Record: 1

Title: Cultural competence and poverty: Exploring play therapists' attitudes.

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Source: International Journal of Play Therapy; Jan2021, Vol. 30 Issue 1, p50-60, 11p

Publication Year: 2021

ISSN: 15556824

Accession Number: 148197165

Database: Supplemental Index

Cultural Competence and Poverty: Exploring Play Therapists' Attitudes

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Acknowledgement:

Culturally competent training is an element of credentialing requirements that ensures mental health providers offer adequate and responsive care to diverse populations. Although the mental health field has embedded cultural competence in their standards and guidelines, there are discrepancies in the way the profession assesses and measures competence (Sue et al., 1996). Researchers have investigated attitudes toward poverty in the helping professions (Levin & Schwartz-Tayri, 2017; Noone et al., 2012; van Heerde & Hudson, 2010; & Wittenauer et al., 2015), but no study has focused on play therapists' attitudes toward poverty. The purpose of this study is to fill a gap in the literature regarding play therapist's attitudes toward poverty because awareness and knowledge are key elements to implement culturally responsive services and skills with diverse children in a variety of settings.

Cultural Competence

Cultural competence is an important component of professional practice, and practitioners are expected to develop skills and understanding pertaining to diverse clientele. Researchers define cultural competence as the set of beliefs, knowledge, and skills mental health providers possess in order to deliver effective interventions and services to members of various cultures (Gilbert et al., 2007; Sue, 2006). The New Freedom Commission on Mental Health (2003) recognized disparities in mental health delivery and viewed the lack of cultural competence for minority populations as a persistent problem. Culturally competent health care is essential to providing effective care to all populations. To aid practitioners in their ability to increase their cultural competence, leading professional mental health associations have published professional cultural competency standards and ethical codes (American Counseling Association [ACA], 2014; American Psychological Association [APA], 2017a, 2017b; National Association of Social Workers [NASW], 2015; Ratts et al., 2015) to promote and guide clinical practice.

Cultural competence is fundamental to effectively building relationships with clients and helping them achieve their mental health goals (Capell et al., 2007). Sue et al. (1996) identified three key components of cultural competence: cultural awareness, cultural knowledge, and cultural skill. Cultural awareness is foundational and necessary for individuals to develop culturally competent attitudes, knowledge, and skills (Gilbert et al., 2007). Furthermore, culturally aware clinicians are individuals who are sensitive to their personal values and biases and acknowledge how their values and biases may influence their view of the client, client's problem, and counseling relationship (Sue, 2006; Sue & Sue, 2016). Sue and Sue (2016) further urged culturally competent mental health to know beliefs, attitudes, principles, and worldviews common to the particular culture of people they serve. Additionally, culturally skilled clinicians benefit from

reading relevant diverse cultural research, pursue educational opportunities on diverse cultural skills, and involve themselves with diverse cultures outside of counseling relationships (Sue et al., 1992; Sue & Sue, 2016).

Sue and Sue (2016) advocated mental health providers to assess their own cultural beliefs, cultural values, and behaviors to increase their self-awareness and cultural understanding to decrease barriers in client-provider relationships and increase comfort in working with diverse clients. Mental health professionals gain personal awareness when they are curious, reflective, vulnerable, and observant (Gilbert et al., 2007). A lack of cultural awareness and competence can have negative consequences for the profession, as well as the clients. Siegel et al. (2005) cautioned professionals that a lack of cultural competence on their part may lead to incorrect assessments and diagnoses and can cause minority and marginalized populations, such as clients with low socioeconomic status and living in poverty, to underutilize services and prematurely terminate care.

Poverty

Cultural competence includes working with clients of diverse backgrounds, such as clients in poverty. The culture of poverty can be a controversial topic because some practitioners believe people in poverty play a role in perpetuating causes of poverty and sustain the cycle across generations (Cummins, 2018; Garrett, 2018). The culture of poverty is important in understanding the concept of poverty because human action is constrained and enabled by how people define their actions. As the root of poverty culture is a multifaceted concept and is challenging to define, poverty culture dynamics help researchers examine the cycle of poverty and social inequality. Researchers and public agencies often highlight personal and environmental factors that contribute to the definition of poverty, with a lack of income and resources being the most defining factors (Ciment, 2013; U.S. Census Bureau, 2018; World Bank Institute, 2005). People living in poverty often lack material essentials, such as shelter, water, clothing, and food, which can impact one's overall well-being (Haughton & Khandker, 2009; Wolff, 2019). The lack of essential material and inability to establish daily living patterns and activities lead individuals in poverty to feel confined by their financial situation (Gordon & Townsend, 2000). When society values financial wealth, people who meet the standard of poverty may feel lesser than those with financial stability; therefore, a lack of autonomy, education, and self-worth are obstacles keeping many in poverty.

Poverty rates can be surprisingly high in developed countries. The United States (US) is one of the wealthiest nations in the world but has one of the highest rates of poverty, with one in eight Americans living in poverty (Poverty Programs, 2017). While poverty affects people of all ages and demographics, minority individuals disproportionately exceed the national average (Koball & Jiang, 2018). Those at greatest risk of living in poverty are families headed by single mothers with children (U.S. Census Bureau, 2018).

Growing up in poverty is a contributing factor to illness, disability, and adverse mental health outcomes, which can have devastating effects on children that can extend into adulthood (Moore et al., 2009). It appears the longer a child lives in poverty, the more devastating the impact (Wickham et al., 2014). Cooper and Stewart (2013) completed a systemic review of the literature on household income and health outcomes and found family income makes a significant impact on all areas of children's development and their level of academic achievement. They posited children living in poverty have lower cognitive ability, lower social engagement, greater behavioral problems, and poorer health outcomes. Furthermore, poverty impacts children's participation in common childhood activities, such as access to extracurricular activities and peer social activities (Turner, 2011). In addition, family poverty impacts living and community environments, social supports, and parental mental health, which can impact the level of stress children experience (Farthing, 2014; National Scientific Council on the Developing Child, 2015; Turner & Rawlings, 2005). High levels of stress can have detrimental impacts on children's holistic development (National Scientific Council on the Developing Child, 2015) and increases the risk of children developing mental health and behavioral problems (Van Allen & Sterling, 2011).

Poverty Attitudes

Attitude is an important predictor of how a mental health professional behaves toward clients and effectively treat clients (Sturm, 2008). Researchers have concluded that attitudes are related to behavior, especially when the attitudes are held with a high degree of assurity, are constant, available, and formed by direct experiences (Appelbaum et al., 2006; Kraus, 1995; Morrow & Deidan, 1992; Shapiro, 2004). There are competing explanations for the rationality for one's attitudes toward poverty (Brady, 2019; Hunt & Bullock, 2016; Jordan, 2004) with two overarching themes: structural cause of poverty or personal causes of poverty (Beeghley, 1988; Feagin, 1975; Howard et al., 2017).

Structural causes of poverty include the belief that poverty is caused by low government investment in education, health, and employment opportunities (Beeghley, 1988; Davids & Gouws, 2013; Feagin, 1975; Goldsmith & Blakely, 2010; Royce, 2018; Weiss-Gal et al., 2009). Structural causes focus on how society limits one's opportunities through low wages, lack of education, and lack of affordable health care (Wittenauer et al., 2015). Society is blamed as a cause in the structural view (Noone et al., 2012), and a person is not responsible or in control of the cause of poverty. In contrast, personal causes of poverty are viewed as exhibiting low motivation, possessing passive or lazy characteristics, or growing up in a "poverty culture" (Levin & Schwartz-Tayri, 2017; Mead, 2011; Royce, 2018). Personal causes focus on the person's inability to pull themselves out of poverty and attribute causes to negative money management or health behaviors. According to Bray and Schommer-Aikins (2015), personal causes of poverty imply that people are responsible and have sufficient chances to succeed if they work hard; therefore, people are viewed as being in control of their own destiny.

Mental health providers' attitudes toward poverty have not been thoroughly examined in the research. Previous research has focused on a single region of the country or a specific population. Three specific studies explored helping professionals' view of poverty: human service practitioners (Anderson, 2018), school counselors (Ricks, 2014), and social workers (Weiss-Gal et al., 2009). Weiss-Gal et al. (2009) studied the views of social workers and service users in the midwestern United States, and they concluded participants held comparable levels of understanding for motivational and psychological causes. Furthermore, they found service users credited more significance to social/structural causes and fatalistic causes compared to the social workers in the study. Additionally, Ricks (2014) examined school counselors' attitudes toward poverty and found school counselors living in the southeastern United States held individualistic attitudes toward poverty and attributed poverty to fatalistic causes. Furthermore, Anderson (2018) interviewed human service practitioners from the southern United States on their view of poverty, and he found human service practitioners held both structural and individualistic views of poverty. Overall, the exploration of poverty attitudes in mental health providers is sparse and more studies are needed to improve cultural competence.

Play Therapy

Play therapists represent diverse professional licensures, including counseling, social work, psychology, and marriage and family therapy (Siu, 2010). The Association for Play Therapy (APT) addresses the importance of diversity in their mission statement, credentialing guidelines and documents but lacks specific cultural competency guidelines. Currently APT (2019) refers to multicultural competence as the process of play therapists becoming aware of one's own culture and biases. For play therapists, instruction occurs in a variety of settings, such as university classrooms, professional conferences, and regional trainings. The variety of educational backgrounds, clinical training, and supervised experience acquired by Registered Play Therapist/Supervisors (RPT/S) and School Based-Registered Play Therapists (SB-RPT) generates unique perspectives to play therapy and creates service delivery options to clients from diverse backgrounds, such as poverty.

Play therapists striving to increase multicultural competence can work with children in poverty more effectively by becoming aware of their own biases toward poverty and learning culturally responsive skills to respond to needs of children in poverty. By exploring biases and beliefs about clients from low socioeconomic status and poverty, play therapists can obtain knowledge to develop active cultural competence (Gil, 2005). Play therapists obtain knowledge

when they gain information about their attitudes toward poverty to provide more responsive services. Therefore, to provide high quality services, play therapists need to explore their beliefs to best attend to the needs of children and their families who are experiencing poverty. In addition, the field of play therapy can benefit from exploring play therapists' attitudes on poverty as a means of identifying areas where further instruction and exposure are needed.

Specifically, the researchers were interested in exploring participant's overall attitudes toward poverty and the relationship between participant's demographic information and their scores on the Attitudes Toward Poverty-Short Form (ATP-SF). The demographic characteristics were age, gender, race, region, highest educational degree, professional discipline, and years of experience. The research questions were (a) What are play therapists' attitudes toward poverty? (b) Are there differences in ATP subscales (personal deficiency, stigma, structural perspective, and total) based on play therapist demographic characteristics?

Method

Procedure

Participants were recruited from the APT mailing list, Counselor Education and Supervision Network (CESNET) listserv, and invited members of four play therapy-related Facebook groups. Participants in the APT mailing list were recruited via email invitation to the online SurveyShare questionnaire. Participants in the play therapy-related Facebook groups and CESNET Listserv were invited to participate from the first author posting in respective groups and Listserv. Upon entry to the survey, respondents first read the informed consent form approved by the university's institutional review board. Participants either accepted or rejected participation in the study. If respondents accepted, they were directed to the survey items. Participants completed the ATP-SF and a demographic survey, and they could access the survey only by using the unique email invitation sent to them. Participants utilized email addresses to sign into SurveyShare, which allowed the researchers to control for one code per person.

Participants

Initially, over 5,000 invitations to participate were sent over one month, and 391 survey packets were received. After removing one incomplete survey, the final sample size for data analysis was 390. The sample size for the present study was deemed sufficient, based on exceeding Cohen's (1988) and Tabachnick and Fidell's (2013) recommendations for the minimal sample sizes needed to achieve adequate power (.80) at a significance level of $p < .05$ (i.e., 120 and 113, respectively). Specific to cultural demographics, participants' ages ranged from 23 to 78 years ($M = 46.13$, $SD = 11.94$). In addition, 367 participants identified as female (94.1%), 18 as male (4.6%), and five identified as other (1.3%). Ethnoculturally, 321 participants identified as White (82.3%), 18 as African American (4.6%), 25 as Hispanic/Latinx (6.4%), and 26 as other cultures (6.7%).

Participants identified as play therapists or play therapy trainees from multiple disciplines: mental health ($n = 181$, 46.4%), social workers ($n = 95$, 24.4%), marriage and family therapists ($n = 46$, 11.8%), and other (e.g., psychologist, international professionals; $n = 68$, 17.5%). In terms of regions of the country, the professionals lived in the following regions: Northeast ($n = 42$, 10.8%), Midwest ($n = 85$, 21.8%), South ($n = 154$, 39.5%), West ($n = 88$, 22.6%), or internationally ($n = 21$, 5.4%). Play therapists' experience levels included: 0–2 years ($n = 48$, 12.3%), 3–5 years ($n = 79$, 20.3%), 6–9 years ($n = 80$, 20.5%), 10–13 years ($n = 51$, 13.1%), and 14 plus years ($n = 132$, 33.8%).

Instrument

The Attitudes Toward Poverty Scale-Short Form (ATP-SF; Yun & Weaver, 2010) is a self-report instrument based on the Attitudes Toward Poverty Scale (ATP; Atherton et al., 1993). The ATP-SF is a multidimensional scale measuring attitudes toward poverty, leaning toward a structural cause or individual deficit cause. Each item is based on a 5-point Likert scale (1 = *strongly disagree* to 5 = *strongly agree*). An example of a structural cause-item on the ATP-SF is, "People are poor due to circumstances beyond their control." An individual deficit-item is, "Poor people are dishonest," and a stigma-item is "Welfare makes people lazy." High scores indicate a belief that structural determinants are the

primary causes of poverty while low scores indicate a personal explanation of poverty (Atherton et al., 1993). The Total score can range from 21 to 105.

The ATP-SF includes three subfactors: Structural Perspective, Personal Deficiency, and Stigma. Structural causes of poverty include the belief that poverty is caused by low government investment in education, health, and employment opportunities (Beeghley, 1988; Feagin, 1975; Weiss-Gal et al., 2009). The Structural Perspective subscale ranges from 6 to 30. Personal causes focus on the person's inability to pull themselves out of poverty by managing money poorly or poor health behaviors. The Personal Deficiency subscale ranges from 7 to 35. Stereotyping people in poverty adds to the stigma of poverty. The subscale of Stigma is important because members of marginalized groups, such as those in poverty, are at a higher likelihood of being stigmatized (Major & O'Brien, 2005). Members of groups with less power often evoke negative responses from those with more power for those in power to keep their position (Jost & Banaji, 1994). The Stigma subscale ranges from 8 to 40. The ATP-SF has a high level of internal consistency with $\alpha = .87$. All of the subscales of the ATP-SF exceeded the minimum acceptable level for internal consistency with all scales being between .50 and .70.

Data Analysis

To examine the impact of play therapists' demographics on their attitudes toward poverty, a series of multivariate analyses of variances (MANOVAs) were conducted. The independent variables were (a) race, (b) age, (c) marital status, (d) gender, (e) region, (f) setting, (g) occupation, (h) years practicing play therapy, and (i) RPT status, and the dependent variables were (a) Personal Deficiency, (b) Stigma, (c) Structural Perspective, and (d) Total Score. Before conducting the MANOVAs, the data were screened for missing data, outliers, noncollinearity, equality of variance/covariance matrices, and normality. Additionally, to examine play therapist's overall attitudes toward poverty, researchers used average scores on the ATP-SF Total, and Structural Perspective, Personal Deficiency, and Stigma subscales.

Results

The researchers strived to explore diverse demographics. Due to the lack of diversity in the sample, specifically regarding gender, race, marital status, setting, occupation, RPT status, and socioeconomic status, the researchers were unable to explore potential differences. A large majority of participants were white masters' level, middle-class women. The average of the Total score was 86.40 ($SD = 10.63$). The average Structural Perspective scale was 23.52 ($SD = 3.94$). The average of the Personal Deficiency scale was 30.32 ($SD = 3.55$). The average of the Stigma scale found was 32.44 ($SD = 5.53$). Table 1 presents the mean scores and standard deviations for the demographic information for the ATP-SF Deficiency, Stigma, Structural Perspective, and Total scores.

Table 1
Attitude Toward Poverty Total and Subscale Scores for Demographic Information

	Average deficiency score (*SD*)	Average stigma score (*SD*)	Average structural score (*SD*)	Total score (*SD*)
Age				
20–29	29.05 (3.30)	30.73 (6.47)	24.37 (3.43)	84.18 (11.51)
30–39	29.42 (3.60)	32.28 (5.59)	23.37 (4.16)	85.20 (10.84)
40–49	30.31 (3.70)	32.49 (5.49)	23.33 (3.74)	86.21 (10.43)
50–59	31.02 (3.19)	32.88 (5.39)	23.74 (4.03)	87.78 (10.54)
60 +	31.48 (3.19)	32.83 (5.21)	23.57 (4.04)	88.03 (10.00)
Region				
Northeast	30.67 (3.97)	32.95 (5.78)	25.33 (3.43)	88.98 (11.30)
Midwest	30.25 (3.10)	33.71 (4.17)	23.65 (3.28)	87.71 (8.30)
South	30.38 (3.58)	31.62 (5.84)	23.21 (8.87)	85.28 (11.14)
West	30.18 (3.65)	32.72 (5.75)	23.10 (4.74)	86.23 (11.21)
International	30.10 (4.10)	31.14 (5.87)	23.52 (3.44)	84.90 (10.86)

Attitude Toward Poverty Total and Subscale Scores for Demographic Information

Differences by Region and Age

A MANOVA was conducted to explore the impact of geographic regions on attitudes toward poverty. Participants were divided into five regions (Northwest, Midwest, South, West, and International). Using Pillai's criterion, the combined dependent variables were statistically affected by the region, $F(12, 1155) = 2.71$, $p < .001$. There was a statistically significant difference at the $p < .05$ level in Structural score based on region ($F(4, 385) = 2.184$, $p = .026$), but not in discipline and years of experience. Post hoc comparison using Scheffé test indicated that the South was significantly lower ($M = 23.21$, $SD = 3.87$) than the Northeast ($M = 25.33$, $SD = 3.43$) in regard to Structural Perspective score ($p = .046$). Researchers did not have statistically significant findings among participants' scores in the Midwest, West, and International.

A MANOVA was conducted to explore the impact of age on Total score and subscales of Stigma, Structural Perspective, and Deficiency. Using the Pillai's criterion, the combined dependent variables were statistically affected by age ($F(12, 1143) = 2.419$, $p = .004$). There was a statistically significant difference at the Deficiency score based on age [$F(4, 60.24) = 4.995$, $p = .001$]. Post hoc comparison using the Scheffé test indicated that the 30–39 group ($M = 29.42$, $SD = 3.60$) was statistically significant from the 60 + group ($M = 31.48$, $SD = 3.19$) in regard to Deficiency ($p = .011$). The 30–39 group is statistically significant from the 50–59 group ($M = 31.02$, $SD = 31.9$) in regard to Deficiency ($p = .045$). Participants in the 30–39 group scored significantly lower on the Deficiency subscale than the 50–59 and 60 + groups. Researchers did not have statistically significant findings among participants who were 20–29 and 40–49. Table 2 presents participants' differences in their attitudes toward poverty by region and age.

Table 2
MANOVA Differences in Attitudes Toward Poverty-SF of Demographic Variables

	Pillai's trace	*F*	Hypothesis *df*	Error *df*	Sig.	Partial eta squared
Region	0.082	2.72	12	1155	0.001*	0.027
Age	0.074	2.42	12	1143	0.004*	0.025

* significant < .005.

MANOVA Differences in Attitudes Toward Poverty-SF of Demographic Variables

Discussion

This study aims to help play therapists explore their attitudes toward poverty and the conscious and unconscious patterns of beliefs, or stereotypes, toward clients who are poor. The findings from this study begin the exploration of play therapists' attitudes toward poverty and open the door for discussion about the impact attitudes have on mental health care delivery. Aiming at an exploration of these attitudes in our scholarship, we found, on average, play therapists disagreed or strongly disagreed with individualistic explanations for poverty, as demonstrated by their mean ATP-SF Total score ($M = 86.40$, $SD = 10.63$), but more telling are the average subscale scores.

The subscale scores range from 23.64 to 32.44. The average of the Stigma scale was the highest, 32.44 ($SD = 5.53$), and indicates play therapists tend not to believe in stereotypes or myths about individuals in poverty. Examples of stigma statements were "poor people think they deserve to be supported" and "Welfare mothers have babies to get more money" (Yun & Weaver, 2010). The average score for the Personal Deficiency scale was 30.32 ($SD = 3.55$) and indicates participants did not agree or strongly disagreed with statements blaming individuals for being poor. Participants did not feel a person's individual deficit is the primary cause of poverty and did not hold individuals personally responsible for their poverty. Personal deficiency statements include "poor people are dishonest" and "poor people act differently." The average score for Structural Perspective scale was the lowest, 23.64 ($SD = 3.71$), and indicates play therapy participants more often disagreed with statements that individuals are responsible for their financial problems and believe policies or resources are needed to help those who are poor. Examples of structural attitudes include "poor people are discriminated against" and "people are poor due to circumstances beyond their control." In comparison to other helping professionals, play therapists appear to have a more favorable attitudes toward poverty than nurses (e.g., Wittenauer et al., 2015) or school counselors (e.g., Ricks, 2014) on the Total, Stigma, Personal Deficiency, and Structural Perspective scales.

As a profession, participants' scores in relation to region and age indicated that there were varying views on the cause of poverty. When exploring regions in the United States, there were differences in how strongly participants believed structural causes influenced their attitudes and explanations toward poverty. Participants living in the Northeast leaned more strongly toward a structural determinant of poverty than participants in the South. This finding may be due to variances in poverty rates between the South and Northeast. The South has the highest poverty rates in the United States, 13.6%, while the Northeast ranks the lowest, 10.3%. Nine of the 10 states with the highest poverty rates in 2017 were Mississippi, Louisiana, West Virginia, Kentucky, Alabama, Arkansas, Oklahoma, South Carolina, and Tennessee (Moore, 2018). Additionally, poverty rates in the South have been continuously high for decades (Jung et al., 2015), and the metro-nonmetro poverty rate gap in the South has historically been the largest (Farrigan, 2020). From 2014–2018, the South's nonmetro poverty rate was 20.5%, nearly 6% higher than in the region's metro areas. In contrast, the Northeast has some of the lowest poverty rates, under 10.5%, in New Hampshire, Massachusetts, Connecticut, Rhode Island, and New Jersey (U.S. Census, 2018). Additionally, regional poverty rates for nonmetro and metro areas in the Northeast were more alike from 2014 to 2018 (Farrigan, 2020). Results might indicate that play therapists' poverty attitudes are potentially impacted by poverty rates in their region of the country. Play therapists may benefit from understanding the impact of socioeconomic and regional differences to work best with economically disadvantaged clients.

Age was the second factor that resulted in varying views on poverty. Specifically, participants who in the 50–59 and 60 plus age groups more strongly disagreed with a personal explanation toward poverty than participants in the 30–39 age group. Life experience and exposure to varying environmental influences may play an important factor in poverty attitudes between the 30–39 years old and 50–59 and 60 plus groups. Participants who are 50–59 and 60 plus were born in the "Baby Boomers" generation. This period was a time of prosperity and optimism potentially leading participants to hold a more positive view of people experiencing poverty (Watts, 2010). People in the Baby Boomer generation may believe that individuals who are poor are not the cause of their poverty and need assistance to work their way out of poverty. Baby Boomers' experiences are different than participants in their 30s, "Millennials." Millennials experienced the largest economic decline since the great depression, the end of the Cold War, and deindustrialization which encouraged people to become reliant on higher education (Brooks, 2008). Millennials reliance on higher education and the belief that education will offer them greater prosperity has caused many to accrue debt with reduced job opportunities and Millennials living at or below the poverty line. Their strong belief in education as a path out of poverty may explain their slightly lower personal explanation of poverty. Generational patterns and exposures may help explain the differences in play therapists' attitudes toward poverty. As we gain a better understanding of play therapist's attitudes toward poverty, this may allow us to better pinpoint opportunities to empower and partner with individuals and communities to seek solutions that will improve the health of those living in poverty.

Looking at poverty attitudes is important because the way play therapists and mental health professionals view poverty potentially affects the way they work with people in poverty (Anderson, 2018; Clark et al., 2017; Krumer-Nevo & Lev-Wiesel, 2005). Play therapists who view poverty from a systemic perspective may treat clients with more respect and compassion. For instance, a play therapist who holds a structural view of poverty may provide traveling services to a homeless shelter to support the potentially transient nature of some families in poverty. In addition, play therapists with a positive understanding of poverty may create structures and policies that support the basic and expanded needs of clients in poverty, such as offering snacks during playtime or providing multidisciplinary resources in the community. Additionally, play therapists who hold a systemic view of poverty may feel comfortable advocating for their clients through social justice advocacy. Play therapists can systemically advocate for their clients by offering availability of resources, increasing involvement in governmental policies and laws, and promoting positive relationships among clients and resources (Crethar et al., 2008; Crethar & Winterowd, 2012). Furthermore, play therapists can be active through social justice advocacy by going to client's environments, such as their schools and neighborhoods (Ceballos & Bratton, 2010; Sheely-Moore & Bratton, 2010), increasing their self-awareness of their work with oppressed children (Baggerly, 2006), and being aware of oppression when looking at their client's emotions (O'Connor, 2005). The reasons discussed above are just a few examples of how varied views of poverty may impact the depth and extent play

therapists' support clients in poverty. Play therapists may benefit from professional development that explores and challenges their attitudes toward poverty on an ongoing basis.

Limitations and Future Directions

The limitations found in this study help inform and shape the implications for future studies. A limitation of the study was the use of a single measure to evaluate the play therapists' attitudes toward poverty. Attitudes and poverty are complex concepts that might benefit from being looked at through multiple lenses. A future study including multiple measures of attitudes toward poverty and people who are poor would be beneficial and give more breadth and depth to understanding play therapist's attitudes toward poverty. Additionally, qualitative data would allow respondents to elaborate on their ideas and experiences.

The authors recruited from two consortiums (APT and CESNET) and several play therapy-related Facebook groups, which may have limited the participation pool. We sought APT members, as APT is the flagship professional organization in the US for play therapists. Unfortunately, not all play therapists are members of APT. Although we expanded the search to sites that may reach other potential participants (CESNET and Facebook), recruitment through other mental health organizations, such as ACA, NASW, and APA, may bridge gaps of play therapists who are not members of APT. A narrow pool of applicants may limit participation and bias the results. Future researchers could recruit through multiple professional organizations to increase the diversity of potential participants.

A few participants in this study had a strong reaction to the ATP-SF. Participants voluntarily emailed the researchers their thoughts and experiences taking the survey. Some participants had a negative reaction to the ATP-SF, such as a dislike for the wording of the measure, and they reported that the ATP-SF made false assumptions and generalizations. The purpose of this research was to evaluate the quantitative responses to the survey, and participants' strong reactions indicate a qualitative study may be needed as well.

Conclusion

The current study is the first study exploring play therapists' attitudes toward poverty. Overall, the authors found that region and age play a factor in how play therapists view poverty. The findings affirm the importance of continued professional development around cultural competence when working with diverse populations. Play therapist's awareness and knowledge impacts the way they work with diverse clients, particularly clients in poverty. Based on findings from this study, we believe it is important for play therapists to examine their own views and explore factors that impact their views of others to ensure they are providing culturally informed practices and ultimately respond with more sensitivity for those struggling in poverty.

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Submitted: February 4, 2020 *Revised:* June 26, 2020 *Accepted:* October 5, 2020

Source: International Journal of Play Therapy. Vol. 30. (1), Jan, 2021 pp. 50-60)
Accession Number: 2021-06749-005
Digital Object Identifier: 10.1037/pla0000144