of integration of Attachment Theory are summarized below in Table 2.

Table 2

Participants’ Self-labeled Stages of Process of Integration of Attachment Theory

| Pseudonym | Self-Labeled Stages of Integration |
|------------------|---|
| Raquel | Intake → Assessing Attachment Itself → Feedback → Intervention → Facilitating Change Through Relationship → Termination |
| Kara | Establishing Safety → Building Trust → Regulation and Mastery → Termination |
| Ezra | Intake → Assessment → Intervention → Tapering Off/ Termination |
| Juanita | Making This a Safe and Predictable Environment → Harder Work → Integration → End of Therapy |
| Nikki | Creating Safety → Assessing → Creating and Implementing a Plan → Generalizing |
| Simone | Assessment → Psychoeducation and Modeling → Active Therapy → Termination |
| Ginger | Intake → Assessment → Education and Intervention → Re-Assessment → Tapering Off |

Theory Development

Each participant was asked a series of questions regarding how they incorporate Attachment Theory within play therapy treatment planning. Data analysis began during the interview process, as I began memoing themes that occurred within and across participant responses. Engaging in transcription allowed for a deepening of analytic insight into the data. I continued memoing throughout the transcription process, making note of any follow-up questions that I wanted to ask, as well as patterns that I noticed within individual and across multiple participant responses. Post-transcription member checks were completed with all participants via e-mail. I also began the formal coding process post-transcription. I used line-by-line coding first and then moved on to focused coding, or coding the initial codes obtained from line-by-line coding. I utilized the constant comparative method and continued to note patterns I witnessed within individual and across multiple participant responses. The categories of data emerged from these patterns. Development of the theory occurred as I considered the tacit and explicit patterns in the processes reported across participant responses and co-constructed the relationships between the core theoretical categories through use of theoretical sampling via follow-up interviews with participants. A follow-up interview was completed with six participants. Saturation occurred once clearly defined categories had emerged within and across participant interviews and the relationships among those categories had been distinguished through use of theoretical sampling and follow-up interviews.

Coding

Data analysis began during the interview process. As I listened to participant responses and asked clarifying questions, themes occurred within the initial interview. I used memoing to

take note of these patterns. This process occurred with each consecutive interview and patterns across interviews were also noted through use of memoing. Once transcription was complete, I began the formal coding process as soon as possible. The initial phase of formal coding consisted of line-by-line coding using gerunds and in vivo codes. Next, I engaged in focused coding, wherein I noted patterns in the initial codes and created a more succinct set of focused codes that described the initial codes. From the focused codes a set of categories emerged. Those categories were further honed, through contemplation of patterns in the data obtained, reviewing memos, and further discussion with participants, to create a set of core categories. Figure 1 illustrates the movement from selected focused codes to core categories. Those core categories, in relationship to one another, formed the finalized grounded theory. The relationships among the core categories were co-constructed through further discourse with participants through use of follow-up interviews. Memoing occurred throughout the entire process. Figure 2 displays the process of data analysis that was followed for constructing this grounded theory.

Figure 1. Example of data analysis illustrating movement from selected codes to core categories.

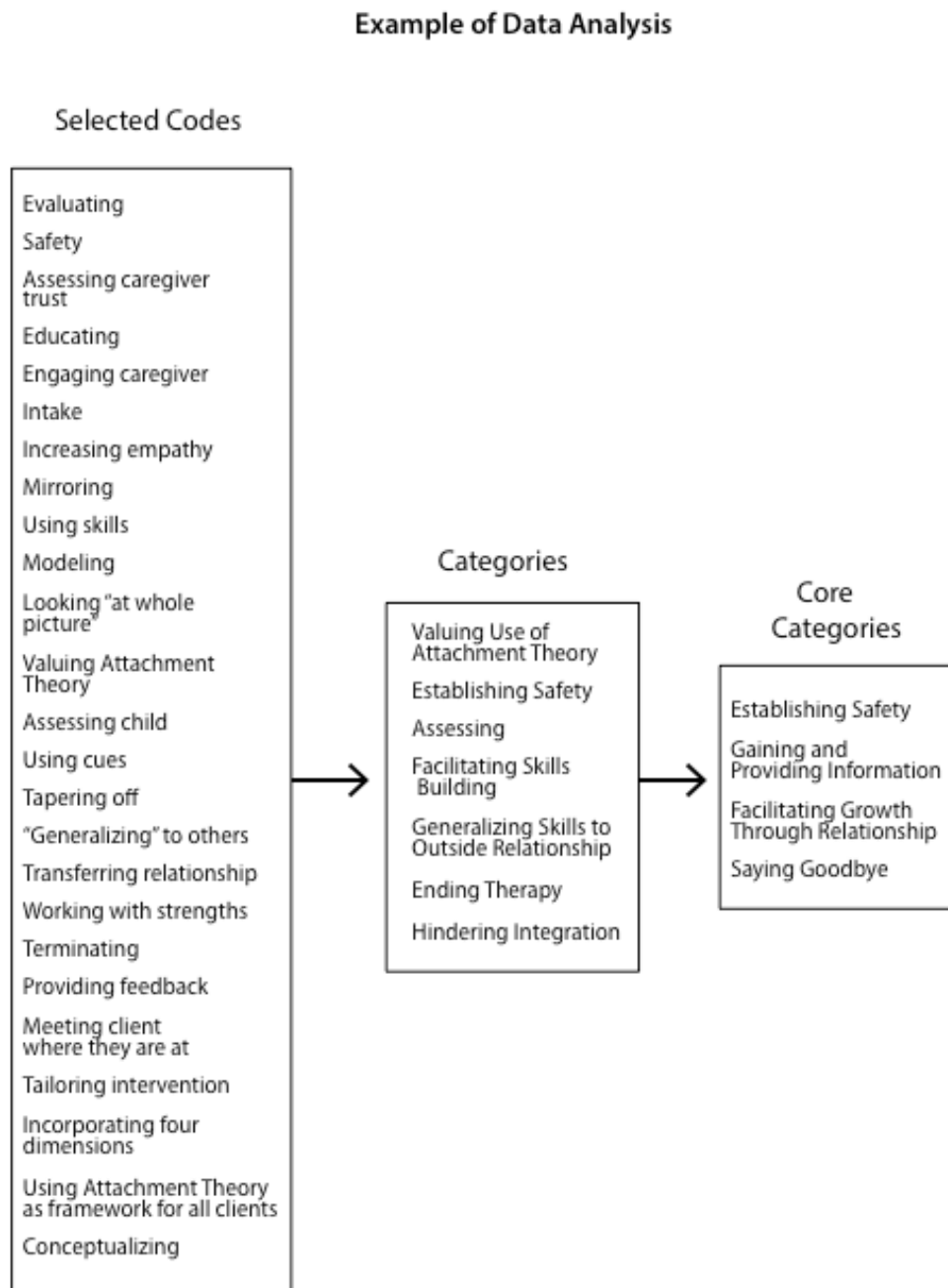
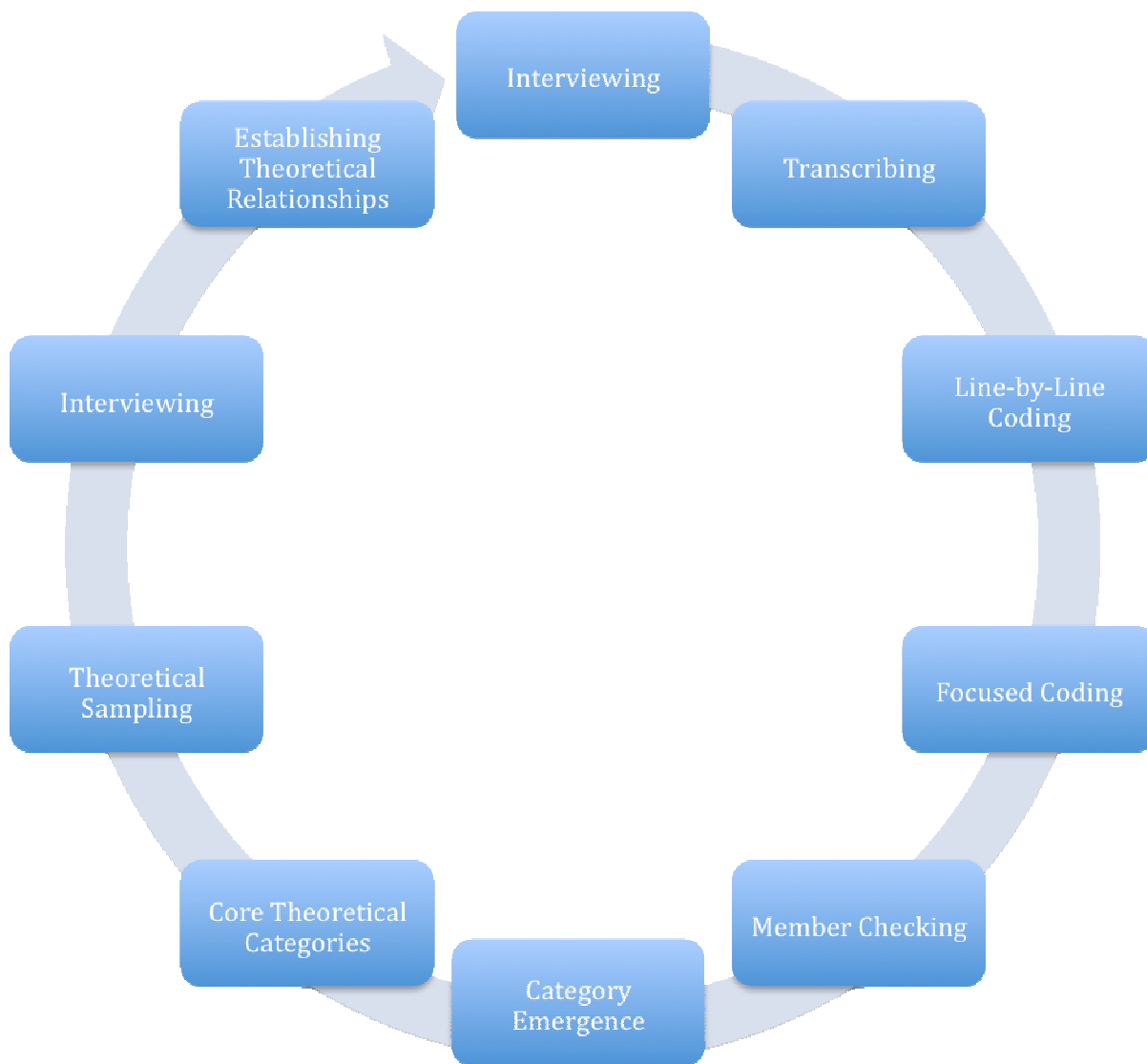


Figure 2. Data analysis process for constructing grounded theory.



Categories

The majority of the categories that emerged from the initial and focused codes were labeled to reflect the phases of the integration process, as participants referred to them. The categories are valuing the use of Attachment Theory, establishing safety, assessing, facilitating

skills building, generalizing skills to outside relationships, ending therapy, and hindering integration.

Valuing the use of attachment theory. All seven participants valued the use of Attachment Theory within their treatment planning process. This category was broken down into three subcategories: always incorporating knowledge of Attachment Theory, healing for future success, and fostering brain development.

Always incorporating knowledge of attachment theory. Many of the participants spoke about the importance of incorporating their knowledge of Attachment Theory within their practice as if they could not imagine addressing client issues without using such knowledge. They saw benefit, and even necessity, in framing their treatment planning through Attachment Theory, regardless of the presenting issue. Nikki stated, “It’s essential! I can’t not incorporate it. It’s always there. It’s something that I’m mindful of the entire session.” Ezra and Raquel also commented on the importance of incorporating Attachment Theory.

I think when I try to conceptualize the cases that come into my practice, I mostly, very definitely, look through this attachment lens, pretty much regardless of what’s going on. I’m looking at the attachment as the foundation. Because I connect deeply with that humanistic piece of the child has within them, or the individual has within them, that ability to heal, but it does need to happen in what I’m going to call a safe place, a safe relationship. (Ezra)

Well, considering that children, part of the way they develop, is centered around their relationships with their caregivers as their primary sense of security, it’s how they get their sense of themselves and the world. So, if we ignore that whole component we’re

really missing a huge piece of their developmental history, their entire wellbeing, their sense of self. (Raquel)

Healing for future success. The importance of healing attachment disruptions for enhanced self-understanding that can lead to future successes in relationships was also noted. Two participants described the benefit of creating healthier dynamics now, so that relational skills may trickle down and positively effect future generations. This intergenerational effect was seen as integral to the value of incorporating Attachment Theory knowledge within treatment planning.

Well, I think that if a parent has a healthy attachment with their child and vice versa, the parent is going to be more protective and also help their child grow and achieve the best that they're capable of achieving. I think the child then gains a sense of inner self and awareness of their self so that they can have good relationships with other people and hopefully when they have children good relationships with their children. So it's propagating, I guess. (Juanita)

Everything that we do, healthy, unhealthy, whatever is within the context of relationships. So, if you're taking your practice orientation believing in that everything comes from how we interact with people in the world, then it's almost like an assumption that the first relationship, being that of child and parent, is going to set the stage for a lifetime of successful relationships. So, you have to do it. (Ginger)

Fostering brain development. The ability to utilize knowledge of Attachment Theory to positively attach later in life, and to heal any pre-existing attachment wounds, was viewed as hopeful. In accordance with Perry and Hambrick (2008), two participants spoke to the benefit of a healthy attachment relationship in terms of fostering brain development. The ability to create

new neural pathways was cited as adding value to integrating Attachment Theory within clinical practice.

Just how we attach to our primary caregivers and how that plays out through our lives and especially now with the neuroscience going on about how we can, the plasticity and how we can change our attachment, you know... that we can really attach later in life even though we haven't had it earlier. It was just so hopeful to me, which I really loved about it. It really aligned with just my paradigm of life and therapy. (Nikki)

I think it's not only important, I think it's essential. I think it's really hopeful in our work that we can create [attachments], especially with the experiential work and the play therapy and expressive arts therapy because you're actually facilitating a whole new way of helping the brain to be able to process. (Simone)

Establishing safety. Establishing safety quickly became a theme across participant interviews. Not only was this category described as being essential to integrating Attachment Theory within clinical treatment planning, it was considered to be a necessary precursor to the integration process. Nikki described the process of establishing safety as beginning “the minute you say hello.” She also stated, “That’s just something that I think we have to have constantly, so you’re creating the safety, but I think you’re constantly maintaining the safety.”

Raquel spoke to the gravity of establishing safety first when she provided a case example of a four-year-old girl who was exhibiting severe behavioral issues at home. This young girl was showing “some pretty oppositional signs toward step-mom and step-mom’s son to the point of pushing them down the stairs and it was dangerous.” Raquel described beginning counseling using Child-Centered play therapy and stated, “It was good because we actually got to work on that trauma piece first because it’s really important before you get into attachment work that you

have safety there.” As the play therapy process progressed, and after extensive work on the child’s history of sexual trauma that emerged through the use of non-directive play, Raquel moved into using Theraplay with the girl and her stepmother. She decided to move into using Theraplay only after safety within the therapeutic environment was established. Raquel believed the establishment of safety allowed for deeper work to take place within the play therapy process. Raquel said, “Now I was a very safe person for her and it really just allowed us to get to a new place of treatment for her.” In Raquel’s example, the establishment of safety was re-occurring, first within the therapeutic relationship and then within the caregiver-child relationship. Ezra believed that in order for an individual to be able to fully self-actualize in the play therapy process, safety needed to be established within the therapeutic relationship.

I do connect deeply with that humanistic piece of the child has within them, or the individual has within them, that ability to heal. But it does need to take place in what I’m going to call a safe place, a safe relationship. (Ezra)

Having safety in the therapeutic relationship, as well as with the caregiver, was considered paramount in conducting attachment-based play therapy work. Safety allowed clients to be more present within the therapy process.

I’m constantly thinking, ‘How can I help this family, first of all, become safe for each other?’ ‘How can I create more safety in this family?’ And if there’s not safety in the family then what’s not safe and we explore that. So I first want to create that safety so that the family really can show up. So whoever they are really can show up. (Nikki)

Participants reported encouraging clients to take risks in discovering themselves and trying new tasks later in the course of therapy. Without the sense of safety, or security, of the therapeutic relationship the child, or caregiver, would be less likely to explore. This concept, that security

leads to exploration, is consistent with the therapist serving as a secure base from which the child or caregiver is supported in self and self and other exploration.

Assessing. Participants assessed attachment styles through use of both formal and informal methods. The most cited formal methods for assessing attachment styles were the Marschack Interaction Method (MIM) and the Adult Attachment Inventory. Other formal assessment methods mentioned included the Child Behavior Checklist and the Trauma Symptoms Checklist for Children. The most widely cited method for informally assessing attachment styles was paying attention to body language cues between the caregiver and the child (such as eye contact and display of affection) and the openness of the child to establishing a relationship with the therapist. Participants also continued re-assessing, through formal or informal methods, throughout the integration process to discern therapeutic progress. Therapeutic progress was noticed through observing cues that there was attachment repair or enhancement. The responses for this category were broken into five sub-categories: intake, caregiver's attachment style, child's attachment style, caregiver-child relationship, and assessing progress.

Intake. The attachment assessment process begins during intake. For the purpose of this category, intake refers to the initial contact the play therapist has with the child's caregivers, as well as the first few sessions the child or family has with the play therapist. The various methods utilized to assess during intake included obtaining psychosocial and developmental history, observations, genograms, and conversation with the caregivers. Ezra stated, "I do a social history, which is more developmental... I'll ask how they reached developmental milestones, at what time, any ongoing illnesses? Family traumas?"

I'm going to be getting a thorough developmental history of the child. So, I want to find out what was going on all the way up from the point of pregnancy through labor and delivery through the first early years, through the whole gamut. Have there been any major changes? Traumas? Changes in caregivers? Breaks in relationships? So we're looking at everything from prenatal to current time. (Raquel)

Caregiver's attachment style. Kara stated, "I take the attachment piece into consideration for both the parent and the child." Attachment Theory described the importance of understanding the attachment dynamics created by the interaction of attachment styles (Levy & Orlans, 1998). If a play therapist focused solely on the attachment of the child, without focusing on the attachment style of the caregiver, then a true understanding of the context within which the child's attachment developed, and is continuing to develop, would be lost.

After I've met with the child and maybe see some issues with the relationship then I may come back at that point and assess through a parent session and kind of say, "Hey, what was your experience as a child? Tell me about your history with your parents." So I want to get a history of the parents themselves. You can't give what you didn't get. (Raquel)

I try to go back at least three generations...the child, their parents, their parents, and sometimes even to the parents' grandparents just so that I can get a feel for what it was like to live in these families." (Ezra)

Child's attachment style. In addition to the information obtained in intake, the child's attachment style can become apparent through his or her exhibited relational skills, or lack thereof, especially when first meeting the therapist. Observations of specific body language cues were used to assess for a child's attachment style. Those cues included open or closed body language, eye contact, and willingness to participate and engage in the new relationship. Both

exhibiting closed behavior and displaying very little boundaries, and being extremely open to the new relationship, were considered indicative of an attachment issue. Ginger said, “How many hoops do I have to jump through to get the kid to be okay with me?” Ezra commented on cues she watched for, even before the initial session began.

The cues that I look for really even start when they enter my waiting room. And I’m looking at...are they anxiously attached? Are they avoidant? Are they ambivalent?... I’m watching for how the child separates from the caregiver... I’m looking for—is there eye contact? Is there that open body piece versus am I cutting myself off? (Ezra)

Caregiver-child relationship. Participants also assessed the caregiver-child relationship by observing body language cues and the relational dynamics between the child and caregiver. These observations took place in the waiting room environment, as well as in the play therapy room. The ability for the child and caregiver to be attuned to one another, and to remain engaged together, served as an indicator as to the health of their attachment relationship. Nikki stated that she watched for disengagement as a cue. She said, “Anytime um, a child or a parent is connecting and on track and then for whatever reason disengages, or overcompensates. Ezra looked for attunement between the child and the caregiver. She said, “Is there that dance, so to speak, going on between the parent and the child where the parent is um, very much matching the child and in tune with them?” Patterns across moments of disengagement were used to discern any possible triggers that may have caused the dissociation or avoidant behavior to occur in the child or the caregiver. Attention was also focused on the response of the individual who was not disengaging; in other words, how did they react to the disengagement? In addition, attention was paid to the temperaments of the caregiver and child and whether or not their temperaments were in harmony with one another.

So when I first met this kid it was very clear to me that there was an attachment issue because mom, for lack of a better way to describe her, was practically a mouse. Just quiet and low and methodical, and the kid was way crazy. So there was a real, just totally not in tune. (Ginger)

Through gaining a clear understanding of the strengths and weaknesses in the child-caregiver relationship, participants were able to conceptualize where to focus their efforts in the play therapy process.

Where are they missing each other? Where are the places they're not connecting? (Nikki)

It also is looking at less positive influences the parent has encountered, so that I can gain, or get a grasp of where they are with attachment. Then I can get a grasp of where the child is with attachment, so that when I'm working with them I'm trying to match them up and help complete, or give them the best services so that we're not banging our heads against a wall. (Juanita)

Assessing progress. Assessing progress was an ongoing process throughout the integration of Attachment Theory. Participants looked for both verbal and non-verbal feedback from the child and caregivers to assess for progress. At times feedback was requested from the caregivers regarding their perception of change and progress occurring outside of the play therapy sessions. Participants also paid attention to behavioral changes occurring in the play therapy sessions as well as changes in the relational dynamics between the caregiver and the child. Behavioral changes that were in sync with the therapeutic goals were considered to be indicative of progress. Changes in the caregiver-child dyadic relationship that reflected a more secure attachment pattern were considered to be markers of therapeutic progress. Raquel said, "...the child seems to be more relaxed in the play, they'll be able to hold eye contact, which is a

big one...we'll see their comfort level with touch increase, that positive, healthy touch". Kara watched for the ability to repair in relationships. She stated, "All relationships have a break. But the break doesn't break you. There's a repair, and that repair can fix it and it doesn't feel significant." When the child or caregiver began to be able to accomplish tasks that were previously more difficult for either of them to complete, progress was considered to have occurred. Nikki stated, "A lot of the things we've been working on they're able to do on their own, inside session and outside session and I know by self-report." Raquel used self-report measures. She said, "I get a self-report inventory from the parents every session, so not only what their behaviors have been but also what their experience of the child is." Kara said, "I'm able to see that child has become regulated when in situations where they've already been in where they were unable to regulate." The gaining of information via observation also served the function of assessing therapeutic progress from an attachment perspective.

Facilitating skills building. Participants integrated Attachment Theory knowledge within their treatment planning to address attachment issues or to work on enhancing attachment. One method for facilitating the enhancement of an attachment relationship or attachment style was through facilitating skills building with the individual and their caregivers. Sometimes the learning of relational skills is facilitated through engaging caregivers directly in play therapy sessions. At other times the play therapist provides skills for the caregiver to use with the child outside of play therapy sessions. The intent of the skills provided to caregivers is to enhance the child-caregiver relationship. Simone said, "They do a lot of calming techniques, both of them, so if either one of them is getting stirred up then they know some things to do physiologically to calm down." Ginger stated that she works to help caregivers set limits within the relationships, as is evident when she reported, "...at that time was to sort of go to the domain of structure and

help mom to, helped mom with her communication, really with this kid. You know, how to talk to her, how to set the limits.” Ezra stated, “I’m teaching them what I’m going to say is the next level of being empathic or the child-centered response, as the child plays, or even in their daily interactions.”

And if in my assessment if that body language is missing, I’ll be as explicit as saying,

“Slow down, take a deep breath, look at your child as you’re talking and try to mirror sort of where they’re at,” to get that parent-child dance going, so to speak. (Ezra)

Facilitating skills building was further broken into the following sub-categories: focusing on strengths, tailoring interventions, and modeling.

Focusing on strengths. Participants incorporated a strengths-based approach to working with caregivers and their children from an attachment perspective. That presented through using a caregiver to enhance a child’s self-awareness. Focusing on existing strengths within the relationship was also used as a starting place from which to begin the attachment-based work.

Nikki said, “Sometimes they do have a secure attachment and then we can work from that.”

If I’ve got a parent that seems to be very connected and engaged with their child, then it’s just trying to get them to kind of come in more purposefully in those areas to help point out where the child is succeeding, where they’re valuable, where they’re worthwhile.”

(Raquel)

Focusing on strengths was also used to bolster caregiver confidence in the attachment-based work. For instance, Ezra stated, “I try very hard to be positive and build the parents up.”

Raquel stated that when she works with caregivers and provides them with feedback, she “focus[es] on at least two areas where things are going really well.” Raquel also stated,

We're going to look at one place where it didn't go so well, but we're going to focus on the positives regardless. We're going to try and get more of those positives and work in the strength area first and then typically we find the other areas will come along with treatment.

Tailoring interventions. Attachment-based interventions often were tailored to fit the specific needs of the client. The phrase "meet them where they're at" was used throughout several participants' responses. Raquel stated, "Basically, I'm going to come in and meet the child where they're at." Ezra said that she asks herself, "Where am I going to meet that client where they're at?" Tailoring interventions referred to individual attachment-based interventions as well as dyadic interventions aimed at addressing presenting concerns. Skills to enhance attachment were provided through the use of tailored interventions. Simone said, "It can be unique and depends on each person too because it's based on helping them reach their goal." Ginger explained, "A lot of our work is about self-regulation and I've introduced mindfulness work and I've targeted mom and her together to do that." Raquel spoke about her process for tailoring intervention when she said, "...it's a targeted way to say, this is where they're lacking, this is their true brain age, if you will, and then we can come in with an intervention specific to those four areas."

I think about what is breaking down the attachment, or what has blocked the attachment from being secure. And then I kind of think, and so, that is going to help me to understand what is going to help the attachment be secure. It's kind of like flipping a coin... okay, this isn't working and so let's flip it over and see what would help it work. And then I think about the child and or family and then try to do something based on what I think is going to work. (Nikki)

In addition to tailoring interventions to address specific needs, interventions were tailored to encourage the continued engagement of the clients. Nikki stated, “a lot of the interventions have to do with what the child and the family already like and tend towards.” She also said, “I will be in with a client and on the spot I can create an intervention based on what’s going on in the room pretty quickly.”

I would only do one nurturing activity in a thirty-minute session because he couldn’t tolerate it. And even that I would water down the nurturing activity and break it up, because it was too much. But once he felt safe, I could fold more nurturing activities into the overall session. (Kara)

I do modify it and add a bit more playfulness, and granted, the trainings are always very structured, but in my office we have fun, and we laugh when the bubbles go up, we try to poke the bubbles with different things...to get that just having fun with each other piece going. (Ezra)

Modeling. Modeling was used to provide an added layer of first-hand education for the caregivers. The therapist not only explained the skills to the caregivers; the therapist demonstrated the skills so the caregivers were able to witness the use of those skills. The therapist also used the skills with the caregivers so the caregivers were able to experience being on the receiving end of those same skills. Simone said, “The parents will be like, ‘I noticed what you said. I noticed the way’ ...so they’ll notice how I’m attuning to their child. Um, or they’ll notice how I attune to them.” Kara stated, “The parent has to be attuned and consistently responding and I have to be attuned and consistently respond.” Modeling was also used to provide caregivers with the opportunity to experience what it feels like to be in a stable attachment relationship with the play therapist.

I have a safe relationship with the parents before we do this vulnerable piece (attachment work). In some respects too, I'm hoping that they're experiencing...not that I'm necessarily attaching to a parent, but the entire time I'm trying to model attachment behaviors, attachment energy, all those types of things for them. And that is throughout the entire process. (Ezra)

Generalizing skills to outside relationships. An important component of reaching attachment-oriented goals in the play therapy process was to reach a point where the child could generalize relational skills learned in session to relationships outside the therapeutic relationship. The play therapist served as an example attachment relationship from which the client could gain an internal framework for what a healthy attachment relationship is like. The hope was that the child would then be able to establish additional healthy relationships outside of the play therapy process, first and foremost with a caregiver. Raquel stated, "My hope is to repair the system and to make it a healthy system so that the child can be attached to their parent. That's my goal from the very beginning."

I end up creating myself up as that attachment figure for the child and so I'm hoping that I can personally launch them and give them that attachment base that they don't have. It's not that I am trying to become their parent. It's just so they can experience what a healthy attachment looks like so I can sort of fill that gap a little bit and then launch them from there. (Raquel)

Because if I'm working with the child and I'm working on attachment with the child then that's really going to help the child, I think in their life. Um, to be able to take that forward if I can help the child and the caregiver to attach then now they both know a

secure connection and they can both take that forward so it just multiplies exponentially.
(Nikki)

...basically being able to help them generalize that to other relationships and that is really when you need somebody else in the room. If it's just me with the child then being able to generalize that safety to somebody else so that they know that it's not just in the play room that this can happen, but it can happen in the real world too." (Nikki)

Raquel clarified that she perceives working with young children to be a little different than working with teenagers. Raquel is willing to work with teenagers even when their caregivers are not engaged in the play therapy process. Raquel believes teenagers have the ability to understand and generalize the attachment qualities within the therapeutic relationship to outside relationships. By contrast, Raquel mentioned that it can be harmful to initiate an attachment relationship with a young child without knowing that you can engage a caregiver in the process. "You don't want to establish a relationship with the child unless you know you can transfer it to somebody else." Raquel was not alone in this belief. Ezra said, "And this, what happens in the office, is their experimental ground, so to speak, and we need to have what happens here develop something within them that says it can now happen outside this office."

Ezra also clarified the relational boundaries of her role as the play therapist, "I don't want therapy to become their primary relationship. I don't want to step into the caregiver role. I want them to feel safe with me, but I want them attaching with the caregiver."

Ending therapy. Termination is a term used in play therapy to refer to the ending of therapy. Two participants specifically chose not to refer to the ending of therapy with this term as they viewed "termination" as having a negative connotation. The majority of participants used termination to refer to the ending of therapy. Attachment Theory refers to significant moments

within attachment relationships and separation is one of those critical moments (Bowlby, 1988). The manner in which a relationship is ended, or the manner in which the ending is experienced, can create or augment an attachment disruption (Levy & Orlans, 1998). The play therapists in this study stated that they take great care in providing a positive ending experience for the children and families with whom they work. The ending of therapy was considered by participants to be a final means for solidifying and re-affirming the child and caregivers' experiencing of the dynamics of a healthy attachment relationship.

Because what's harmful, for lack of a better word, to do is to have this child to create a safe place here in therapy and then to just drop out... or to not have the appropriate termination process occur, because we're working on this whole idea of trust. (Ezra)

"We celebrate the work that we've done and the relationship and I let them know that I'm so thankful that we got to work together. And we also process before the last session, you know, how does it feel to think about ending our playtime together? And I think it's really important to teach them to say goodbye and not to say, 'see you later' because I think it's an easy way for us to not deal with endings in our society. To be able to say goodbye and say goodbye well. That's what I do with kids. (Nikki)

Hindering integration. The primary barrier to integrating Attachment Theory within treatment planning was caregiver unavailability. "Unavailable" refers to either the physical or emotional inability to be present in the play therapy treatment process. Often, this unavailability was referred to as resistance due to caregiver's own attachment issues. When this occurred, caregivers tended to refer those clients to see other practitioners who they perceived might be a better fit for addressing the caregiver's concerns.

I think, really, quite honestly, parents are my biggest barrier to integrating attachment work because sometimes they have such big hang-ups on their own that they just, they can't do it. And I have empathy for that, I really do. Sometimes they come in and they're like, 'This is just too awkward. I don't play with my kid. That's just weird. It's uncomfortable.' And they're not open to changing it. (Raquel)

I think when someone is so disorganized that it's hard for them to tolerate the connection and so um, I think sometimes it's just not the right time for them to do the work... That can be really frustrating and that's sometimes when you see a parent pull a child from therapy. (Nikki)

Then another barrier I struggle with is the parent's own attachment breaks and how I, because I am the child's therapist, because the child is my priority first, but the amount of parent work that is needed... and then that sometimes becomes a billing difficulty. (Kara)

In addition to caregiver unavailability, fiscal concerns, a lack of education, and a lack of understanding of the importance of attachment were cited as potential barriers to implementing an attachment-based perspective in treatment planning. Medicaid was cited as the primary barrier to being reimbursed for services provided. Simone said, "Sometimes funding is an issue. You know, wanting us to use a medical model and diagnose things."

Talking from a structural, bureaucratic way, working with children...what's billable and what's not billable. How long you can work with the family if you're billing certain services through Medicaid, or whatever. (Kara)

Ginger described a lack of education in her graduate school program as being a potential barrier other play therapists may face to integrating Attachment Theory within their clinical practice.

When I did mine the textbook I used for family therapy, that book talked about Bowen and Family Systems but there was no chapter that I remember hearing something that was clearly targeting the primary relationship, attachment-based. Juanita described caregivers' lack of understanding of the purpose of enhancing attachment as a potential barrier to integrating Attachment Theory within clinical practice.

Awareness of how important attachment is from the foster parents or the biological parents. That is definitely another piece that hinders attachment work. So many people bring their children to counseling and say 'fix them.' Then you try to explain how trauma has affected them and their ability to trust and how that has affected their ability to have a relationship and then they just... I do trauma training, and um, the foster parents say, 'yeah, yeah. I get it.' But they still say 'fix this!' (Juanita)

Core Categories and Final Theory Development

The initial categories were further honed to develop the final theory through further analytic review of transcripts, discussion with participants via follow-up interviews, and additional examination of memos. Several of the original categories and subcategories that emerged were condensed into the following four core categories: establishing safety, gaining and providing information, facilitating growth through relationship, and saying goodbye. In accordance with Charmaz's (2014) guidelines for sound analytic insight to generate a grounded theory, only categories that subscribed to the criteria of "fit and relevance" (p. 133) were integrated into the final core categories. Valuing integration of Attachment Theory and hindering integration were not found to be a part of the actual process of Attachment Theory integration and therefore were not included in the final theory. However, these two categories do provide contextual information about the process and therefore are discussed briefly in a section below.

The four core categories reflect the stages of integrating Attachment Theory within play therapy treatment planning and clinical practice. This section describes what occurs within each stage of the integration process, with a focus on decision-making, as well as the relationship of the stages to one another. The description of movement from one phase to another is provided within each section describing a phase of the process. References to participant statements are included to provide in vivo data support within the stages. Additionally, a summary of the movement through the integration process is provided at the end of this section. Figure 3 illustrates the act of moving through the integration process. The relationships between the final theoretical categories were further understood through follow-up interviews with participants. Follow-up interviews were completed with six participants. Attention was paid to both explicit and implicit relationships verbalized directly or shown across each participant's reported case example of their integration process. No participant was found to follow a strictly linear integration process. Nikki stated, "I don't think they're mutually exclusive steps... there definitely is a lot of overlap." Ginger said, "I would say it's not really linear."

Establishing Safety

The initial phase of the integration process is establishing safety. This phase is considered a necessary precursor for initiating any attachment-based clinical work and begins, according to Nikki, "the minute you say hello." Safety in this context refers to physical and emotional safety. Physical safety includes safety within the therapeutic environment as well as with the caregivers and family. Emotional safety includes emotional safety with the therapist as well as with the caregivers and family. Simone stated, "I want to take a little time to allow that family to have an initial phase of therapy, or the individual, where they begin to develop therapeutic safety and trust." Safety includes avoiding harm. During this initial phase of the integration process,

commitment is sought from the caregiver to diminish the likelihood of premature termination, which could exacerbate an attachment disruption and cause emotional and psychological harm to the child.

“I tell them that I will not contract with you unless you give me the opportunity to have at least two termination sessions... Because that is just another way we injure the child if we’re not modeling and teaching that there can be relationships that end without a rip” (Simone).

Establishing safety sets the stage for the beginning of trust building, which is a cornerstone of the therapeutic relationship, particularly within attachment work. Once safety is established, the therapist seeks to maintain safety throughout the process. Play therapists encourage clients to “show up” within the therapeutic process and allow them to be who they are through the safety created. Continued safety is a necessity for completing attachment-enhancing therapy. Clients are encouraged to take risks in exploring their self and self and others within this established safety of the therapeutic relationship and the play therapy environment. Nikki stated, “You’re creating the safety but I think you’re constantly maintaining the safety, even when you’re finishing and wrapping up with a client you’re constantly maintaining that safety.”

Gaining and Providing Information

Gaining and providing information begins with initial contact with the client and family. This core category includes assessing attachment quality through formal and informal methods, re-assessing attachment, and educating caregivers and receiving feedback from the child and caregiver. Ginger said, “I feel like so many things are woven together. Intake is about gathering information and making an assessment.”

From the time that they walk in the door and I'm explaining therapy, from then on, in addition to creating safety, I'm also assessing for what the attachment is like, so I think simultaneously it's like, 'what is this attachment like?' (Nikki)

Assessing attachment quality. Assessment typically begins within the intake session, or initial session. Assessment refers to the use of both formal and informal assessments. Some of the formal assessments that can be used are the Child Behavior Checklist (CBCL), the Marschack Interaction Method (MIM), and the Adult Attachment Inventory (AAI). Informal assessment occurs through observing relational dynamics between the child and their caregivers. Simone stated, "I've added a new level to it, which is watching parents who are so addicted to their technology that they are distracted from their child." Nikki said, "I'm assessing for what's getting in the way of the connection."

...observing the parent and the child together. How much eye contact do they make with one another? Um, is there any touch? Is there warmth? Where do they sit in the room?

Those kinds of things are a part of assessment as well. (Simone).

Intake questionnaires and genograms, in conjunction with conversation, may also be used to obtain attachment-related information about the child, as well as the caregiver. The types of information the therapists look for, from an attachment perspective, includes the child's developmental history (pre-natal to current time), trauma history, social history (focusing on relational breaks as attachment indicators), and the caregiver's attachment history. Ezra stated, "I do a social history, which is more development... I'll ask how they reached developmental milestones, at what time, any ongoing illnesses? Family traumas?"

I think that getting a really good history allows a lot of information. If we do a really thorough assessment before birth, what was happening in the family's life during the time

they were expecting the baby, during the first year of life of the child. What were the stressors? Were they working? Were they home? Were they, um, living one parent overseas? You know...I just think that gathering a lot of information about what the environment for the child was like. And then also what was happening emotionally for the parent at that time. Were they under stress? (Simone)

Assessing the child's attachment style through informal observation, as described by a few participants, begins the moment the therapist meets the child for the first time. Information such as body language cues (eye contact, open or closed body language), and the length of time it took the child to warm up to the relationship with the therapist was used by several participants to assess the child's attachment style. Raquel said, "...when I first meet the child the informal assessment is going to begin and it's more subjective because there's not an instrument involved and that is ongoing." Ginger spoke about observing and assessing the child's receptivity to a new relationship when she said, "How many hoops do I have to jump through to get the kid to be okay with me?" Regardless of the presenting issue, all participants tended to integrate their knowledge of Attachment Theory following a similar process. The types of interventions were a bit more directive when focusing on a specific attachment disruption. This is further discussed in the 'tailoring interventions' portion of this theoretical framework.

Re-Assessment. Assessment is ongoing and occurs throughout the integration process to assess for progress. This type of assessment is referred to within this theory as re-assessment. Re-assessment is sparked through receiving feedback from the child or the caregiver. This information gathering can occur through observational or formal methods. For instance, one participant reported using a parental report scale to assess and re-assess the caregiver's perceptions of his or her child regularly throughout the treatment planning process. Raquel said,

“I get a self-report inventory from the parents every session, so not only what their behaviors have been but also what their experience of the child is.” Other participants reported observing changes in the child’s play, using pre- and post- art techniques, or using a child’s disclosures as indicators of new emerging issues or that progress had occurred. Special attention was paid to enhanced trust and security within the therapeutic relationship, increased taking of risks within the therapeutic environment, and self-disclosures regarding enhanced attachment in the home environment to discern progress from an attachment-based perspective. Nikki stated, “I am definitely assessing the entire time.” Raquel said, “...we’ll see the child being able to regulate themselves and the behaviors have changed and the parents are understanding where their child is coming from and can regulate themselves.”

I do a lot of art therapy techniques and a lot of play therapy...I watch for where they position themselves in position to the family. Watching for attachment in art therapy techniques and using those at the beginning and endings of treatment and seeing the changes in those. (Simone)

Educating caregivers. Providing information occurs through educating caregivers and teaching relational skills. This is an ongoing process and typically occurs through caregiver consultations, held every three to five sessions. As new understanding or conceptualization of the client, the client’s presenting issue, and the caregivers’ ability to relate to the child emerges, then new psycho-education may be provided to the caregiver. This psycho-education may be provided in the form of educating about a presenting concern or through teaching the caregiver or family members new relational skills to employ with the child. Simone stated, “It isn’t uncommon for me to do things that foster relationship. So that’s why I like Child-Parent Relationship Therapy because you’re teaching attunement.”

I think it is the art of the relationship that helps you to know there is something missing. Either I'm not getting something or they're not receiving something and so either we go back to get more information, which is assessment, or we um, ask questions to sort of clarify where we need to be, do we need to be looking for more information or trying new strategies? Or did we totally miss some clue as to direction... so, um, that's so I think the reassessment is as the heart of every one step to the next step to the next step. You're taking your cues from how things are going. Um, to sort of make your decisions."

(Ginger)

Moving from the gaining and providing information phase to the facilitating growth through relationship phase of the process of integration is somewhat linear, but is also cyclical. Once the therapist has obtained initial assessment and begins conceptualizing the client's concerns and how to address those concerns, the process of growth through relationship begins. However, as growth emerges through relationships, then re-assessment may occur. Once re-assessment occurs, there may be a need to gain or provide information to or from the child or caregiver for clarification or educational purposes. From there, as new information is obtained, new conceptualization occurs, or conceptualization is confirmed, and the desired growth continues to be facilitated through relationship through use of tailored interventions to address specific needs. This cycle does not end until the goals of play therapy are met.

Once I have a pretty decent idea of what the dynamic is within the relationship, which could take one session or quite a few sessions, then I'm creating a plan. So after that first session, um, for sure, the first and second session, I've got some ideas about how I want to help the dyad or triad or however many people are in there deal with the attachments they have but then also create that more secure attachment. (Nikki)

Facilitating Growth Through Relationship

Throughout the process, the therapist uses the therapeutic relationship as an example attachment relationship for the child as well as the caregiver. The play therapist takes great care to provide consistency in his or her responses to the child's needs, and the caregiver's needs as well. Through consistent responding and attunement to the child's and caregiver's needs, the child and caregiver are able to gain a new relational experience. It is through this "attachment experience" that the child's and caregiver's perceptions of self and self and others, or internal working models, can begin to shift to reflect enhanced security. Nikki said, "This is what a secure attachment feels like. We're going to fill this hole right here and now between the two of us."

Every time you look at me, call for me, or want something from me I will be here because it's constancy. It's not I'm sometimes here and sometimes not. And what you do does not determine how I care for you. (Nikki)

Additionally, the therapist facilitates relational skills building for both the child and the caregiver, and fosters the development of a healthier attachment relationship between the caregiver and child. Sometimes this means including the caregiver in the session directly. At other times, it involves working with the caregiver and the child separately, and providing the caregiver with skills to use outside of the play therapy sessions. When participants perceived that they were addressing a specific attachment disruption as the primary presenting concern, they tended to incorporate more directive Theraplay techniques with the caregiver and child together in session. The focus, in these instances, was on assessing the relationship through the four dimensions of Theraplay: structure, challenge, engagement, and nurture. Once the deficit areas and strength areas were understood within the relationship, the Marschack Interaction Method of

assessment was typically used. Then, specific Theraplay activities were provided to address those needs. Participants tended to tailor the interventions they used to address specific needs of the child and the caregiver, whether working with them together or separately. This tailoring of interventions to “meet the client where they’re at” is consistent with being attuned to the client’s needs. Attunement is an indicator of a healthy attachment relationship (Booth & Jernberg, 2010; Levy & Orlans, 1998). The participants were attuned to the needs of both the child and the caregiver. Several participants mentioned that they perceived the process of attachment-enhancing work to benefit both the child and the caregiver. In other words, it was reported that the caregiver and child were each able to enhance their individual internal working models as well as to enhance their dyadic relationship together.

But I also think there’s a piece where their (the caregiver’s) past attachment wounds can heal as they’re in a healthier attachment relationship. So I don’t think it’s necessarily always just parent down, but it can go both ways. Because I think that, for lack of a better word, I’m going to call it an energy, an experience, and as I experience it in that attachment piece in safety in other relationships, it... it changes me. When I say ‘me’ I’m talking about the parent. (Ezra)

Many of the parents don’t have a template. They might have their own history of attachment problems. So with that in mind, it’s really giving them an opportunity to practice in a very affirming relationship... the warmth of the therapeutic relationship, um, to be able to practice how to foster a relationship for parent and child.” (Simone)

Saying Goodbye

Once the initial goals that were set at the beginning of play therapy are met, the termination process occurs.

Often times the parental report and the child's report and even observing...I'm thinking again of that one young man who had multiple caregivers and that disrupted adoption. There was just a time when it was very... they both reported that, and it was very observable, that they felt much more comfortable with one another and they felt an affection that before had not been present. (Simone)

The termination process is referred to within this theory as saying goodbye to honor the unique nature of the termination process as reported by participants from an attachment perspective. The first step in the termination process is to be sure that the child has generalized the skills learned in therapy to outside relationships, primarily the caregiver-child relationship. This is to ensure that the child has learned that positive relationships, or healthy attachments, can occur in relationships outside of the therapeutic environment. Throughout the process of saying goodbye, the caregiver and therapist work as a team to monitor the child's adjustment to the ending. As long as no new presenting issues arise, the saying goodbye process proceeds. Saying goodbye involves allowing time to acknowledge the ending. The therapist and child have multiple sessions together when they process the upcoming ending. They focus on the progress that was made in therapy, their relationship, and any feelings surrounding the process of saying goodbye. Special attention is paid to honoring the time they spent together through celebration. The celebration serves as a type of final nurturing, supportive act. Sometimes physical nurturing occurs through the presence of food. Nurturing is an attachment-enhancing activity (Booth & Jernberg, 2010). The therapist and the child plan for their last session ahead of time, together.

So once we've met those goals then we're going to look at terminating treatment as long as nothing else has come up along the way. So that's how we'll know... that the goals we set from intake will have been met. (Raquel)

So when I end with a client that is a process as well in being able to let them know that we had a really great experience and we had a really fun time and it's kind of and they usually kind of know and want to go on with their life. They want to play with their friends. So we kind of slowly wind down with 'this has been so fun' and we recap with what we have done, where they were when they first came in, all the different changes. And then we celebrate the relationship so a lot of times we'll have food or something like that. I'll ask the child, "How do you want to spend our last session?" "We celebrate the work that we've done and the relationship and I let them know that I'm so thankful that we got to work together. (Nikki)

If a new presenting issue arises, then the play therapist returns to the cyclical process of gaining and providing information and facilitating growth through relationship phases.

If we're both very comfortable with the process and where we're at then we'll start shifting to the termination piece. But because I've had the ongoing conversation, they know that we're not just going to stop but we'll lengthen out the space between sessions until pretty much, okay, this is our last time. We celebrate usually as a family unit when there is attachment going on, but always with the understanding that all they have to do is call and then I'll open up that file, that case again. (Ezra)

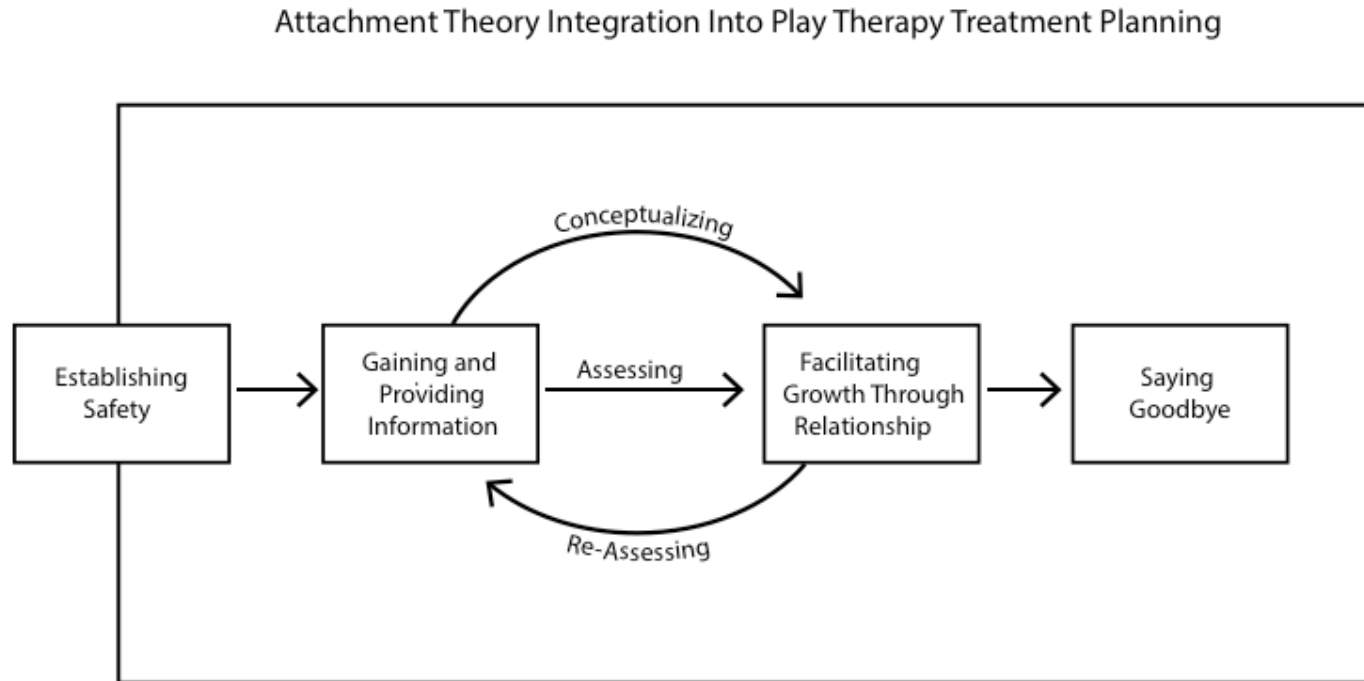
Saying goodbye is the final step in solidifying the healthy attachment experience for the child and the caregiver. The therapist makes sure that several sessions are used to focus on saying goodbye. The final sessions are used to send the child and caregiver off in a supportive manner. In essence, it is a "celebration" of the "attachment experience" they had created and engaged in together. Some participants focused on ensuring that the caregivers and child understood that they are always welcome back if they need further services, while others

emphasized the importance of saying goodbye without giving any potential false hope of seeing one another again. Whether saying goodbye was perceived as temporary or permanent, the focus was on providing a supportive ending experience to the therapeutic relationship. Simone said, “I tell people all the time, ‘Sometimes when you hit a new developmental stage they may want to return to therapy’ because again, it brings up some new things.”

Valuing Integration and Hindering Integration Serve as Contextual Understanding

Both the valuing integration and hindering integration categories provide a context through which to understand the occurrence of the integration of Attachment Theory within the play therapy treatment planning process. Valuing integration of Attachment Theory may be viewed as a motivator for integrating Attachment Theory within the treatment planning process. Many of the participants reported viewing their integration of Attachment Theory within the process as being integral to any work they completed, particularly when working with a child and his or her caregiver. This suggests that perhaps exposure to Attachment Theory training fosters the desire to integrate such knowledge into the treatment planning process. On the opposite end of the spectrum, clear themes emerged within the hindering integration category. Caregiver unavailability, either emotional or physical, and financial barriers through Medicaid reimbursement were the most cited barriers to implementing an attachment-based perspective within the treatment planning process. When caregivers were unable or unwilling to engage in the therapeutic process, participants tended to refer those clients to other practitioners for services. Ezra stated, “Personally I would probably refer them out.” Raquel said, “Well, sometimes I do refer them out. If it gets to the point where they’re saying ‘I just can’t do this.’”

Figure 3. Movement through attachment theory integration into play therapy treatment planning.



Moving Through the Theory

The general flow through the stages of the integration process was found to be somewhat linear with a cyclical component linking the second and third stages. Figure 3 illustrates the movement through the stages of the finalized theory. Establishing safety, the first stage, is considered to be a precursor to completing any attachment-based work. The safety created is sought to be maintained throughout the integration process. One way to perceive the establishing safety phase is that it serves as a protective blanket covering the entire attachment-based therapeutic process.

Gaining and providing information is the second phase of the integration process. This phase includes the play therapists gathering and providing of information through intake, assessment processes, educating caregivers, and providing and receiving feedback. Assessing and re-assessing was considered to be ongoing and therefore serves as a cyclical bridge between the gaining and providing feedback and facilitating growth through relationship phases. Initial assessment was used to move from the conceptualizing phase of intake to facilitating growth through relationship. Re-assessment of progress, gaining and providing information, and conceptualizing to decipher how to tailor interventions to fit the client's needs lead the second and third phases to be cyclical with one another. Once the initial goals of therapy are met and there are no additional goals for therapy, the fourth and final phase, saying goodbye, occurs.

Primary Theoretical Orientation and Integration of Attachment Theory

Participants' primary theoretical orientation did not appear to affect their overall integration process of Attachment Theory. However, the majority of participants practiced from a Prescriptive play therapy perspective. Perhaps the effect of theory on the integration process was shrouded due to the already flexible nature of the Prescriptive approach. The majority of

participants tended to integrate Attachment Theory across their clinical practice, regardless of the presenting concern. Some evidence was found of the effects of primary theoretical orientation on the tailoring of interventions from an attachment-based perspective. Simone practiced from a Cognitive-Behavioral perspective and tended to focus strongly on addressing negative cognitions about self and self and others in interventions from an attachment perspective. Raquel mentioned utilizing cognitive-behavioral techniques in her practice, but did not state that these techniques were of primary focus when working from an attachment perspective.

Linking Participant-Labeled Stages to the Final Theory

Each participant labeled her own perceived stages of the process of integration of knowledge of Attachment Theory within her practice. Participants' self-labeled stages are shown in Table 2. Although the labeling of the stages differed, upon close examination of initial reports, researcher memos, and follow-up discussion with participants, the general points of integration were found to be similar across all participants. Participants' reported points of integration and how each participant's reported phases fit within the stages of the finalized theory are shown in Table 3. Note that Simone does not appear, at first glance, to establish safety before beginning attachment-based work. This is due to the fact that this table represents initial explicit descriptions the participants used to label their integration process. Upon further examination of Simone's interview transcripts and follow-up discussion, Simone reported that she does begin the integration process by establishing safety.

I don't want to jump in too fast with lessons. I want to take a little time to allow that family to have an initial phase of therapy, or the individual, where they begin to develop therapeutic safety and trust.

Some participant stages were found to occur in two of the stages of the final theory. One example can be seen in Nikki's self-labeled stage of creating and implementing a plan. Creating the plan involved gaining and providing information, whereas the implementing a plan portion of this phase was found to fit into the facilitating growth through relationship phase of the final theory. The overlapping presence of Nikki's creating and implementing a plan stage demonstrates the cyclical movement between the gaining and providing information and facilitating growth through relationship phases of the final theory. Nikki's creating and implementing a plan stage involved discerning and "filling in the holes" in the relationship. Thus, gaining information and assessing occurred to decipher what the holes were and then the relationship was used to facilitate growth, or to fill in those holes. In addition to Nikki, Juanita and Kara also presented stages that overlapped in the phases of the final theory. Kara's building trust stage was described to include modeling and consistent responding to the caregiver and the child, as well as assessing the caregiver's needs. The use of modeling and consistent responding to the caregiver is indicative of the facilitating growth through relationship phase of the final theory, whereas the assessing of the caregiver's needs fits into the gaining and providing information phase of the final theory. Kara's regulation and mastery phase included using skills that were learned from the therapist in relationships outside of the therapeutic relationship in addition to the practicing of those same skills within the therapeutic relationship. Thus, the portion of this stage where the therapist educates the client on relational skills was found to fall within the gaining and providing information phase of the final theory and the portion that includes the practicing of the skills within the therapeutic relationship was found to fall within the facilitating growth through relationship phase of the final theory. Juanita's harder work and integration phases were found to overlap within the gaining and providing information and

facilitating growth phases of the final theory. Juanita stated that her harder work phase included changing negative cognitions to more positive cognitions. She used education within this process of changing the cognitions, which falls into the gaining and providing information category of the final theory. She also facilitated growth through the relationship within her harder work phase to foster the development of a more positive sense of self and self and others. Also, Juanita's integration phase included learning skills and using those skills outside the therapeutic relationship. Thus, her integration phase fell into gaining and providing information (educating) and facilitating growth through relationship, as those skills were practiced within the therapeutic relationship.

Table 3*Participant-reported Stages and the Respective Integration Points Within the Finalized Theory*

| Pseudonym | Stages of the Final Theory | | | |
|------------------|---|--|---|------------------------------|
| | Establishing Safety | Gaining and Providing Information | Facilitating Growth Through Relationship | Saying Goodbye |
| Raquel | Intake | Assessing Attachment Itself, Feedback | Intervention, Facilitating Change Through Relationship | Termination |
| Kara | Establishing Safety | Building Trust, Regulation and Mastery | Building Trust, Regulation and Mastery | Termination |
| Ezra | Intake | Assessment | Intervention | Tapering Off/ Termination |
| Juanita | Making This a Safe and Predictable Environment | Harder Work, Integration | Harder Work, Integration | End of Therapy |
| Nikki | Creating Safety | Assessing, Creating and Implementing a Plan | Creating and Implementing a Plan | Generalizing |
| Simone | | Assessment, Psychoeducation and Modeling | Psychoeducation and Modeling, Active Therapy | Termination |
| Ginger | Intake | Assessment, Education and Intervention, Re-Assessment | Education and Intervention | Tapering Off |

Therapeutic Relationship from an Attachment-Based Perspective

Regardless of primary theoretical orientation, all participants perceived the therapeutic relationship to serve as an attachment experience for the child and caregiver, and growth was facilitated primarily through the use of the therapeutic relationship and the caregiver-child relationship. Juanita was the only participant who did not tend to work with caregivers unless working to reunite children in the foster care system with their biological caregivers or when they were being placed in “pre-adoptive” or “forever” homes. In lieu of working with caregivers, Juanita emphasized facilitating self-esteem development and growth through the therapeutic relationship from an attachment-perspective, as the therapeutic relationship may be the only stable relationship in her client’s life at the time. Juanita stated, “Sometimes the attachment that they have with us allows them to take some more risks.”

How do you fill a sponge up too much? I think the kids that come to us are just so dry and they just don’t have that inside of them and if we can give them a little bit and then a little bit more then... because the whole idea is not so much that they’re attaching to us. It’s that they’re learning that they’re wonderful and they’re important and they’re terrific.

(Juanita)

Juanita, unlike other participants who tended to primarily utilize caregivers within their attachment-enhancing interventions, focused on enhancing sibling attachment relationships, as the children in foster care may not have other long-term relationships. She stated,

...we’ll do it with the sibling instead and have the siblings together. If they remain together then the attachment is with each other so they can develop a healthy attachment relationship that way.

All participants viewed the attachment with the therapist to be a temporary attachment relationship and stated that the goal was to generalize the attachment to a more long-term relationship in the child's life before termination occurred.

Summary

The purpose of this study was to explore and describe the play therapists' integration process of their knowledge of Attachment Theory into their treatment planning. Seven Registered Play Therapists, each with a minimum of 18 clock hours of education in Attachment Theory, were interviewed to co-construct a grounded theory describing the process of Attachment Theory integration into play therapy treatment planning. Purposeful sampling was used to select participants from various geographical locations, theoretical orientations, and practice settings. Two rounds of interviewing were used to obtain data. The initial set of interviews occurred with each of the seven participants. Theoretical sampling was used to conduct a second round of interviews with six participants, for a total of thirteen interviews. The second round of interviews focused on gaining clarification regarding categories and the relationship between the core categories of the finalized theory. In accordance with Charmaz's (2014) constructivist approach to grounded theory, the data analysis procedures included line-by-line initial coding, focused coding, emergence of categories, and final theory development through relating the core categories. The stages of the process of integration of knowledge of Attachment Theory within play therapy treatment planning were found to be: establishing safety, gaining and providing information, fostering growth through relationship, and saying goodbye. The relationship between, or movement through, these stages was explicated. Specific occurrences within each stage were outlined. Additional contextual information regarding the

integration process was provided through addressing themes that arose in participants' responses regarding the valuing integration and hindering integration categories.

CHAPTER FIVE

DISCUSSION

In this chapter the purpose of the study is reiterated and a summary of results is provided. The research findings are discussed and related to pertinent literature. Implications for play therapists and educators are discussed, and suggestions for future research are provided. The limitations of the study are examined and a personal reflection is presented as a conclusion.

Purpose

The primary purpose of this study was to explore and define how play therapists with knowledge of Attachment Theory integrate such knowledge into their treatment planning. Treatment planning was defined in a broad sense to encompass treatment planning across all clinical practice, and was not limited to written or electronic treatment plan documentation. Attention was paid to the decision-making process behind each participant's integration of knowledge. The primary research question was: How do play therapists with knowledge of Attachment Theory incorporate that knowledge into their play therapy treatment planning? Additional research questions explored the value, if any, play therapists placed on incorporating Attachment Theory within their treatment planning, as well as discovering any barriers that might hinder the integration process.

Summary of Methods

The constructivist approach to grounded theory was selected to explore and describe the process of integration of Attachment Theory within play therapy treatment planning. A screening survey was sent by e-mail to Association for Play Therapy members. I interviewed seven selected participants. Two rounds of interviews were conducted, for a total of 13 interviews.

Data analysis was completed following Charmaz's (2014) suggested methods for constructivist grounded theory. The final theory was co-constructed with participants through use of data obtained in the interviews, researcher memos, and constant comparative methods.

Discussion of Results

The grounded theory that was co-constructed with participants and described the process of integration of Attachment Theory had four primary stages. Those stages were labeled establishing safety, gaining and providing information, facilitating growth through relationship, and saying goodbye. The transitioning through the theory from one stage to the next was found to be semi-linear, with a cyclical component among the gaining and providing information and facilitating growth through relationship stages. The final stage of the theory, saying goodbye, began when the initial goals of therapy had been met. In the following sub-section, findings are discussed as they pertain to each stage of the theory: establishing safety, gaining and providing information, facilitating growth through relationship, and saying goodbye.

Stages of the Theory

Establishing Safety. Establishing safety was found to be a necessary precursor to initiating attachment-based play therapy work. Three participants explicitly stated that creating safety was their primary stage of the integration process. The other four participants did not initially state that this was their beginning stage; however, they described the act of creating safety in their initial contact with clients as one focus from an attachment-perspective. Therefore, the integration of Attachment Theory into treatment planning was found to begin with the establishment of safety. Establishment of safety refers to physical and emotional safety with the caregiver as well as within the therapeutic relationship and the therapeutic environment.

The therapist serves as the facilitator for establishing safety in the therapy environment and caregiver-child relationship. Thus, the therapist is working to establish a sense of security in the therapeutic environment as well as in the caregiver-child relationship. From an attachment-based perspective, the working or exploratory phase of play therapy can not begin without that sense of security. Bowlby (1988) discussed the importance of having a secure base from which to be able to venture out and to explore one's environment. It is through this exploration that learning occurs (Bowlby, 1988; Johnson & Whiffen, 2003). According to Johnson and Whiffen (2003), one of the primary tenets of Attachment Theory is the experiencing of a sense of security within the attachment relationship; the relationship also offers a safe haven for the individual from which the environment can be explored. It is within the therapeutic relationship, or safe haven, that the individual is able to emotionally regulate and to experience a sense of safety (Crenshaw & Stewart, 2015). Once an individual is calm, that individual's mental faculties and self are free to explore the environment using the relationship as a secure base (Bowlby, 1988; Johnson & Whiffen, 2003; Whelan & Stewart, 2014). The self, as well as the self and others, are a part of the play therapy environment and were perceived by participants in this study as more likely to be explored only after a sense of safety or security had been established. Establishing safety was perceived by several participants to be a precursor to completing any attachment-based play therapy work. The notion of "precursor" is an important finding. Whelan and Stewart (2014) discussed the use of the therapeutic relationship, in the Circle of Security intervention, as a safe haven and a secure base for the child throughout play therapy sessions. Participants in this study perceived establishing safety as being the beginning of providing attachment-based services. Although Whelan and Stewart (2014) discussed the use of the relationship as a safe

haven and a secure base throughout play therapy services, they did not explicitly identify safety as a precursor to beginning attachment-based services.

Gaining and Providing Information. The gaining and providing information phase includes intake, assessment, and re-assessment for progress. The process of gaining and providing information is not a new idea in play therapy treatment planning. The intake session, in conjunction with ongoing consultation sessions throughout the course of treatment, is meant to provide the play therapist with opportunities to gain information and provide information to the caregiver (Ray, 2011). The gaining and providing information stage of the theoretical framework developed from this study focuses on the types of information to which the counselor pays attention when incorporating knowledge of Attachment Theory.

Intake. The intake process marks the beginning of the gaining and providing information phase of the integration of Attachment Theory within play therapy treatment planning. According to Ray (2011), intake interview includes obtaining a thorough understanding of the presenting concerns of the caregivers and a thorough developmental history of the child. The findings of this study are consistent with those aspects of Ray's (2011) intake process. The finding of this study that adds to our understanding of the intake process from an attachment-perspective is that the developmental and social history of the child is evaluated through the Attachment Theory framework. In other words, the therapist looks for specific breaks in relationships for the child, as well as the caregivers, as indicators of attachment-related experiences that may have shaped the individual's current attachment pattern. Several participants discussed assessing for the caregiver's attachment history as well as that of the child, to gain contextual information as to the nature of the relational environment in which the child had developed.

Assessment and Re-Assessment. From an attachment-based perspective, participants used developmental history, psychosocial history, self-report measures, and both formal and informal methods for assessing the attachment dynamics of the child, the caregivers, and the child and the caregivers together. Initial assessment was found to occur in the intake session and in the first few sessions. Ray (2011) discussed the use of developmental information to assess the child's current state of development, as well as to understand previous patterns in the child's development that may have contributed to the child's current state. The primary difference when working from the attachment-perspective is the lens through which such information is filtered. From an attachment perspective, factors such as trauma and any breaks in relationships were cited by participants as providing additional understanding of the child's development. The initial assessment of the quality of the attachment bond between the caregiver and the child has been addressed in previous literature. The Marschack Interaction Method (MIM), which was also the most widely reported formal assessment used by participants, is the assessment utilized when providing Theraplay (Booth & Jernberg, 2010).

Although initial assessment has been discussed from an attachment perspective, the re-assessment phase has not been discussed from an attachment-based perspective. Participants utilized formal and informal methods for re-assessing progress from an attachment perspective throughout the course of treatment. The informal methods utilized included observing the child's and caregiver's relational dynamics, as well as the child's initial and ongoing receptivity to relationship with the therapist. Specific behavioral cues that were generally considered to indicate a more secure attachment relationship were increased eye contact, increased receptivity to relationship, and increased attunement to others. One participant indicated that a child who was too receptive to relationship might have an indiscriminate attachment style. Other methods

for re-assessment included observing changes in the child's play and using art therapy methods to discern change. One participant used art as an assessment intervention as a sort of pre- and post- test. She stated that she would have the child draw a picture of the family initially, and then periodically throughout the course of treatment would ask the child to again draw a picture of the family. She would assess for progress from an attachment-based perspective by watching for changes in proximity and relationship of the child and the caregiver in the pictures. The findings regarding tools for re-assessment might be used to create an assessment form for play therapists to use from an attachment-based perspective. Such an assessment tool might clarify how to observe progress when integrating Attachment Theory into treatment planning.

Facilitating Growth Through Relationship. According to Landreth (2012), most of what children learn in a play therapy relationship is not cognitive; rather, it is “a developing experiential, intuitive learning about the self that occurs over the course of the therapeutic experience (p. 87).

The necessity of establishing a strong rapport through which to communicate with the child is not a new concept within the field of play therapy. Landreth (2012) described the importance of creating a relationship through which the child is able to become increasingly self-aware and is able to harness his or her inner capabilities to strive toward change. Landreth described the relationship as the primary means for facilitating growth in play therapy from a Child-Centered perspective. The findings of this study suggest that play therapists operating from varying theoretical orientations, who are integrating an attachment-based perspective, work to create a similar relationship with the child. Also, when working from an attachment-based perspective, the focus is not solely on the therapeutic relationship between the therapist and the child; the focus is also on enhancing the relationship between the caregiver and the child.

Participants reported their perception that it is through these relational experiences, or “attachment experiences,” that the child’s and caregiver’s internal working models are facilitated to change toward enhanced security.

Current attachment-based interventions focus on enhancing the child-parent relationship through enriching attunement and relational skills, whereas the findings of this study demonstrate that therapists working from an attachment-based perspective utilize all relationships to facilitate growth across the play therapy process. One example in the findings was that the majority of participants reported using modeling within and across relationships to enhance the learning of attunement and relational skills for the benefit of caregivers. This occurred outside of sessions as well as within dyadic play therapy sessions. The therapist provided attunement to both the caregiver and the child in the hope that providing such an “attachment experience” would lead to enhancement of the attachment relationship between the child and caregiver. This finding supports Crenshaw and Stewart’s (2015) suggested use of attunement skills with the child in play therapy sessions, as well as with the caregiver during consultation sessions. Although Crenshaw and Stewart (2015) developed the attachment framework based on their own experiences providing attachment-based services, these authors did not report any research findings regarding this technique. Thus, the findings of this study lend support for the applicability of the attachment framework technique of attunement across relationships, as suggested by Crenshaw and Stewart (2015).

Saying Goodbye. Termination is the term used frequently in literature to describe the ending of play therapy services. Landreth (2012) defined termination as the “discontinuing of the [therapeutic] relationship” (p. 361) and noted that the termination process varies in length from practitioner to practitioner. Some therapists consider the final session to be the termination of the

therapeutic relationship, whereas others view a series of final sessions as comprising the termination process. Ray (2011) recommended a minimum of three termination sessions, and possibly more depending on the length of time the child has been in play therapy. Participants in this study focused on saying goodbye. The nature of the ending of a relationship can cause or worsen an attachment disruption (Johnson & Whiffen, 2003; Levy & Orlans, 1998). Participants took great care to avoid harming the client when ending the therapeutic relationship. In fact, one participant reported she refuses to contract for services without an up-front commitment that the child will have an appropriate length of time for termination. The majority of participants in this study took care to celebrate the relationship they had created with the child and caregivers. At times food was included in the final celebrations, which could be viewed as a final form of nurturing from an attachment-perspective. Several participants also reported that they made sure clients understood that they would be welcomed back if any new presenting issues arose. This viewpoint is consistent with the idea that the therapist serves as a safe haven and secure base for the family to which they may return to whenever deemed necessary.

Additional Findings

Additional findings are discussed in this section. These findings are described in the following sub-sections: an abstract process with concrete points, valuing integration of Attachment Theory, and hindering the integration process.

An Abstract Process with Concrete Points. Enhancing attachment between a child and his or her caregiver early in life can serve as a protective measure against a variety of mental health concerns and can enhance that child's ability to engage in future relationships (Aguilar, Sroufe, Egeland, & Carlson, 2000; Carlson, 1998; Cassidy & Shaver, 2008; Deklyen & Greenberg, 2008; Johnson & Whiffen, 2003; Levy & Orlans, 1998; Ogawa et al., 1997; Renken

et al., 1989; Warren, Huston, Egeland, & Sroufe, 1997). Prior to this study, no theoretical framework existed to describe how play therapists integrate their knowledge of Attachment Theory in their treatment planning, from intake through termination. Although several attachment-based interventions exist, literature was lacking that would foster understanding of how play therapists actually apply their knowledge of Attachment Theory across treatment planning (Parker, 2012). Additionally, Haslam and Harris (2010) decried the dearth of research investigating play therapists' values regarding the use of Attachment Theory in their practice.

The cyclical portion of the theoretical framework I generated occurs between the gaining and providing information and facilitating growth through relationship stages. Assessment provides the initial bridge between these two stages. Ongoing conceptualization and re-assessment occur throughout the bulk of the process, continuously moving through the gaining and providing information and facilitating growth through relationship stages until the goals of therapy are reached. This is a new description of a process that occurs when working from an attachment-based perspective. Although most of the integration process was found to be abstract, concrete application of Attachment Theory occurs in a few very specific areas. The first is the assessment aspect of the gaining and providing information phase, specifically through use of formal assessments. The second occurs within the facilitating growth through relationship phase when attachment-based interventions are used. Participants tended to tailor interventions to fit the specific needs of the client. This tailoring of interventions consisted of conceptualizing the client's needs through an ongoing cycle of re-assessment and attunement to the child's, caregiver's, and the caregiver-child's relationship needs. Almost all participants reported tailoring Theraplay activities to fit their client's areas of growth.

Valuing Integration of Attachment Theory. Haslam and Harris (2011) reported a deficit in knowledge “about what beliefs and attitudes drive the practice decisions of play therapists around their work with families” (p.52). In this study, themes were discovered in play therapists’ perceived value of integrating Attachment Theory in clinical practice. One theme was that addressing presenting concerns from an attachment-based perspective is perceived to benefit the child and caregiver, and to enhance the child-caregiver relationship. Participants also reported that they valued using their knowledge of Attachment Theory because it helped to position the child for successes in future relationships. Participants valued the trickle-down effect of enhancing attachment dynamics in the caregiver-child relationship so that the child could, in the future, pass on a secure attachment to his or her child. One participant described secure attachment to be “propagating.” Thus, play therapists’ valuing the utility of Attachment Theory knowledge to benefit the child, the caregiver, and the child-caregiver relationship provides further insight into possible motivations for working from an attachment-based perspective.

Hindering the Integration Process. Parker (2012) suggested that barriers may exist to integrating Attachment Theory in clinical practice; she encouraged research to further investigate the existence of such barriers. In this study, the two primary barriers to integrating knowledge of Attachment Theory within play therapy treatment planning are caregiver unavailability and financial barriers. Two participants reported experiencing a fiscal barrier due to being unable to be reimbursed by Medicaid for attachment-based services. Six of the seven participants reported caregiver unavailability, either physically or emotionally, to be a primary barrier to integrating Attachment Theory knowledge within their clinical practice.

The Grounded Theory and Play Therapy Treatment Planning

Charmaz (2014) recommended, as a final step in the development of the grounded theory, relating findings back to relevant literature. At first glance the stages of the theory constructed from this research may seem to mimic or be very similar to existing information regarding play therapy practices. One explanation for this similarity may be due to the fact that participants were asked to describe their process of integration into their treatment planning. “Treatment planning” suggests certain aspects of clinical practice, such as assessment, intervention, and termination. Thus, the similarities across participants’ responses may be partially attributable to the wording of the question asked. This section describes findings in relation to pertinent literature regarding Attachment Theory and play therapy treatment planning, and regarding theoretical orientation and use of Attachment Theory knowledge.

Play Therapy Treatment Planning

The APT (2012) recommended, as part of best practices, that play therapists utilize treatment plans and regularly update caregivers throughout the play therapy process regarding progress toward treatment goals. The findings of this study confirm that play therapists who utilize Attachment Theory in their treatment planning engage caregivers throughout the treatment planning process, through gaining and providing information. The participants also monitored and reported progress to the caregivers through use of consultation sessions. One participant, Juanita, who worked with children in the foster care system, did not hold consultation sessions unless she was engaging the child’s caregivers in the play therapy process. She provided updates to the child’s case manager periodically throughout the play therapy process. With respect to engaging caregivers, APT (2012) also recommended that

“play therapists recognize that clients often have family members and other significant adults that have influence in the client’s psychosocial growth and development, and strive

to gain understanding of the roles and involvement of these other individuals so that they may provide positive therapeutic support where appropriate.” (p.7)

The participants in this study engaged caregivers throughout the treatment planning process and several participants acknowledged that working from an attachment-based perspective benefited the caregiver as well as the child. This finding suggests that integrating Attachment Theory knowledge may provide therapeutic support to the caregiver as well as the child throughout the play therapy process. Several of the participants also reported that they perceived their knowledge of Attachment Theory to be of benefit to the therapeutic process any time they were working with a child, because the child is developing in the context of relationships with the caregivers. As a result, having knowledge of Attachment Theory, as well as understanding how to utilize such knowledge in treatment planning, may provide play therapists with an added ability to provide support to the children and families with whom they work.

Ray (2011) described diagnosing as an integral part of play therapy treatment planning, primarily for reimbursement purposes. The participants in this study did not focus on any set of presenting issues or specific diagnoses as indicators of an attachment disruption. However, several participants did refer to working with adopted children and their families and reported that when adoption came up in the history of the client, they immediately began conceptualizing from an attachment perspective. One participant, Juanita, spoke specifically about working with children in the foster care system. No participants in this study focused on specific diagnoses that motivate them to work from an attachment-based perspective.

Theoretical Orientation and Use of Attachment Theory Knowledge

Participant use of Attachment Theory knowledge across presenting issues suggests that Attachment Theory may be broadly applicable. The participants’ primary focus, from an

attachment perspective, was on increasing the child's positive sense of self and self and others and enhancing the relational dynamics between child and caregiver. This is consistent with Landreth and Bratton's (2006) Child-Parent Relationship Therapy tenet, "focus on the doughnut, not the hole" (p.131). This means to focus on the person and their strengths instead of the problem. Landreth (2012) noted that when a child feels better about his or her self, he or she exhibits more adaptive behaviors. The participants in this study practiced from differing theoretical orientations, yet utilized the therapeutic relationship within the play therapy process as the means through which to facilitate change. The only difference observed due to theoretical orientation was the slight change in tailoring of interventions to address client concerns from an attachment-perspective. For instance, the participant who practiced from a primarily Cognitive-Behavioral play therapy orientation focused on changing the child's cognitions about self and self and others. This suggests that the play therapists' primary theoretical orientations may influence the types of interventions they use when working from an attachment-based perspective.

Implications

Play Therapists

Ryan and Bratton (2008) stated, "Attachment theory and research is a well established framework for understanding children's normal and atypical social/emotional development. It is used extensively by clinicians to design interventions, understand interactions, and assess clinical progress" (p. 28). Parker (2012) asserted that there was a lack of understanding regarding the integration of Attachment Theory within treatment planning. The final theory developed from this research study could be used by play therapists and play therapist supervisors to more fully understand the process of integrating Attachment Theory in the treatment planning process. This

process has not been described in previous literature. Play therapists may also utilize the co-constructed theory of integration as a reference for caregivers throughout the play therapy process. It could be used in the intake session as a tool to introduce caregivers to the process of becoming engaged in the play therapy process. It could also be used in regularly scheduled consultation sessions as a tool to show caregivers where they are in the process of progressing through treatment. Utilizing the theory in this manner may provide a clear informed consent for the caregivers to become engaged in the play therapy treatment process. It may also provide an additional mechanism through which to educate and update caregivers on the process and progress of working from an attachment-based perspective. Additionally, an assessment form could be developed for play therapists to use to report progress from an attachment-based perspective; such a form might prove useful in observing and reporting progress across therapy.

Educators

The Association for Play Therapy does not require education in Attachment Theory as a requirement for obtaining the Registered Play Therapist credential. Participants reported perceived benefits to the caregiver, the child, and the caregiver-child relationship when working from an attachment-based perspective. These reported benefits, coupled with the extant literature describing the protective factors of addressing attachment issues early in life, indicate the importance of integrating knowledge of Attachment Theory in play therapy treatment planning. Ginger reported a lack of exposure to education in Attachment Theory in her graduate program. All other participants reported obtaining the vast majority of their knowledge of Attachment Theory through continuing education workshops and conferences attended. This suggests there is limited exposure to Attachment Theory education in graduate school programs in the mental health disciplines. Clients might be better served if graduate students in mental health disciplines

are provided opportunities to learn about Attachment Theory and the process of integrating such knowledge in their treatment planning. The theory co-constructed in this study could serve as a framework from which to educate students and play therapists as to how they may integrate Attachment Theory knowledge in their clinical practice.

Recommendations for Future Research

The stages of integration of Attachment Theory that I co-constructed with my participants describe only the integration processes of the participants in this particular study. Future studies might examine the generalizability of these stages of the integration of Attachment Theory across play therapists, as well as the treatment planning practices of other mental health practitioners.

Caregiver unavailability, either emotional or physical, and financial barriers through Medicaid reimbursement were the most frequently cited barriers to implementing an attachment-based perspective within the treatment planning process. Six of the seven participants reported caregiver unavailability, most often perceived as emotional unavailability, as a primary barrier to integrating Attachment Theory. Those participants tended to refer those caregivers and their children elsewhere for services. Further qualitative research to discover effective methods for navigating caregiver emotional unavailability and to determine the most effective advocacy strategies to establish Medicaid reimbursement for attachment-based therapies may strengthen therapists' ability to address attachment issues in play therapy. If such strategies are already described in the literature, a quantitative research study may prove useful in discerning the efficacy of certain strategies in terms of obtaining financial re-imbusement through Medicaid.

Several of the findings of this study were related to Child-Centered Play Therapy and the relational dynamics created to facilitate growth from the child-centered perspective. Future

research to discover additional distinguishing, or similar, characteristics between the Child-Centered Play Therapy relationship and the relationships fostered when utilizing an Attachment Theory perspective could serve to further characterize and describe the qualities of working from an attachment-based perspective in play therapy. A qualitative approach to research would be appropriate for obtaining rich data that could be used to describe the similarities and differences between the Child-Centered Play Therapy relationship and the relationship created when working from an Attachment-based perspective. Gaining a greater understanding of any additional similarities among these theoretical approaches to relationships may help to establish the reason a primary Attachment Theory orientation to play therapy does not exist. Perhaps it is already too similar to an existing theoretical orientation, so that particular aspects of the theory are integrated secondarily rather than developing a primary attachment-based perspective.

If there is a dearth of exposure to Attachment Theory in graduate school coursework, a meta-analysis of Attachment Theory in course syllabi could be conducted to identify a gap in the curriculum. The findings of this research study indicate the broad applicability of Attachment Theory across presenting issues and theoretical orientations. Previous research reported the benefit of addressing attachment issues early in life (Aguilar, Sroufe, Egeland, & Carlson, 2000; Carlson, 1998; Cassidy & Shaver, 2008; Deklyen & Greenberg, 2008; Johnson & Whiffen, 2003; Levy & Orlans, 1998; Ogawa et al., 1997; Renken et al., 1989; Warren, Huston, Egeland, & Sroufe, 1997). Creating curriculum and understanding how and when to expose graduate students to Attachment Theory may further prepare new professionals to provide beneficial services to their child clients and their caregivers.

Limitations

One limitation of this study was the use exclusively of semi-structured interviews to obtain data from participants. It may have proved useful to obtain additional data through reviewing participants' intake questionnaires, observing participants in their interactions with clients when working from an attachment-based perspective, or reviewing (with permission) written treatment plans that these play therapists created. Another limitation of this study was the small number of participants. Although I perceived data saturation to occur, additional findings may have emerged had additional participants been included.

Personal Reflections

I thank each of the participants for sharing their time and knowledge with me throughout this research process. I am grateful to have had the opportunity to learn from them. Undertaking this research definitely has enhanced my understanding of how Attachment Theory can be integrated across play therapy treatment planning. I hope that this research will provide insight to others interested in learning about the incorporation of Attachment Theory in play therapy treatment planning. I plan to use what I have learned within my clinical practice as a play therapist, future supervisor, and future educator.

When I began this research, I had no idea just how complicated and rich the information would be that I would obtain through the interviews I conducted. I was also surprised at how similar many of the participants' reports were. The data analysis process was complex and the reporting of results was difficult given the vast amount of data obtained. I did my best to accurately represent participants' reports and to provide as much information as possible.

The grounded theory process amazed me! It was truly exciting to see order emerge from participant reports. I recommend the use of grounded theory to any practitioner looking to discover and explain a process. At times, I doubted the significance of my findings. I had to

revisit the data and existing literature several times, and remind myself that addressing any deficit in the field is a contribution. The final theory generated through this research is more abstract than I anticipated. I had hoped to demonstrate a more concrete process for therapists to use. Attachment Theory is a multi-faceted theory with many aspects that can be incorporated into treatment planning. One participant reported in her follow-up interview that participating in this research was helpful for her because she gained further insight into her own process of integration. She mentioned that having to think of how she went about integration was helpful to her because she often acts out of instinct when operating from an attachment-based perspective. Before conducting this study I had hoped to be able to explain that same instinctive process of integration, and hope that this goal has been met.

Summary

This chapter began with an overview of methods used to conduct the research. Research findings were summarized and discussed. Aspects of the final constructed theory were related to pertinent literature. Additional findings, as well as implications for play therapists and educators, were described. The limitations of the study were addressed, and a personal reflection concluded the chapter.

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APPENDIX A

Semi-Structured Interview Guide

Background/ Knowledge:

What is your background in learning Attachment Theory?

What trainings, if any, have you had in Attachment Theory?

What value do you place, if any, on the importance of incorporating Attachment Theory within your clinical practice?

Integrating Attachment Theory:

Describe how you integrate Attachment Theory within your clinical practice.

Define the stages of integration of Attachment Theory within your clinical practice.

Describe what occurs within each stage of integration you identified.

Describe your decision-making process in applying your knowledge of Attachment Theory within your clinical practice. For example: What indications, if any, do you look for to decide whether or not to approach a client or family from an attachment-based perspective?

Please provide a case example of a time you incorporated Attachment Theory within your clinical practice.

Barriers to Integration

What barriers, if any, have you encountered, or do you imagine other clinicians may encounter, to integrating Attachment Theory within clinical practice?

APPENDIX B

Hello APT member,

My name is Karen Swanson Taheri and I am a doctoral candidate in Counselor Education under the direction of Professor Barbara Herlihy in the Department of Educational Leadership, Counseling, & Foundations at the University of New Orleans.

I am requesting your participation in my dissertation study titled *How Play Therapists Integrate Knowledge of Attachment Theory Into Clinical Practice: A Grounded Theory*. The purpose of this study is to decipher the decision-making process used by play therapists in their clinical work with children and families from an attachment theoretical perspective and to generate a framework to describe the integration process that may serve as a guide for play therapists and families. **The only criteria for participating in the screening survey is membership in the Association for Play Therapy.** I developed this screening survey (adapted from Parker's (2012) Play Therapists Decision-Making Inventory-R) specifically for the purpose of screening participants for my qualitative dissertation. Through the survey, I am asking play therapists to respond to questions about their demographic information and training in and use of Attachment Theory within their clinical practice.

At the end of the screening survey (the final question), you will have an opportunity to enter your e-mail address if you are willing to participate in an initial qualitative interview. The initial interview will be scheduled through e-mail, will be conducted via videoconferencing technology (such as Skype or iPhone Facetime), will be audio recorded for transcription and data analysis purposes, will last approximately 45 minutes, and will consist of a series of semi-structured interview questions regarding your background education and perceptions about Attachment Theory, as well as your decision-making process for incorporating knowledge of Attachment Theory into your clinical practice. A more brief, follow up interview will be requested which will last approximately 15 minutes. The intent of the follow up interview is for the researcher to clarify any questions from the initial interview and for participants to provide additional information pertinent to the research. Additional brief interviews may be requested if further information or clarification is needed to complete the research. Participants will be provided with the final theoretical framework generated that describes play therapists' integration of Attachment Theory within their clinical practice.

My hope is that the information obtained from this research will provide valuable information regarding use of attachment theory within play therapy clinical practice for members of the Association for Play Therapy and that the resulting framework may be of use to educators, clinicians, and families.

Possible benefits of participating in the study are that you may become increasingly aware of your own practice patterns and values regarding the use of Attachment Theory within your clinical practice. A possible risk of participating in the study is that you may become fatigued as the study requires an initial lengthy interview (approximately 45 minutes) and a minimum of one follow up interview. Another potential discomfort, or risk, of participating in the study is that you may experience frustration in the event that any technological difficulties occur.

Your participation in this study is voluntary at all times. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. The results of the research study will be provided to participants, may be re-analyzed for future research, and may be published, but your name will not be used. The questionnaire is anonymous.

Follow this link to the Survey:(enter link)

Or copy and paste the URL into your internet browser: (enter URL)

If you have any questions concerning the research study, please call Dr. Herlihy at (504) 280-6661 or myself at (512) 771-1018. Thank you for your time, consideration, and interest in this study!

Karen Swanson Taheri, LPC, Registered Play Therapist
Doctoral Candidate
The University of New Orleans

APPENDIX C

Play Therapists' Demographics, Education, and Use of Attachment Theory

Q1 Sex

Male (1)

Female (2)

Q2 Age

Q3 Ethnicity

African American (1)

Asian American (2)

Caucasian (3)

Hispanic (4)

Native American (5)

Middle Eastern (6)

Pacific Islander (7)

Other (8) _____

Q4 Current Credentials (Please check all that apply)

Counselor Intern (CI) (1)

Licensed Marriage and Family Therapist (LMFT) (2)

Licensed Professional Counselor (LPC) (3)

Licensed Clinical Social Worker (LCSW) (4)

National Certified Counselor (NCC) (5)

National Certified School Counselor (NCSC) (6)

Registered Play Therapist (RPT) (7)

Registered Play Therapist Supervisor (RPT-S) (8)

School Psychologist (9)

Psychologist (10)

Psychiatric Nurse (11)

Other (12)

Q5 How many years of experience do you have in providing play therapy services?

None (1)

1 – 5 years (2)

5 – 7 years (3)

8 – 10 years (4)

10 – 15 years (5)

16 – 20 years (6)

21 – 30 years (7)

over 30 years (8)

Q6 In what setting do you primarily provide play therapy?

Agency (1)

Private Practice (2)
School (3)
University (4)
Hospital (5)
Other (6)

Q7 When providing play therapy, what theoretical orientation do you use most often?

Child-Centered (1)
Jungian (2)
Adlerian (3)
Cognitive- Behavioral (4)
Ecosystemic (5)
Psychodynamic (6)
Object Relations (7)
Gestalt (8)
Prescriptive (9)
Unsure of theoretical orientation (10)
Other (11)

Q8 Primarily, what ages are the clients to whom you provide play therapy services?

0-5 (1)
6-10 (2)
11-15 (3)
16-20 (4)
21-25 (5)
Other (6)

Q9 How many clock hours of education in Attachment Theory have you received? (Ex: an entire graduate-level course devoted to Attachment Theory alone may provide approximately 30 hours of education, whereas a single 3-hour workshop, or 3 hours of a class lecture, would provide 3 clock hours of education).

None (1)
1-3 (2)
3-9 (3)
9-18 (4)
18-24 (5)
24-36 (6)
more than 36 (7)

Q10 How often do you incorporate your knowledge of Attachment Theory into your play therapy clinical practice and/or treatment planning process?

(1= Never; 2= Rarely; 3= Sometimes; 4= Often; 5= Almost Always)

1 (1)
2 (2)
3 (3)
4 (4)

5 (5)

Q11 In what state do you currently practice?

Q12 If you are interested in participating in the interview portions of this research study, please provide your e-mail address. Providing your e-mail address here serves as consent for a researcher to contact you via e-mail to initiate an initial interview, which will be conducted via videoconferencing (Skype or iPhone Facetime), will be audio recorded for transcription and data analysis purposes, and will last approximately 45 minutes. Your participation is voluntary. You may withdraw your participation at any time without penalty. Providing your e-mail does not ensure that you will be contacted.

APPENDIX D

IRB Exemption Letter

***University Committee for the Protection
of Human Subjects in Research
University of New Orleans***

Campus Correspondence

Principal Investigator: Barbara Herlihy

Co-Investigator: Karen Swanson Taheri

Date: December 11, 2014

Protocol Title: How Play Therapists Integrate Knowledge of Attachment Theory Into
Clinical Practice: A Grounded Theory

IRB#: 01Dec14

The IRB has deemed that the research and procedures described in this protocol application are exempt from federal regulations under 45 CFR 46.101 category 2, due to the fact that any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Exempt protocols do not have an expiration date; however, if there are any changes made to this protocol that may cause it to be no longer exempt from CFR 46, the IRB requires another standard application from the investigator(s) which should provide the same information that is in this application with changes that may have changed the exempt status.

If an adverse, unforeseen event occurs (e.g., physical, social, or emotional harm), you are required to inform the IRB as soon as possible after the event.

Best wishes on your project.

Sincerely,



Robert D. Laird, Ph.D., Chair
UNO Committee for the Protection of Human Subjects in Research

APPENDIX E

Hello APT member,

My name is Karen Swanson Taheri and I am a doctoral candidate in Counselor Education under the direction of Professor Barbara Herlihy in the Department of Educational Leadership, Counseling, & Foundations at the University of New Orleans.

You are receiving this e-mail because you provided your e-mail in response to the final question on the screening survey for my dissertation study titled *How Play Therapists Integrate Knowledge of Attachment Theory Into Clinical Practice: A Grounded Theory*. You have been selected to participate within the research study.

The purpose of this study is to decipher the decision-making process used by play therapists in their clinical work with children and families from an attachment theoretical perspective and to generate a framework to describe the integration process. The hope is that the generated framework may serve as a guide for educators, play therapists, and families.

Participation in the study involves an initial interview (that will last approximately 45 minutes), and a minimum of one additional follow-up interview will be requested (that will last approximately 15 minutes). Additional brief interviews (10 to 15 minutes) may be requested if further clarification or information for the research study is needed. Each of the interviews will be conducted via videoconferencing technology (such as Skype or iPhone Facetime) and will be audio recorded for transcription and data analysis purposes.

My hope is that the information obtained from this research will provide valuable information regarding use of Attachment Theory within the clinical practice of play therapy for members of the Association for Play Therapy that may be of use to educators, clinicians, and families.

Possible benefits of participating in the study are that you may become increasingly aware of your own practice patterns and values regarding the use of attachment theory within your clinical practice. A possible risk of participating in the study is that you may become fatigued as the study requires an initial lengthy interview (approximately 45 minutes) and a minimum of one follow up interview. Another potential discomfort, or risk, of participating in the study is that you may experience frustration in the event that any technological difficulties occur.

The results of this research study and data obtained may be re-analyzed for future research, will be provided to participants, and may be published but your name will not be used. **Your participation in this study is voluntary at all times.** If you choose not to participate or to withdraw from the study at any time, there will be no penalty.

Response to this e-mail to schedule an initial interview indicates your consent to participate within this research study and to be audio recorded during interviews for research purposes. The audio recordings will be deleted once transcription has occurred. The interviewer will transcribe the interview as soon as possible once the interview has been completed.

I will use videoconferencing technology in a secure and private place to conduct interviews. I recommend that you do the same to reduce the risk of a break in your confidentiality. If you have a preference for a type of videoconferencing program that you would like to use other than Skype or iPhone Facetime, please notify me of your preference and I will do my best to make the necessary accommodations.

If you have any questions concerning the research study, please call Dr. Herlihy at (504) 280-6661 or myself at (512) 771-1018. Upon completion of my dissertation I will provide you with a copy of the final theoretical framework generated.

To schedule your initial interview please reply to this e-mail with dates/times that will work best for you within the next three to four weeks.

Thank you for your time,
Karen Swanson Taheri
Doctoral Candidate
The University of New Orleans

APPENDIX F

Dear APT member,

My name is Karen Swanson Taheri and I am a doctoral candidate in Counselor Education under the direction of Professor Barbara Herlihy in the Department of Educational Leadership, Counseling, & Foundations at the University of New Orleans.

You are receiving this e-mail because you provided your e-mail in response to the final question on the screening survey for my dissertation study titled How Play Therapists Integrate Knowledge of Attachment Theory Into Clinical Practice: A Grounded Theory. You have not been selected to participate within the research study. I really appreciate you taking the time to complete the screening survey!

Upon completion of my dissertation I will provide you with a copy of the final theoretical framework generated.

Best Wishes,

Karen Swanson Taheri
Doctoral Candidate
The University of New Orleans

APPENDIX G

Example Memo

February 17, 2015

This participant has an interesting contribution to the study as her agency she works in typically works with children in the foster care system who have experienced trauma. One of the questions that has sort of lingered in the back of my mind from the initial three interviews was the idea of the therapist being/serving as a temporary attachment figure for the child. A couple of participants used the language ‘transfer’ to describe the termination process and the transferring of their relationship or attachment bond to a more stable/permanent individual in the child’s life as part of that process. This participant was able to describe how she sees her role in working with children that she may not necessarily get to transfer that relationship for. She used the word ‘vessel’ to describe herself. She also spoke about how she does not think the goal is for the child to attach to her, but she also recognized that she may be the only stable figure in that child’s life for a while. At first I wasn’t quite sure whether or not she viewed the potential for an abrupt termination as being potentially harmful to the child. On one hand she mentioned that she thought it could cause harm, and on another she described viewing her role as being so important that she didn’t think working with the child could cause harm, whether there was an abrupt ending or not. It is as if she perceived the relationship itself to be so beneficial that the child’s experiencing the relationship outweighed the possibility of an abrupt ending. She said “how do you fill a sponge up too much?” She also mentioned that she works to generalize the relationship but acknowledged that it’s not always possible. I’ll need to continue paying attention to the manner in which relationships are generalized and the way endings occur within the therapeutic relationship.

APPENDIX H

Research Audit

| Date | Event | Outcome of Event or Memo Excerpt |
|--------------------|--|--|
| 12/9/14 | Dissertation Proposal Defense | Successfully passed proposal |
| 12/10/14 | Applied for UNO IRB approval | Successfully submitted application via e-mail |
| 12/11/14 | Received IRB approval | Received approval via e-mail |
| 1/2/15 | Applied for the APT member e-mail list | Successfully submitted application via e-mail |
| 1/4/15 | Created Survey | Created using Qualtrics |
| 1/20/15 | Received APT e-mail list | Received via e-mail in Excel spreadsheet format |
| 1/21/15 | Disseminated Survey | Successfully disseminated survey to 5,707 members of the APT via e-mail |
| 1/25/15 to 2/11/15 | Screening | Memo: "I've gotten international participants interested in completing interviews; how exciting! I hope that I am able to find a male participant that meets criteria to interview. All of the willing participants who meet the criteria are women...and most are Caucasian and working in private practice from a Child-Centered theoretical orientation." |
| 2/4/15 | E-mailed participants to schedule interviews | Several responses, several non-responses |
| 2/7/15 | Resent the initial e-mail call to participants to schedule | Several responses, several non-responses |

| | | |
|-------------------|--|---|
| | interviews | |
| 2/5/15 to 2/24/15 | Scheduled Seven Initial Interviews | Scheduled via e-mail |
| 2/9/15 | First Interview | Successfully completed interview using iPhone FaceTime |
| 2/10/15 | Re-emailed participants that had not responded | Successfully sent via e-mail |
| 2/11/15 | Second Interview | Some technology difficulties; completed interview via iPhone FaceTime for first portion of interview and audio only for latter portion Memo: "The idea of establishing safety was a very prominent theme." |
| 2/11/15 | Transcribed First Interview | Transcribed using Microsoft Word Memo: "Caregivers acting as barriers to the integration process; I wonder if this will be a theme with other participants too." |
| 2/15/15 | Transcribed Second Interview | Transcribed using Microsoft Word Memo: "Caregivers as a barrier to integration came up again." |
| 2/16/15 – 3/2/15 | Coding transcripts and Linking of Categories | Hand-coding/ Linked Core Categories |
| 2/16/15 | E-mailed member check to first participant | Successfully sent to participant via e-mail; participant approved |

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|---------|------------------------------|--|
| 2/17/15 | Third Interview | Successfully completed Interview 3 using Skype Memo: “The idea of an ‘attachment experience’ really fits well with what I’ve been hearing other participants say about the therapeutic relationship they create.” |
| 2/17/15 | Fourth Interview | Successfully completed interview 4 using audio only at participant’s request Memo: “Creating safety, generalizing skills, engaging caregivers, caregivers as barriers, funding barriers, taking risks” |
| 2/18/15 | Fifth Interview | Successfully completed interview 4 using iPhone FaceTime Memo: “Pre-mature termination causing harm and working to avoid that harm; creating safety. This is something I’ve come up against in my own practice. I agree that it can be ‘heartbreaking’ when caregivers pull their child from therapy without a proper goodbye.” |
| 2/19/15 | Follow Up Interview 1 | Successfully completed |
| 2/19/15 | Transcribed Third Interview | Transcribed using Microsoft Word |
| 2/19/15 | Transcribed Fourth Interview | Transcribed using Microsoft Word |
| 2/20/15 | Transcribed Fifth Interview | Transcribed using Microsoft Word |

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|---------|--|---|
| | | |
| 2/21/15 | Sixth Interview | iPhone voice only Memo: "Neuroscience and attachment/ using a brain model; teaching self-nurture to caregivers" |
| 2/22/15 | Seventh Interview | iPhone voice only Memo: "Tailoring interventions and meeting clients where they're at; assessing from beginning and conceptualizing" |
| 2/23/15 | Emailed member check to second participant | Successfully sent to participant via e-mail; participant approved |
| 2/23/15 | Emailed member check to third participant | Successfully sent to participant via e-mail; participant approved |
| 2/23/15 | Emailed member check to fourth participant | Successfully sent to participant via e-mail; participant approved |
| 2/23/15 | Emailed member check to fifth participant | Successfully sent to participant via e-mail; participant approved |
| 2/23/15 | Transcribed Sixth Interview | Transcribed using Microsoft Word |
| 2/23/15 | Transcribed Seventh Interview | Transcribed using Microsoft Word |
| 2/24/15 | Emailed member check to sixth participant | Successfully sent to participant via e-mail; participant approved |
| 2/24/15 | Follow Up Interview 2 | iPhone voice only |
| 2/24/15 | Follow Up Interview 3 | iPhone voice only |

| | | |
|---------|---|---|
| 2/25/15 | Follow Up Interview 4 | iPhone FaceTime |
| 2/25/15 | Emailed member check to seventh participant | Successfully sent to participant via e-mail; participant approved |
| 3/1/15 | Follow Up Interview 5 | iPhone voice only |
| 3/1/15 | Follow Up Interview 6 | iPhone voice only |
| 3/1/15 | Transcribed Follow Up Interview 1 | Transcribed using Microsoft Word |
| 3/1/15 | Transcribed Follow Up Interview 2 | Transcribed using Microsoft Word |
| 3/1/15 | Transcribed Follow Up Interview 3 | Transcribed using Microsoft Word |
| 3/1/15 | Transcribed Follow Up Interview 4 | Transcribed using Microsoft Word |
| 3/2/15 | Transcribed Follow Up Interview 5 | Transcribed using Microsoft Word |
| 3/2/15 | Transcribed Follow Up Interview 6 | Transcribed using Microsoft Word |

VITA

Karen Swanson Taheri grew up in Southeast Texas. She obtained her Bachelor of Journalism degree with a focus in Photography from the University of Texas at Austin in 2006. She graduated in 2009 with a Master of Arts degree in Counseling from the University of Texas at San Antonio. Karen is a Registered Play Therapist and a Licensed Professional Counselor. She specializes in providing services to children and their families and looks forward to supervising and educating future clinicians and play therapists.