THE EFFECTS OF ADLERIAN PLAY THERAPY ON MALADAPTIVE PERFECTIONISM AND ANXIETY IN CHILDREN

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I used singlecase A-B-A experimental design to examine the effectiveness of Adlerian play therapy (AdPT) for children identified with clinical levels of perfectionism on the Conners Parent Rating Scale-Revised and Conners Teacher Rating Scale-Revised. Participants were 2 children, a 10 year-old Hispanic male and a 7 year-old Caucasian female. To examine the effect of AdPT on maladaptive perfectionism and anxiety, the Child-Adolescent Perfectionism Scale and the Revised Children’s Manifest Anxiety Scale were administered to the children twice weekly over 3 phases of the study: baseline (6 administrations), intervention (12-16 administrations), and maintenance (6 administrations) for a total of 24 to 29 data points. Additionally, parents and teachers completed the Conners Rating Scales-Revised5 times: (1) prior to study, (2) following baseline/prior to treatment, (3) midpoint of treatment, (4) following treatment, and (5) following maintenance phase. During the intervention phase, the male and female participants attended 21 and 16 play therapy sessions, their mothers attended 6 and 5 parent consultations, and their teachers attended 6 and 3 teacher consultations, respectively. Analysis of the child self-report assessments indicated mixed and inconclusive results regarding the effects of AdPT on target behaviors. However, results of the parent and teacher reports indicated clinically significant reductions in maladaptive perfectionism and anxiety over the five points of measurement for both participants. The participants’ maladaptive perfectionism moved from the clinical to the normal range. Implications for practice and future research are indicated.
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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACKNOWLEDGEMENTS</strong></td>
</tr>
<tr>
<td><strong>LIST OF TABLES</strong></td>
</tr>
<tr>
<td><strong>LIST OF FIGURES</strong></td>
</tr>
<tr>
<td><strong>THE EFFECTS OF ADLERIAN PLAY THERAPY ON MALADAPTIVE PERFECTIONISM AND ANXIETY IN CHILDREN</strong></td>
</tr>
<tr>
<td>Introduction</td>
</tr>
<tr>
<td>Purpose of the Study</td>
</tr>
<tr>
<td>Methods</td>
</tr>
<tr>
<td>Results</td>
</tr>
<tr>
<td>Discussion</td>
</tr>
<tr>
<td>References</td>
</tr>
<tr>
<td><strong>APPENDIX A  EXPANDED LITERATURE REVIEW</strong></td>
</tr>
<tr>
<td><strong>APPENDIX B  DETAILED METHODOLOGY</strong></td>
</tr>
<tr>
<td><strong>APPENDIX C  UNABRIDGED RESULTS</strong></td>
</tr>
<tr>
<td><strong>APPENDIX D  DISCUSSION</strong></td>
</tr>
<tr>
<td><strong>APPENDIX E ADDITIONAL MATERIALS</strong></td>
</tr>
<tr>
<td><strong>COMPREHENSIVE REFERENCE LIST</strong></td>
</tr>
</tbody>
</table>
LIST OF TABLES

Table C.1  Dillon’s Treatment Process and Data Points.............................................. 100
Table C.2  Jasmine’s Treatment Process and Data Points ......................................... 111
LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Dillon’s perfectionism scores on the CAPS throughout the three study phases.</td>
<td>19</td>
</tr>
<tr>
<td>2</td>
<td>Dillon’s anxiety scores on the RCMAS-2 throughout the three study phases.</td>
<td>21</td>
</tr>
<tr>
<td>3</td>
<td>Dillon’s perfectionism and anxiety scores on the CRS-R throughout the three study phases.</td>
<td>22</td>
</tr>
<tr>
<td>4</td>
<td>Jasmine’s perfectionism scores on the CAPS throughout the three study phases.</td>
<td>25</td>
</tr>
<tr>
<td>5</td>
<td>Jasmine’s anxiety scores on the RCMAS-2 throughout the three study phases.</td>
<td>26</td>
</tr>
<tr>
<td>6</td>
<td>Jasmine’s perfectionism and anxiety scores on the CRS-R throughout the three study phases.</td>
<td>28</td>
</tr>
<tr>
<td>C.1</td>
<td>Dillon’s perfectionism scores on the CAPS throughout the three study phases.</td>
<td>102</td>
</tr>
<tr>
<td>C.2</td>
<td>Dillon’s SOP and SPP subscale scores for the baseline phase.</td>
<td>103</td>
</tr>
<tr>
<td>C.3</td>
<td>Dillon’s SOP and SPP subscale scores for the intervention phase.</td>
<td>104</td>
</tr>
<tr>
<td>C.4</td>
<td>Dillon’s SOP and SPP scores in the maintenance phase.</td>
<td>104</td>
</tr>
<tr>
<td>C.5</td>
<td>Dillon’s anxiety scores on the RCMAS-2 throughout the three study phases.</td>
<td>105</td>
</tr>
</tbody>
</table>
Figure C.6. Dillon’s anxiety scores on the RCMAS-2 through the baseline phase. Decrease in the RCMAS-2 scores demonstrates improvement in anxiety. The scores above 60 show clinical anxiety. ................................................................. 106

Figure C.7. Dillon’s anxiety scores on the RCMAS-2 through the intervention phase. Decrease in the RCMAS-2 scores demonstrates improvement in anxiety. The scores above 60 show clinical anxiety. ................................................................. 107

Figure C.8. Dillon’s anxiety scores on the RCMAS-2 through the baseline phase. Decrease in the RCMAS-2 scores demonstrates improvement in anxiety. The scores above 60 show clinical anxiety. ................................................................. 108

Figure C.9. Dillon’s perfectionism and anxiety scores on the CRS-R throughout the three study phases. 70+ markedly atypical, 66-70 moderately atypical, 61-65 mildly atypical, 56-60 borderline. Decrease in the CPRS-R and CTRS-R scores demonstrate improvement in maladaptive perfectionism and anxiety. ............................................. 109

Figure C.10. Jasmine’s perfectionism scores on the CAPS throughout the three study phases. Decrease in the CAPS scores demonstrates improvement in maladaptive perfectionism. The highest (ceiling) score in SOP is 60, and the highest score in SPP is 50. ....................................................................................... 113

Figure C.11. Jasmine’s SOP and SPP subscale scores for the baseline phase. Decrease in the CAPS scores demonstrates improvement in maladaptive perfectionism. The highest (ceiling) score in SOP is 60, and the highest score in SPP is 50. ........... 114

Figure C.12. Jasmine’s SOP and SPP subscale scores for the intervention phase. Decrease in the CAPS scores demonstrates improvement in maladaptive perfectionism. The highest (ceiling) score in SOP is 60, and the highest score in SPP is 50. ............... 115

Figure C.13. Jasmine’s SOP and SPP scores in the maintenance phase. Decrease in the CAPS scores demonstrates improvement in maladaptive perfectionism. The highest (ceiling) score in SOP is 60, and the highest score in SPP is 50. .............................................. 115

Figure C.14. Jasmine’s anxiety scores on the RCMAS-2 throughout the three study phases. Decrease in the RCMAS-2 scores demonstrates improvement in anxiety. The scores above 60 show clinical anxiety................................................................. 116

Figure C.15. Jasmine’s anxiety scores on the RCMAS-2 through the baseline phase. Decrease in the RCMAS-2 scores demonstrates improvement in anxiety. The scores above 60 show clinical anxiety................................................................. 117

Figure C.16. Jasmine’s anxiety scores on the RCMAS-2 through the intervention phase. Decrease in the RCMAS-2 scores demonstrates improvement in anxiety. The scores above 60 show clinical anxiety................................................................. 118
Figure C.17. Jasmine’s anxiety scores on the RCMAS-2 through the maintenance phase. Decrease in the RCMAS-2 scores demonstrates improvement in anxiety. The scores above 60 show clinical anxiety. ................................................................. 118

Figure C.18. Jasmine’s perfectionism and anxiety scores on the CRS-R throughout the three study phases. 70+ markedly atypical, 66-70 moderately atypical, 61-65 mildly atypical, 56-60 borderline. Decrease in the CPRS-R and CTRS-R scores demonstrate improvement in maladaptive perfectionism and anxiety. ......................................................... 120
THE EFFECTS OF ADLERIAN PLAY THERAPY ON MALADAPTIVE
PERFECTIONISM AND ANXIETY IN CHILDREN

Introduction

The increase in the number of research studies targeting perfectionism over the past decade reveals interest in perfectionism as a relevant construct in mental health (Castro et al., 2004; Kenney-Benson & Pomerantz, 2005; Rice, Ashby, & Gilman, 2011). Historically, literature and research on perfectionism have focused on dysfunctional, maladaptive, or even pathological aspects of this personality characteristic (Flett & Hewitt, 2002). Alfred Adler (1956) was one of the first authors to describe a multidimensional view of perfectionism in relation to mental health, emphasizing its adaptive as well as maladaptive aspects. Adler proposed the main differences between adaptive and maladaptive perfectionism as setting unrealistically high standards and rigidity in behaviors towards achievement. Research results support that adaptive perfectionism facilitates positive outcomes such as conscientiousness, coping and positive affect (Rice et al., 2011; Rice & Mirzadeh, 2000; Stoeber, Hoyle, & Last, 2013); whereas, maladaptive perfectionism is associated with a host of psychological problems throughout the lifespan (Essau, Conradt, Sasagawa, & Ollendick, 2012; Flett & Hewitt, 2002; Flett & Hewitt, 2007; Frost & DiBartolo, 2002; Rice et al., 2011; Stoeber et al., 2009; Tsui & Mazzocco, 2007). One of the most recognized mental health problems associated with perfectionism in adults and children is anxiety (e.g., Kawamura, Hunt, Frost, & Dibartolo, 2001; Tsui & Mazzocco, 2007). High standards for performance is a strong factor in perfectionism and anxiety that begins in childhood (Ashby, Kottman, & Martin, 2004; Stoeber, 2012).
Nationally, government reports over the past decade (Mental Health America [MHA], 2011; President’s New Freedom Commission on Mental Health, 2003; U.S. Public Health Service, 2000) emphasized the importance of early mental health intervention to prevent unnecessary suffering and costs associated with long-term effects of untreated psychological problems in childhood. Although there is an increase in the number of research studies focused on maladaptive perfectionism in adults (Flett & Hewiitt, 2002; Kenney-Benson & Pomerantz, 2005; McCreary et al., 2004), research regarding the mental health treatment of perfectionism in children is in its infancy. Ashby et al. (2004) suggested the use of Adlerian Play Therapy (AdPT) as a uniquely suited intervention for maladaptive perfectionism in children due to its emphasis on modification of maladaptive thoughts and behavior and its developmentally responsive properties.

Perfectionism

Adler (1956) stated that, "the striving for perfection is innate in the sense that it is a part of life, a striving, an urge, a something without which life would be unthinkable" (p. 104). According to Adler, the goal of striving from a "felt minus" to a "perceived plus" starts in early childhood as children naturally experience themselves as less capable or inferior to adults and proceeds until the end of life. Adler suggested that perfectionism has the potential to help individuals advance themselves and their society by working towards improvement. On the other hand, perfectionism can become unhealthy when individuals show rigidity in behaviors as a result of aiming for unrealistically high standards. Compared to healthy perfectionists, unhealthy perfectionists struggle with
beliefs of not being good enough when they fail to meet the idealistic standards they set for themselves. Consistent with Adler’s conceptualization of healthy and unhealthy perfectionism, several researchers categorized perfectionism as adaptive and maladaptive (Frost, Heimberg, Holt, Mattia, & Neubauer, 1993; Rice & Mirzadeh, 2000).

Perfectionism impacts individuals’ psychological and physical well-being throughout the life span (Hewitt & Flett, 2001). A growing body of research has revealed short-term and long-term mental health and adjustment issues that children with maladaptive perfectionism encounter. Although anxiety is the most commonly reported mental health problem linked to maladaptive perfectionism in childhood, researchers have shown the relationship between perfectionism and a variety of additional long-term psychological issues, such as depression, low self-esteem, eating disorders, interpersonal problems including marital difficulties, and personality disorders (Hewitt & Flett, 2002; Kenney-Benson & Pomerantz, 2005; Rice, Ashby, & Gilman, 2011; Stoeber, Feast, & Hayward, 2009).

Despite literature suggesting the detrimental effects of maladaptive perfectionism in childhood, research focused on the mental health treatment of perfectionism in children is lacking. An exhaustive review of the literature revealed one study that, although not a mental health intervention, explored the impact of maladaptive perfectionism on 9 to 12 year-olds (Essau et al., 2012). The researchers studied a teacher-led, classroom intervention and examined mediators and moderators that predicted the effectiveness of a cognitive behavioral prevention program on reducing childhood anxiety. There was no statistically significant difference between anxiety levels of treatment and no-treatment groups at postintervention, however the treatment
group showed greater reduction in anxiety after 12 months follow-up. Essau et al. also found that low levels of perfectionism were predictive of a greater treatment effect in children.

Although research regarding the treatment of perfectionism and related disorders is beginning to emerge with older children, adolescents, and adults, research on interventions for maladaptive perfectionism with young children is a noticeable gap in the literature. Because play therapy is a developmentally appropriate approach that focuses on early and middle childhood (Ray, 2011), Ashby et al. (2004) suggested the use of play-based counseling with children who exhibit maladaptive perfectionism and anxiety. Several researchers have recommended the importance of offering school-based interventions for children in order to provide mental health services in a setting where all children have equal access to receiving help (Bratton, Ceballos, Sheely-Moore, Meany-Walen, & Pronchenko, 2013; Meany-Walen, Bratton, Kottman, in press; Ray, Schottelkorb, & Tsai, 2007). This recommendation is particularly relevant for children presenting with maladaptive perfectionism in light of research showing the prevalence of perfectionism related to academic work (Stoeber & Stoeber, 2012).

Play Therapy in School Settings

Play therapy is a developmentally appropriate tool for counselors that has been successfully implemented in school settings for over seven decades (Bratton, 2010; Landreth, Ray, & Bratton, 2009). Controlled, outcome research studies on the efficacy of school-based play therapy has doubled between 2000 and 2010 (Bratton, 2010) indicating its applicability and effectiveness with a variety of presenting issues in the
school setting. The majority of research has focused on the efficacy of child-centered or non-directive play therapy interventions (Baggerly, Ray, & Bratton, 2010) with students exhibiting externalized problem behaviors (Bratton et. al, 2013; Garza & Bratton, 2005; Ray, Blanco, Sullivan, & Holliman, 2009; Ray, Schottelkorb, & Tsai, 2007; Schottelkorb & Ray, 2010) and other issues such as academic achievement (Blanco & Ray, 2011). A recent randomized controlled study examined the effectiveness of Adlerian Play Therapy (AdPT) on disruptive behavior in elementary school students (Meany-Walen, et al., in press). AdPT demonstrated statistically significant improvement and moderate to large treatment effects on disruptive behavior in the classroom and on stress in the teacher-child relationship.

Kottman (2009) suggested access to teachers as an additional benefit of providing play therapy in schools. Counselors can readily engage teachers as partners in the intervention process to help children overcome psychological and behavioral problems, especially those difficulties related to school. School-based play therapy research supports the beneficial effects of teacher consultation (Ray, 2007) and teacher involvement (Helker & Ray, 2009; Morrison & Bratton, 2010) on children's behavior.

Adlerian Play Therapy

Kottman (2003) integrated the Individual Psychology concepts of Adler (1927) with play therapy principles to develop AdPT as a therapeutic intervention for children. AdPT incorporates non-directive and directive play techniques to help children to gain a deeper understanding of how they view themselves, others, and the world, and facilitates rehearsal of their changing perceptions (Kottman, 2009). Kottman also
suggested that AdPT requires attention to the Crucial Cs, which Lew and Bettner (1998) suggested as the areas that every child needs to master for healthy development. Lew and Bettner defined Crucial Cs as the need to (a) connect with others, (b) perceive oneself as capable, (c) feel like one counts in his or her environment, and (d) have courage. Adlerian play therapists utilize a variety of toys, materials, and playful interventions, such as art techniques, story-telling, and puppetry to help children learn socially appropriate ways to feel significant in their environments.

Adler (1927) emphasized children’s need for support from their caregivers to deal with difficulties of life. Healthy development of children is determined by their caregivers’ ability to provide a nurturing and egalitarian environment. Consistent with Adler’s emphasis on the family atmosphere in healthy development, an essential component of AdPT is the involvement of parents in the change process (Kottman, 2003). Furthermore, Kottman (2003) suggested that teachers exert significant influence on the lives of school-aged children, and that they can provide important information about children’s learning styles and interactional styles.

Ashby et al. (2004) suggested that Adlerian play therapists might help perfectionist children develop strategies for “dealing more easily with life in all of its glorious imperfection” (p. 52). Adlerian play therapy offers unique ways of working with children who exhibit maladaptive perfectionism and high anxiety. Ashby et al. defined the goals of AdPT as helping perfectionist children to (a) recognize self-defeating themes in their play and begin to shift their behaviors; (b) learn to moderate their reaction to perceived criticism from others; (c) restructure their distorted cognitions; (d) expand their choice of play materials; (e) readjust their attitudes toward and behavior
related to orderliness in the play room; (f) learn strategies to recognize and cope with anxiety; and (g) accept greater responsibility for themselves by developing greater tolerance for risk and making mistakes (p. 48). Furthermore, Adler (1929) proposed that excessive feelings of inferiority may result in lack of interest in the world and others. Thus, Kottman suggested an additional therapeutic goal for perfectionist children of improving their sense of social interest, which Adler defined as the concern for others' wellbeing as well as one's own welfare.

Among all theoretical approaches, Individual Psychology is one of the most commonly used theoretical approaches with which child counselors align (Lambert et al., 2007; Muro & Kottman, 1995). However, a review of the literature revealed only one research study that explored the effectiveness of AdPT (Meany-Walen et al., in press), and revealed no studies examining the effectiveness of AdPT with perfectionist children.

**Purpose of the Study**

Given the strong link of perfectionism to psychological problems, the current gap in the literature related to effective treatments, and the developmentally appropriate and systemic nature of AdPT, the purpose of this study was to examine the effect of AdPT on children identified with maladaptive perfectionism. Specifically, this study was designed to investigate the effects of school-based AdPT on reducing maladaptive perfectionism and anxiety in elementary school children.

**Methods**

Single-case research allows experimentation with individual participants in order
to show causal relationships (Kazdin, 2003). Using single case experimental design to test therapeutic interventions has the potential to present strong empirical support for the treatment efficacy (Kennedy, 2005). In line with growing literature promoting the use of single-case design in effectiveness studies, counseling and play therapy research began to use single-case design to investigate treatment effects (McLeod, 2003; Ray, Barrio Minton, Schottelkorb, & Brown, 2010; Ray & Schottelkorb, 2010). According to Ray and Schottelkorb (2010) single-case studies are effective tools to promote the effectiveness of play therapy interventions.

In conducting this study, I hypothesized that AdPT, which includes parent and teacher consultations in conjunction with individual play sessions, would demonstrate a decrease in children’s maladaptive perfectionism and anxiety. I employed a single-case A-B-A experimental research design to investigate changes in children’s maladaptive perfectionism and anxiety levels across baseline, treatment, and maintenance conditions.

*Instrumentation*

For study purposes, I used the Revised Children’s Manifest Anxiety Scale: Second Edition (RCMAS-2; Reynolds & Richmond, 2008) Total Anxiety score as the twice-weekly repeated measure for anxiety, and the Child–Adolescent Perfectionism Scale (CAPS; Flett et al., 2002) Self-Oriented Perfectionism (SOP) and Socially-Prescribed Perfectionism (SPP) subscales as the twice-weekly repeated measure for maladaptive perfectionism. I utilized parent and teacher report on the CRS-R (Conners et al., 1998) Perfectionism and Anxious-Shy subscales to qualify children to the study
and as a measurement of children’s perfectionism and anxiety levels over 5 points of measurement throughout the study.

Child–Adolescent Perfectionism Scale (CAPS)

Flett et al. (2002) developed the CAPS as a 22-item self-report perfectionism scale for children and adolescents up to age 18 with a minimum Grade 3 reading level. The CAPS measures two dimensions of perfectionism: socially prescribed and self-oriented. The Socially Prescribed Perfectionism (SPP) subscale consists of 10 items (e.g., “My family expects me to be perfect”), and the Self-Oriented Perfectionism (SOP) subscale consists of 12 items (e.g., “I want to be the best at everything I do”). Children score each item on a 5-point Likert-type scale ranging from 1 (not at all true of me) to 5 (very true of me). Higher total scores on the CAPS demonstrate higher levels of perfectionism. Although the developers did not indicate cut-off scores for the subscales, study findings demonstrated average SOP and SPP scores for 247 participants between Grades 3 and 12. The mean scores were 34.27 (SD = 8.43) for SOP and 24.77 for SPP (SD = 8.42).

One-week interval test-retest correlation was .82 for SPP and .75 for SOP (Castro et al., 2004), and five-week test-retest correlation was .74 (p < .01) for SOP and .66 (p < .01) for SPP (Flett et al., 2002). Hewitt et al. reported internal consistency of .86 for SPP and .85 for SOP subscales. In a validity study, Flett et al. found statistically significant (p < .05) correlations between the CAPS subscales and perfectionism related questions in the Academic Reasons Survey (Ryan & Connell, 1989), as well as the Eating Disorder Inventory Perfectionism Scale (Garner et al., 1983).
Revised Children’s Manifest Anxiety Scale: Second Edition (RCMAS-2)

The RCMAS-2 (Reynolds & Richmond, 2008) is a 49-item self-report scale that assesses trait anxiety in children and adolescents between ages 6 and 19 years. The RCMAS-2 provides a Total Anxiety score, as well as scores for the following subscales: Physiological Anxiety, Social Anxiety, Worry, and Defensiveness. The Defensiveness subscale assesses willingness to admit common imperfections. Individuals give a 'yes' or 'no' answer to each question based on how they think and feel about themselves (Reynolds & Richmond, 2008).

According to Reynolds and Richmond (2008), the alpha reliability internal consistency coefficient for the RCMAS-2 was .92 for Total Anxiety. At a one-week interval, test-retest reliability was highest for the Total Anxiety scale (.76). Lowe, Grumbein, and Raad (2011) established convergent validity (.70) for the RCMAS-2 with the Test Anxiety Scale for Elementary Students (TAS-E). C. Reynolds (personal communication, September 29, 2012) indicated appropriateness of the instrument for repeated measures.

Conners Rating Scales-Revised (CRS-R)

(CTRS-R) included six factors: oppositional, cognitive problems/inattention, hyperactivity, anxious-shy, perfectionism, and social problems.

For the CPRS-R, coefficient alphas ranged from .75 to .94 for males and .75 to .93 for females (Conners et al., 1998). At a 6-week interval, test-retest correlations were .42 ($p < .05$) for Anxious/Shy and .60 ($p < .05$) for Perfectionism. The authors developed criterion validity by comparing ADHD and non-ADHD groups. For the CTRS-R, coefficient alphas ranged from .73 to .95 for males and .76 to .94 for females (Conners et al., 1998). Using Pearson product-moment correlations, Conners et al. found the following 6-week test-retest correlations: .88 ($p < .05$) for Anxious/Shy and .77 ($p < .05$) for Perfectionism. Connors et al. established the discriminate validity of the CPRS-R by correctly classifying 85% of children identified with ADHD. The authors did not provide validity information for the subscales.

Participants

The sample included two children, ages 7 and 10, from two elementary schools in a suburban school district in the Southwestern region of the United States. Teachers and school counselors identified children with maladaptive perfectionism according to a checklist that I developed using the list of behaviors Ashby et al. (2004) and Adderholdt-Elliott (1989) defined. The list included statements such as “Avoids difficult projects, assignments, or tasks,” “Sees one or two errors as a complete failure,” and “Is hesitant to engage in activities that might result in a mess of some sort.” I introduced the checklist to teachers and school counselors as the Perfectionism Behavior Checklist for the purpose of helping teachers identify children for the study. Identified children who
received the necessary parental consent qualified for the study based on clinical scores on the Perfectionism subscale of the CRS-R (Conners, Sitarenios, Parker, & Epstein, 1998). In order to reduce the likelihood that comorbid factors contributed to the identified children’s behaviors that might influence treatment outcome, I excluded children who had clinical scores on any DSM subscales of the CRS-R other than the Total Anxiety subscale. Additional inclusion criterion included: 1) parents and children speaking and comprehending English, and 2) children identified by their teachers as reading at a third grade level. Referred children who did not meet all criteria were eligible to receive play therapy services outside of the study.

Parents of five children consented to participate in the study and their children signed assent forms. Two children did not meet the inclusion criteria and one decided to drop out. Therefore, two out of five children participated in the research study. One of the participants was a 7-year-old Caucasian female and the other was a 10-year-old Hispanic-American male. The participants \((n = 2)\) met the inclusion criteria for the study by scoring in the clinical range for perfectionism on CTRS-R and/or CPRS-R. Teachers of both children agreed to attend teacher consultations. Only mothers of the participants consistently attended parent consultations.

**Treatment**

The children participated in 30-minute individual AdPT sessions, twice per week, and their teachers and mothers participated in consultations based on their availability. The children left their classrooms during the school day to participate in AdPT in specially-equipped playrooms at identified schools. The teachers selected times that did
not interfere with instructional schedules. The mothers were available to attend consultations at the school every other week for 20 to 30 minutes. I met with the teachers during their planning periods or during times that were most convenient for them.

I conducted play therapy sessions and teacher and parent consultations according to Kottman’s (2009) AdPT treatment protocol. In AdPT protocol, Kottman (2001) defined four phases: (a) building an egalitarian relationship with the child, (b) exploring the child’s life style, (c) facilitating the child’s insight related to his or her life style, and (d) providing reorientation. In AdPT treatment protocol, Kottman (2009) suggested consistent use of specific skills throughout all phases, such as tracking behavior, restating content, reflecting feeling, encouraging, asking questions, metacommunication, giving explanations, and answering questions. Kottman also suggested returning responsibility to children, using their own metaphor, actively interacting with them, cleaning the room together, and setting limits depending on their unique needs.

Kottman defined a variety of techniques to use in each phase of AdPT. In the first phase, play therapists meet children and provide them with information about what play therapy is and what they can expect in play therapy sessions. During the second phase, therapists use techniques such as questioning, art, metaphors, and sandtray to explore children’s life style. Schulman and Mosac (1988) defined life style as the organization of rules that individuals utilize as cognitive blueprint of their behaviors. In the third phase, play therapists help children to gain insight about their life styles through techniques such as metacommunication, metaphors, and mutual storytelling.
During the last phase, therapists use metacommunication, puppet play, didactic teaching, and modeling in order to assist children in determining alternatives to their dysfunctional behaviors.

Adlerian parent and teacher consultations mirror the four phases in AdPT (Kottman, 2001). Kottman (2009) defined specific skills and techniques to utilize in parent and teacher consultations, such as art and sand tray. Adlerian consultations focus on helping parents and teachers to understand the importance of their involvement in the therapy process, gathering information regarding children's life styles, facilitating parents’ and teachers’ insight about their attitudes that maintain children’s dysfunctional behaviors, helping parents and teachers to understand children’s life styles, and reeducating them about alternative parenting and teaching skills.

In this study, I, a doctoral candidate at the University of North Texas specializing in play therapy, provided play therapy for both participants. I have received extensive supervised training in play therapy and participated in several Adlerian play therapy trainings and workshops with Terry Kottman, the developer of AdPT. In order to ensure treatment fidelity for Adlerian play therapy, I video recorded all my sessions, received weekly supervision, and submitted video recordings of 10% of my sessions to an expert in AdPT who checked 15 minutes of randomly selected sessions for my adherence to the AdPT protocol. In order to check treatment fidelity, the AdPT expert used the Adlerian Play Therapy Skills Checklist (APTSC; Kottman, 2009) and Adlerian Play Therapy Parent Consultation Skills Checklist (APTPCSC).
Data Collection

Upon receiving parental consent for identified children to participate in the study, their teachers completed the CTRS-R and their parents completed the CPRS-R. In order to prevent assessment bias, a doctoral research assistant administered the CAPS and RCMAS-2 to all participants. The research assistant was a doctoral candidate at the University of North Texas, specializing in play therapy. She has received extensive supervised training in child and adolescent assessments. I also interviewed the mothers to gather detailed background information and support the qualification criterion of exhibiting maladaptive perfectionism.

Consistent with the single-case A-B-A experimental research design, the doctoral research assistant administered the CAPS and RCMAS-2 to participants twice per week during the three phases of the study: (a) baseline, (b) treatment, (c) and maintenance. Horner et al. (2005) suggested documentation of five or more data points to establish baseline patterns. In the present study, a research assistant collected baseline and maintenance data over three-week periods in the beginning and at the end of the study, resulting in six data points in each phase. The number of data points during the treatment phase for each participant varied upon the length of the treatment and circumstances that impacted data collection, such as spring break and the state mandated academic assessment. Teachers completed the CTRS-R and parents completed the CPRS-R five times: (1) prior to study, (2) following baseline/prior to treatment, (3) midpoint of treatment, (4) following treatment, and (5) following maintenance phase.
Data Analysis

Consistent with recommendations for analyzing data for single case design (Kenedy, 2005; Ray et al., 2010), I performed visual analyses to analyze participants’ behavioral responses on the CAPS and RCMAS-2 across conditions. Visual analyses consisted of changes in level, trend, and variability within and across the baseline, intervention, and maintenance phases. According to Kennedy (2005), variability is the extent to which the individual data points vary from the trend line. Kennedy suggested that evidence of an effective intervention can be shown through meaningful differences between participants’ mean scores across conditions. Thus, I visually inspected each participant’s mean performance across each phase in respect to baseline to assess the changes in level during the intervention and maintenance phases. According to Tankersley, Harjusala-Webb, and Landrum (2008), the change in trend is the best evidence to support a treatment effect in single case research designs. Thus, I evaluated the data both between and within conditions, and analyzed an ascending or descending trend in data.

I calculated least-squares regression lines according to Kennedy’s (2005) description to provide an effect size statistic of $R^2$ and examine variability of data. Cohen (1988) provided guidelines to examine practical significance of research results: $R^2 = .25$ demonstrates a “large” effect, .09 demonstrates a “medium” effect, and .01 demonstrates a “small” effect. In order to explore the effectiveness of AdPT, I also computed percent of data exceeding the median (PEM; Ma, 2006). PEM involves drawing a horizontal median line through baseline phase and extending it through intervention phase. Calculation of percentage of intervention phase data above that
extended line yields effect size. According to Ma’s (2006) guidelines, 50% or less indicates no effect, 50-70% indicates a questionable effect, 70-90% indicates a moderate effect, and 90% and above indicates a strong effect. Furthermore, I analyzed the quantitative data collected from parents and teachers via CPRS-R and CTRS-R Perfectionism and Anxious-Shy subscales over 5 points of measurement to examine the clinical significance of AdPT on each participant’s maladaptive perfectionism and anxiety. Clinical significance refers to the symptom reduction and the practical importance of an intervention's impact on the client and/or the client's social environment (Perdices & Tate, 2009).

Results

The results section includes additional information regarding the children’s demographics and number of sessions that children, parents, and teachers attended. Pseudonyms are used to protect the participants’ identities.

**Participant 1**

Dillon was a 10-year-old Hispanic-American male. Dillon had lived in two households since his parent’s divorce 5 years prior to the study. He spent 4 days of the week in his mother’s house and 3 days in his father’s house. His mother, Heather (38) was in her second marriage. Dillon’s family on his mother’s side consisted of 5 members: stepfather, Daniel (38); mother, Heather; brother, Gary (7); and stepsister, Mary (4). Dillon’s biological father, William (37), lived by himself and his extended family lived in the same neighborhood. Dillon attended 21 play sessions. Dillon’s mother
attended 6 parent consultations and Dillon’s biological father attended one. Dillon’s teacher attended 6 teacher consultations.

Dillon’s teacher referred him to play therapy for his extreme concern over mistakes, excessive frustration when things did not go the way he wanted, avoidance of difficult school work, negative self-statements when he did not live up to his standards, extreme focus on negative qualities about himself, vigilance to external evidence to support his negative self-evaluation, extreme sadness and disappointment when he has less than perfect results, perception of one or two errors as being complete failure, and unwillingness to participate in group discussions or activities based upon his fear of being wrong. Dillon qualified for this study because of his markedly atypical results in CTRS-R perfectionism subscales and his borderline score in the CPRS-R Perfectionism subscale. Additionally, initial parent and teacher meetings indicated that Dillon did not feel that he was significant in his home or school environments, as he verbalized believing that his parents were mostly paying attention to his brother and his teacher cared more about his classmates.

Child-Adolescent Perfectionism Scale (CAPS)

Figure 1 represents Dillon’s scores on the CAPS across baseline, treatment, and maintenance phases. According to Dillon’s mean scores on the CAPS, the level of phases did not demonstrate an improvement in SOP or SPP as a result of AdPT. The level (mean) for SOP was 41.33 in the baseline phase, 49.44 in the intervention phase, and 44.33 in the follow up phase. The level for SPP was 35.33 in the baseline phase; 43.39 in the intervention phase, and 46.33 in the follow up phase. Through visual
analysis, the trend line indicated small upward trend for SOP and a moderate upward
trend for SPP. When analyzing the data across all phases, Dillon’s perfectionism scores
demonstrated a moderate amount of variability, making the data difficult to interpret.

Figure 1. Dillon’s perfectionism scores on the CAPS throughout the three study phases. Decrease in the CAPS scores demonstrates improvement in perfectionism. The highest (ceiling) score on SOP is 60, and the highest score on SPP is 50.

Because visual analysis alone does not make clear the effectiveness of the interventions, PEM statistics and least square regressions were calculated. According to PEM statistics, for SOP scores, median of the baseline phase was 41.5 and none of the data points in intervention phase was below the median. For socially-prescribed perfectionism scores, median of the baseline phase was 36.5 and none of the data points in intervention phase was below the median. The PEM statistic results indicated that AdPT was ineffective in reducing maladaptive perfectionism. According to Cohen’s (1988) guidelines, there was a small negative relationship for SOP ($R^2 = .05$) and large negative relationship for SPP ($R^2 = .32$) between the treatment phases and data points,
indicating worsening of Dillon’s maladaptive perfectionism over time. However, individual phase analysis for SPP demonstrated a large upward trend \((R^2 = .42)\) in baseline, followed by a moderate downward trend \((R^2 = .14)\) in treatment phase, indicating moderate improvement in Dillon’s SPP as a result of the AdPT intervention phase. This improvement is followed by a large upward trend \((R^2 = .28)\) in maintenance phase, indicating regression towards pre-treatment levels of SPP. The individual phase analysis for Dillon’s SOP demonstrated a large upward trend \((R^2 = .38)\) in baseline, followed by a small upward trend \((R^2 = .06)\) in the treatment phase, and a large downward trend \((R^2 = .59)\) in the maintenance phase. According to these results, Dillon’s SOP demonstrated an improvement during the maintenance phase, but not the intervention phase.

Revised Children’s Manifest Anxiety Scale: Second Edition (RCMAS-2)

According to Dillon’s mean score on the RCMAS-2 Total Anxiety subscale, the level of phases indicated a minor decrease in anxiety from baseline to maintenance. Figure 2 shows Dillon’s RCMAS-2 Total Anxiety scores. The level was 38.83 in the baseline phase, 37.94 in the intervention phase, and 35.16 in the follow up phase. Visual analysis demonstrated a slight downward trend, which indicated a small improvement in his anxiety as a result of AdPT. According to Cohen’s (1988) guidelines, there was a moderate relationship for anxiety \((R^2 = .12)\) between the treatment phases and data points. However, individual phase analysis demonstrated a moderate improvement \((R^2 = .22)\) in Dillon’s anxiety during baseline phase, indicating that his anxiety was decreasing before the intervention. PEM statistic was also calculated for the Total
Anxiety subscale. Median of the baseline for the Total Score was 37.5, and 8 out of 18 data points in the intervention phase were below the mean. The PEM statistic result was 44%, indicating no effect for AdPT on anxiety.

Figure 2. Dillon’s anxiety scores on the RCMAS-2 throughout the three study phases. Decrease in the RCMAS-2 scores demonstrates improvement in anxiety. The scores higher than 60 demonstrate clinical anxiety.

Conners Rating Scales-Revised (CRS-R)

I explored the clinical significance of AdPT on each child’s daily functioning via Perfectionism and Anxious-Shy subscales in the CRS-R for parents (CPRS-R) and teachers (CTRS-R). Figure 3 represents Dillon’s CPRS-R and CTRS-R scores. According to parent report on the CPRS-R Perfectionism subscale, Dillon demonstrated borderline perfectionism prior to the study and following baseline. Dillon’s perfectionism scores decreased to the normative range at the midpoint of treatment and stayed in the
normal range following the end of treatment and following the maintenance phase. Dillon’s CPRS-R Anxious-Shy subscale scores were on low end of the normal range prior to the study. At the midpoint of treatment, his anxiety scores showed a decrease and remained constant from mid-point to end of treatment and through the maintenance phase.

Figure 3. Dillon’s perfectionism and anxiety scores on the CRS-R throughout the three study phases. (70+ markedly atypical, 66-70 moderately atypical, 61-65 mildly atypical, 56-60 borderline. Decrease in the CPRS-R and CTRS-R scores demonstrate improvement in maladaptive perfectionism and anxiety.)
According to CTRS-R results, Dillon’s Perfectionism subscale scores were at the markedly atypical range prior to the study and following baseline. His score decreased to the mildly atypical range at the midpoint of intervention. Dillon’s perfectionism scores declined to the normative range following the end of treatment and stayed in the normal range following the maintenance phase. Dillon’s CTRS-R Anxious-Shy subscale scores were at the markedly atypical range prior to and after the baseline. His scores decreased to the mildly atypical range at the midpoint of the intervention. Dillon’s anxiety score declined to the normal range following the end of treatment and stayed at the normal range following the maintenance phase. In summary, AdPT demonstrated clinically significant reduction in Dillon’s maladaptive perfectionism and anxiety, as reported by the parents and the teachers.

Participant 2

Jasmine was a 7-year-old Caucasian female. Jasmine’s parents divorced when she was 6 years old. She lived with her mother, Gloria (37); twin brother, Jason (7); sister, Suzy (5); and grandfather, James (65). Jasmine’s father, Jonathan (35), had lived in a different city for last two years. Jasmine, her mother, sister, and brother had moved in with her grandfather eight months prior to the study. Jasmine attended 16 play sessions and Gloria attended 5 parent consultations. Jasmine’s teacher attended 3 teacher consultations.

Jasmine’s teacher referred her to play therapy for her excessive seriousness about schoolwork, extreme concern over mistakes, difficulty completing hand-writing assignments because of re-doing them, excessive frustration when things do not go the
way she would like, extreme sadness and disappointment when she had less than perfect results, and perception of one or two errors as complete failure. Jasmine qualified for this study because her CTRS-R score indicated borderline perfectionism and her CPRS-R score indicated mildly atypical perfectionism. Furthermore, according to the informal reports during initial parent and teacher consultations, Jasmine was shy and withdrawn in social environments, and she did not perceive herself as good enough to count at home or school. Both her parent and teacher reported that Jasmine was a competent and smart child who was underachieving as a result of her concerns over making mistakes.

Child-Adolescent Perfectionism Scale (CAPS)

According to the Jasmine’s mean scores on the CAPS, the level of phases did not demonstrate improvement in SOP or SPP as a result of AdPT. Figure 4 shows Jasmine’s SOP and SPP scores. The level for SOP was 40.66 in the baseline phase; 46.75 in the intervention phase, and 45.67 in the follow up phase. The level for SPP was 35.67 in the baseline phase; 40.78 in the intervention phase, and 44.67 in the follow up phase. Visual analysis showed moderate upward trends, indicating worsening of both SOP and SPP. When analyzing the data across all phases, Jasmine’s perfectionism scores demonstrated moderate to large variability throughout the study except for the SPP baseline phase, making data difficult to interpret.
Figure 4. Jasmine’s perfectionism scores on the CAPS throughout the three study phases. Decrease in the CAPS scores demonstrates improvement in maladaptive perfectionism. The highest (ceiling) score in SOP is 60, and the highest score in SPP is 50.

According to Cohen’s (1988) guidelines, there was a small negative relationship for SOP ($R^2 = .08$) and a moderate negative relationship for SPP ($R^2 = .10$) between the treatment phases and data points. Individual phase analysis for SPP demonstrated a moderate upward trend ($R^2 = .19$) in baseline, followed by a small upward trend ($R^2 = .04$) in the treatment phase, and a small downward trend ($R^2 = .01$) in the maintenance phase. Additionally, individual phase analysis for Jasmine’s SOP demonstrated a large upward trend ($R^2 = .85$) in the baseline phase, a small upward trend ($R^2 = .06$) in the treatment phase, and a small downward trend ($R^2 = .06$) in the maintenance phase. Although these results indicated an improvement in SOP and SPP during the maintenance phase, the outlier data (22\textsuperscript{nd} data point) had a potential impact on the validity of effect size calculation. PEM statistics were also calculated. For SPP, median
of the baseline phase was 40.66 and there were no data points in intervention phase below the median. For socially-prescribed perfectionism scores, median of the baseline phase was 35.66 and none of the data points in the intervention phase was below the median. PEM statistic results indicated that AdPT was ineffective in reducing maladaptive perfectionism.

Revised Children’s Manifest Anxiety Scale: Second Edition (RCMAS-2)

Figure 5 represents Jasmine’s RCMAS-2 Total Anxiety scores. According to mean scores of Jasmine’s RCMAS-2 Total Anxiety subscale, the level of phases indicated a small increase in anxiety from baseline to maintenance phase.

Figure 5. Jasmine’s anxiety scores on the RCMAS-2 throughout the three study phases. Decrease in the RCMAS-2 scores demonstrates improvement in anxiety. The scores above 60 show clinical anxiety.

The level was 61 in the baseline phase, 64.25 in the intervention phase, and 68.5 in the
follow up phase. Visual analysis showed a slight upward trend, indicating worsening of anxiety. Jasmine’s anxiety scores demonstrated a moderate amount of variability, making data difficult to interpret.

According to Cohen’s (1988) guidelines, there was a moderate negative relationship for anxiety ($R^2 = .13$) between the treatment phases and data points. Consistently, individual phase analyses did not indicate improvement in Jasmine’s anxiety. The PEM statistic was calculated for the RCMAS-2 Total Anxiety score. The median of the baseline for the Total Anxiety score was 60.5, and 1 out of 12 data points during the intervention phase were below the median. The result for the PEM statistic was 8%, indicating that AdPT was ineffective in improving Jasmine’s anxiety.

Conners Rating Scales-Revised (CRS-R)

I explored the clinical effectiveness of AdPT via Perfectionism and Anxious-Shy subscales in CRS-R for parents (CPRS-R) and teachers (CTRS-R). Figure 6 shows Jasmine’s CPRS-R and CTRS-R scores. Jasmine’s CPRS-R perfectionism scores were in the mildly atypical range prior to study and in the markedly atypical range following baseline. Jasmine’s perfectionism scores stayed in the markedly atypical range at the midpoint of treatment, and decreased to the moderately atypical range following treatment. The perfectionism score decreased to the normative range following maintenance phase. According to CPRS-R Anxious-Shy subscale results, Jasmine’s anxiety scores were in the markedly atypical range prior to study, following baseline, and at the midpoint of treatment. Her anxiety scores decreased to the moderately
atypical range following treatment and decreased to the normal range following maintenance phase.

Figure 6. Jasmine’s perfectionism and anxiety scores on the CRS-R throughout the three study phases. 70+ markedly atypical, 66-70 moderately atypical, 61-65 mildly atypical, 56-60 borderline. Decrease in the CPRS-R and CTRS-R scores demonstrate improvement in maladaptive perfectionism and anxiety.

According to the CTRS-R results, Jasmine’s Perfectionism subscale scores were in the borderline range prior to study and following baseline. Her perfectionism score increased to the markedly atypical range at the midpoint of treatment, and it declined to the normal range following treatment. Jasmine’ perfectionism score decreased to the normative range following maintenance phase. Jasmine’s CTRS-R Anxious-Shy subscale scores were moderately atypical prior to the study and markedly atypical.
following baseline. Her anxiety scores stayed in the markedly atypical range at the midpoint of treatment. Her scores declined to the normal range following treatment and stayed in that range following maintenance phase. In summary, AdPT demonstrated clinically significant reduction in Jasmine’s maladaptive perfectionism and anxiety, as reported by the parents and the teachers.

Discussion

According to PEM results on the CAPS and RCMAS-2 self-report, AdPT did not demonstrate effectiveness on decreasing maladaptive perfectionism or anxiety for either child in the study. On the other hand, according to Cohen’s guidelines, effect size calculations for individual phases showed improvement in Dillon’s SPP during the intervention phase. Additionally, parent and teacher reports on the CRS-R demonstrated Dillon and Jasmine’s improvement from clinical to normal range in maladaptive perfectionism and anxiety, indicating the clinical significance of the findings regarding the effect of AdPT on Dillon and Jasmine’s day to day functioning at home and school.

Although the results of the individual phase analyses, which indicated improvement in Dillon’s SPP score, were encouraging, the majority of child self-report results were inconsistent with parent and teacher reports making it difficult to interpret findings. One explanation for the discrepancy between children’s self-report and reports of parents and teachers is social desirability bias. Given the potential for perfectionists to be sensitive about reporting their own imperfections, children’s self-report might have resulted in invalid findings (Rice et al., 2011). This reasoning is supported by Dillon’s
moderately problematic defensiveness scores on the RCMAS-2, as well as his lower than normal anxiety subscale scores. Additionally, using negative items in instruments is one of the main factors that reduce reliability and validity (Dimitrov, 2012). The presence of reverse items in the CAPS that were not capitalized or boldface might have impacted reliability and validity of the results in the present study. The research assistant who administered the self-reports instruments interview style supported possible existence of this specific issue by stating that in particular Jasmine seemed to be confused by the items that included the words “do not” or “cannot.” Additionally, less than adequate psychometrics of the CAPS might have influenced accuracy of the results.

Another explanation for the discrepancy between Dillon and Jasmine’s self-assessment results and the parent and teacher reports is the potential resistance of perfectionistic beliefs to change. According to Flett and Hewitt (2007), perfectionist individuals often have difficulties giving up their perfectionistic beliefs because their need to be perfect is an important part of their identities. In the present study, in addition to formal and informal parent and teacher reports, I observed Dillon and Jasmine improve in their dysfunctional behaviors related to maladaptive perfectionism. Some main differences that I observed in play sessions were Dillon and Jasmine’s increased willingness to open up about negative situations in their lives, decreased worry about messiness, and improved ability to work on challenging tasks. The inconsistency between behavioral observations and child self-report, specifically for Jasmine, may be related to inadequate number of AdPT sessions to see a clear change in children’s perfectionistic beliefs. According to my observations in the playroom, neither Dillon nor
Jasmine was ready to terminate play therapy process at the end of the study. However, Dillon moved through the AdPT phases faster than Jasmine, which may explain Dillon’s encouraging results on the CAPS and lack of improvement in Jasmine’s self-reports.

Although the overall findings for the child self-report were not promising regarding AdPT’s effectiveness, the results from parent and teacher report, along with parent and teacher comments and my observations, suggest that AdPT demonstrated beneficial effects on the children’s maladaptive perfectionism and anxiety. It is plausible that Adlerian techniques and strategies, such as facilitation of insight into problematic thoughts and attitudes, attention to Crucial Cs, and encouragement of functional behaviors facilitated Dillon and Jasmine’s behavioral change reported by teachers and parents. Throughout this study, I focused on the Crucial Cs (courage, connect, capable, and count) to understand the children’s strengths and needs as well as their change process. According to Adler (1929), individuals who come to therapy lack the courage to deal with life’s difficulties. Encouraging clients to overcome their hesitant attitudes towards life is the main road to improvement and change. The use of encouragement throughout the four phases of AdPT (Kottman, 2003) facilitated the children’s “courage” to take risks and learn from their mistakes, which resulted in decreased maladaptive perfectionism and anxiety. According to the informal reports during parent and teacher consultations, throughout the therapy process Dillon and Jasmine showed increased effort to work on difficult assignments, try new behaviors, and complete tasks on time. Additionally, parents and teachers verbally reported continued improvement throughout the maintenance phase. It seems reasonable to believe that the change in parent and teacher attitudes after receiving Adlerian consultations contributed to the children’s
improvement during the intervention phase and extended the effects of their overall improvement during intervention through the maintenance. Dillon’s and Jasmine’s mothers and Dillon’s teacher stated that encouragement was the skill that they found most helpful because both children seemed to respond to encouragement with increased cooperation and effort on challenging tasks.

According to Adler (1929), perceived imperfection can be a burden for children and cause excessive feeling of inferiority, which may generate lack of interest in the world and others. Adler believed that striving for adaptive perfectionism requires a sense of social interest, which he defined as the concern for others’ wellbeing as well as one’s own welfare. Prior to the intervention phase, parents and teachers reported that the participants were preoccupied with avoiding imperfect outcomes, resulting in isolation from their classmates. These statements indicated that both children had limited ability to “connect” and feel “capable” (Lew & Bettner, 1998). In the teacher consultation following the intervention phase, Jasmine’s teacher stated that Jasmine reported a reduction in Jasmine’s worry about receiving less than perfect results in class assignments. Consequently, she finished her tasks early and demonstrated increased social interest and ability to connect through helping her peers who struggled with their assignments. Similarly, Dillon’s mother reported his increased willingness to help his brother with challenging homework and school related tasks. Dillon’s mother also stated that Dillon began to use encouragement statements with his brother when his brother felt discouraged. Based on these anecdotal reports, Dillon and Jasmine’s reduction in maladaptive perfectionism and improved courage resulted in increased social interest and ability to connect with others.
During the reorientation phase, Jasmine and Dillon began to express their negative feelings more openly rather than shutting down and withdrawing. During parent consultations, both parents expressed concern over their children’s expression of negative emotions. I worked with the mothers to accept and encourage their children’s verbalization of negative feelings and understand their children’s underlying concerns. Additionally, the parents worked on changing their family atmosphere from one that overly focused on high standards for performance into a more democratic family environment, in which they communicated love and respect in ways that encouraged the Crucial Cs (Kottman, 2001). As they felt more accepted and encouraged, Jasmine and Dillon demonstrated more self-enhancing ways to “count” in their environments that involved pursuing high standards with increased courage and reduced self-criticism. These observations and informal reports are consistent with Kottman and Ashby’s (2000) suggestion that play therapists can encourage adaptive aspects of perfectionism as they facilitate reduction in self-criticism and fear over mistakes.

According to the individual phase analyses results for the CAPS, Dillon’s socially oriented perfectionism scores showed moderate improvement during the intervention phase and worsened during maintenance. Assuming the effectiveness of AdPT in reducing Dillon’s maladaptive perfectionism during treatment, the worsening in his behavior after treatment ended may indicate Dillon’s termination was premature. The loss of support and acceptance might have contributed to his regression to high SPP during maintenance.

In their study examining the relationship between parenting styles and perfectionism, Enns et al. (2002) demonstrated that perfectionist parenting style is
correlated with perfectionism in children. The result is consistent with Kottman’s (2001) suggestion to work with the parents and other significant caregivers, such as teachers, to alter their perceptions and behaviors that maintain children’s maladaptive perfectionism. In the beginning of the study, both Dillon and Jasmine’s mothers reported struggling with their own perfectionist tendencies. During the intervention phase, as a result of gaining insight into own perfectionist tendencies during parent consultations, Jasmine’s mother decided to seek personal counseling to work on maladaptive aspects of her own perfectionism. At the end of the study, both mothers reported improved understanding of their roles in maintaining the participants’ maladaptive perfectionism and anxiety through having high expectations for themselves and modeling fear of being perceived as imperfect by others. Consistent with Kottman’s suggestion to work with the system, teacher consultations seemed to impact the therapeutic process. Dillon’s and Jasmine’s teachers indicated increased use of encouragement rather than negative consequences when Dillon and Jasmine failed to complete their class assignments. In the present study, in addition to the impact of new skills that they learned, improvement in the reports of parents and teachers may also be connected to change in their perceptions of Dillon and Jasmine’s dysfunctional behaviors.

In summary, although there is discrepancy in the findings, parent and teacher reports were consistent in indicating the clinical significance of AdPT on Dillon and Jasmine’s day to day functioning at home and school. According to parent and teacher reports, AdPT demonstrated a beneficial effect on reducing maladaptive perfectionism and anxiety. This finding is consistent with Meany-Walen et al.’s (in press) results regarding the beneficial effect of school-based AdPT on children’s classroom behavior.
Furthermore, parent and teacher statements were in line with the Adlerian view of the therapeutic change process, specifically the importance of encouragement, facilitating Crucial Cs, and nurturing social interest. Consistent with the emphasis of AdPT on systemic change, parent and teacher consultations were integral to the treatment process.

_Limitations and Recommendations for Future Research_

One of the challenges in single case research with children is identification of assessments to objectively measure behavior (Ray et al., 2010). Ray et al. suggested the use of behavioral observations to reduce assessment bias in single case research. However, the lack of instruments to measure maladaptive perfectionism and anxiety in children resulted in reliance on child self-report measures as weekly assessments. The only perfectionism instrument found that was suitable for young children, the CAPS, had questionable reliability and validity. Heppner, Wampold, and Kivlighan (2008) stated that one of the limitations of single case studies occurs when data is collected using instruments with weak psychometrics, which obscures the interpretation of findings. Thus, it is possible that the effect size calculation using weekly data yielded invalid results because of issues related to child self-report. Rigorous single case research studies on perfectionism and anxiety may be possible with development of objective instruments with strong psychometrics.

Another limitation was the design of the present study. Establishing a stable baseline is an essential requirement in single-case studies in order to demonstrate experimental control within a single participant (Kennedy, 2005). Although a major
strength of the present study is applicability of AdPT to school settings where all
children have access to services, it was challenging to establish stable baselines, in
particular with Dillon, due to school schedules and time limitations. A rigorous study with
stable baseline would provide more reliable and valid results, offering potential
implications for informing effective practices with children who exhibit maladaptive
perfectionism and anxiety.

A major limitation in single-case design research is the inability to generalize
findings (Heppner et al., 2008). According to Kazdin (2003), replication of single case
research with a variety of participants is required to show generalizability. Another
limitation of this study is significant time requirement for the treatment. Although it may
be possible for researchers to replicate the present study, school counselors and
clinicians may not have adequate time and resources to implement the protocol as
presented. School counselors may benefit from utilizing counseling interns or
independent counselors from community to reduce their caseloads. It is also important
to note that clinicians and school counselors need extensive training and supervision in
the protocol in order to conduct AdPT effectively.

Experimenter bias was another limitation of the present study. According to
Heppner et al. (2008), one disadvantage of intensive single-case design is that
researchers may overlook the information that contradicts the results that they expect to
find. Expectations of the researcher may cause the contrary data to be undetected
during analysis of the data. As the lead researcher, I was heavily involved in carrying
out the intervention and the study. I utilized a research assistant to administer self-
report assessments to decrease researcher bias. However, my involvement in
conducting AdPT sessions, providing parent and teacher consultations, analyzing data, and my strong belief in the value of play therapy might have influenced the treatment and data analysis processes. Future researchers would benefit from utilizing additional research team members or blinded raters to provide treatment in order to further remove themselves from the treatment and research activities.

**Implications for Practice**

There are several implications of the present research for clinical practice. The present study is the first of its kind to use AdPT as a play therapy intervention for children presenting with maladaptive perfectionism and anxiety. Given the limitations of present findings, the following are tentative implications for practice.

Parent and teacher reports demonstrated initial support for Ashby et al.’s (2004) claim that AdPT can provide beneficial outcomes on children’s maladaptive perfectionism and anxiety. Despite the findings from child self-report assessments indicating no improvement on target behaviors as a result of AdPT, the parent and teacher reports demonstrated that practitioners should consider utilizing AdPT with children who exhibit maladaptive perfectionism and anxiety.

The results give credence to Kottman’s (2001) recommendations of including parents and teachers in treatment. Conducting play therapy sessions in school settings presents opportunities for counselors to facilitate the change process by easy access to teachers. Although parent involvement may be more feasible in clinical settings, the school environment allows counselors to include both parents and teachers in therapy process. Additionally, school-based AdPT shortens the duration of therapy by allowing
counselors to see children more than once a week. Jones and Landreth (2002) suggested that intensive play therapy provides the opportunity for more immediate and long-lasting change in children. Ray et al. (2008) compared short term (8 weeks) and long term (16 weeks) play therapy interventions for 16 sessions and concluded that short term intensive play therapy was more effective in reducing overall teacher-student relationship stress. Considering the limited time to facilitate improvement in children’s dysfunctional behaviors in order to prevent long-term academic and social impacts, the relevance of intensive AdPT for school counselors to work with children exhibiting maladaptive perfectionism and anxiety is promising.

The results indicated that number of AdPT sessions to show improvement in maladaptive perfectionism and anxiety may vary. According to parent and teacher assessments, Dillon showed improvement before session number 10. Dillon’s teacher reports demonstrated decrease in maladaptive perfectionism and anxiety from the markedly atypical to mildly atypical range, and his mother reports showed a reduction in maladaptive perfectionism from borderline to the normal range. On the other hand, Jasmine needed more than 14 sessions to demonstrate a clinically significant decrease in her maladaptive perfectionism and anxiety. In the final meeting, Jasmine’s mother stated that her own emotional issues impacted her ability to fully implement parenting strategies that she learned during consultations. Also during play therapy process, Jasmine reported recent history of parental divorce and change of social environment that might have contributed to the increase in number of sessions to demonstrate improvement. Researchers, clinicians, and school counselors may need to consider factors that impact therapeutic change, such as history and background, stability of their
support system, parent and teacher involvement, and severity of maladaptive
perfectionism and anxiety, in order to tailor intensity and duration of AdPT according to
unique needs of children. Additionally, considering children's different needs and
backgrounds, clinicians and school counselors will benefit from utilizing measurement
throughout the therapy process to assess improvement.

In the present study, both parents and teachers showed relative consistency in
attending consultations. However, involvement in the therapy process is a significant
commitment for parents and teachers. Researchers, clinicians, and school counselors
may benefit from providing flexible consultation schedules and educating parents and
teachers regarding importance of their roles in the therapeutic process. Considering that
delivery of counseling services is only one of the several responsibilities of school
counselors (ASCA, 2005), they may also benefit from conducting group consultations
for parents and teachers rather than scheduling individual meetings.

Conclusion

Perfectionism is an overlooked trait that has short and long term impacts on
children's psychological well-being. With its focus on encouragement and modification
of maladaptive thoughts and behaviors, as well as its strong emphasis on systemic
change, AdPT offers potential as a treatment for children with maladaptive
perfectionism and anxiety (Ashby et al., 2004). Adlerian theory has historically been
used in the school environment to create an atmosphere that facilitates healthy
development in children (Kottman, 2003; Nelsen, 2000; Watts, 2006). Kottman and
Ashby (2000) suggested the use of AdPT to facilitate a shift from maladaptive to
adaptive perfectionism in children. However, there is only one study to date that explored and demonstrated effectiveness of AdPT on behavioral problems (Meany-Walen et al., in press). Prior to the present study, the claim of AdPT’s impact on maladaptive perfectionism and anxiety (Ashby et al., 2004) was an assumption without any research support. Although there is discrepancy in the present findings between the children’s self-report and reports of the parents and teachers, AdPT demonstrates initial promise as an intervention for children with maladaptive perfectionism and anxiety that warrants future research.

References


APPENDIX A

EXPANDED LITERATURE REVIEW
Introduction

The increase in the number of research studies regarding perfectionism over the past decade shows interest in perfectionism as a relevant construct in mental health. Historically, attempts to define perfectionism focused on the negative aspects of this personality construct (Flett & Hewitt, 2002). Several researchers have shown the relationship between perfectionism and a variety of psychological disturbances throughout the life span, such as anxiety, depression, anger, guilt, social stress, low self-esteem, eating disorders, interpersonal problems including marital difficulties, procrastination, internalizing and externalizing problems, and personality disorders (Hewitt & Flett, 2002; Kenney-Benson & Pomerantz, 2005; McCreary, Joiner, Schmidt, & Ialongo, 2004; Rice, Ashby, & Gilman, 2011; Stoeber, Feast, & Hayward, 2009; Tsui & Mazzocco, 2007).

Alfred Adler (1956) was one of the first authors to describe a multidimensional view of perfectionism in relation to mental health, emphasizing its adaptive as well as maladaptive aspects. Several other researchers supported a multidimensional structure of perfectionism (Hewitt & Flett, 1991; Frost, Heimberg, Holt, Mattia, & Neubauer, 1993; Hamachek, 1978; Rice & Mirzadeh, 2000). Hamachek and Adler proposed the main differences between maladaptive and adaptive perfectionism as unrealistically high standards and rigidity in behaviors towards achievement. Research results showed that whereas maladaptive perfectionism is associated with a variety of psychological problems (Rice et al., 2011; Stoeber et al., 2009; Tsui & Mazzocco, 2007), adaptive perfectionism may facilitate positive outcomes (i.e. Rice et al., 2011; Rice & Mirzadeh, 2000). One of the most recognized psychological problems associated with
perfectionism is anxiety. In addition to research results that could indicate degree of relationship between maladaptive aspects of perfectionism and anxiety in children (Kawamura, Hunt, Frost, & Dibartolo, 2001; Tsui & Mazzocco, 2007), Essau, Conradt, Sasagawa, and Ollendick (2012) concluded that perfectionism is a mediator of the effects of treatment on anxiety in children.

Although there is an increase in the number of research studies exploring the relationship between maladaptive perfectionism and psychological issues, research largely focused on adolescents and adults. Research targeting mental health interventions to treat perfectionism in children is in its infancy. Play therapy is one of the most commonly used child interventions due to its responsiveness to children’s unique maturational needs (Bratton, Ray, Rhine, & Jones, 2005). Play therapists use toys and play materials to facilitate children’s communication and expression in a developmentally responsive manner (Landreth, 2012). In their meta-analysis, Bratton et al. examined the overall efficacy of play therapy and concluded that it is effective with a broad range of behavioral and emotional difficulties, such as anxiety, social adjustment issues, negative self-concept, relationship problems, and developmental difficulties.

Ashby, Kottman, and Martin (2004) suggested the use of Adlerian Play Therapy (AdPT) as a uniquely suited treatment to address maladaptive perfectionism in children. AdPT is a distinct approach to play therapy based on the theoretical constructs of Alfred Adler’s individual psychology (Kottman, 2003). The techniques and skills used in AdPT such as encouragement, metacommunication, metaphors, and mutual story telling offer the potential to help children with maladaptive perfectionism gain insight and redirect their emotions, thoughts, and behaviors (Ashby et al.). Parenting style is demonstrated
as a factor that impact the development of perfectionism in children (Enns, Cox, & Clara, 2002; Yoon & Lau, 2008). AdPT emphasizes parent involvement as an essential component of the treatment protocol (Kottman, 2009). Kottman suggested that parents’ involvement in the therapy process may increase parents’ understanding of their roles in the maintenance of the child’s maladaptive perfectionism. Furthermore, teacher consultation is a significant part of AdPT, especially when problems impact children’s school performance. According to Kottman, AdPT offers an effective means to help children modify their maladaptive thoughts and behaviors related to their perfectionism and anxiety.

Statement of the Problem

According to the literature, maladaptive perfectionism in children has a strong link to short and long term maladjustment (Ashby et al., 2004; Flett & Hewitt, 2002). Researchers suggested that interventions provided in the childhood years may reduce the impact of perfectionism on future psychological well-being (Kim, Heo, Kang, Song, & Treasure, 2010). The lack of research targeting child counseling interventions to address the potential self-destructive aspects of maladaptive perfectionism, especially with young children, warrants research in this area. Play therapy is an intervention that is uniquely suited to the developmental needs of children. Adlerian play therapy, in particular, with its focus on helping children change maladaptive thoughts and behaviors as well as its strong emphasis on parental involvement, offers potential as a treatment for children exhibiting maladaptive perfectionism and anxiety. This claim warrants
Purpose of the Study

The purpose of the study was to examine the effectiveness of AdPT for children identified with maladaptive perfectionism and anxiety. Specifically, this study investigated the effects of AdPT on reducing maladaptive perfectionism and anxiety in children ages 7 and 10. I used an experiential A-B-A single-case design to investigate the changes in children’s (n = 2) behaviors across three conditions: (a) no-treatment/baseline, (b) intervention, and (c) no-intervention/maintenance phase.

Review of Related Literature

Perfectionism

Adler (1956) stated that, "the striving for perfection is innate in the sense that it is a part of life, a striving, an urge, a something without which life would be unthinkable" (p. 104). According to Adler, the goal of striving from a "felt minus" to a "perceived plus" starts in early childhood as children naturally experience themselves as less capable or inferior to adults and proceeds until the end of life. Adler suggested that perfectionism has the potential to help individuals advance themselves and their society by working towards improvement. On the other hand, perfectionism can become unhealthy when individuals show rigidity in behaviors as a result of aiming for unrealistically high standards. Compared to healthy perfectionists, unhealthy perfectionists struggle with beliefs of not being good enough when they fail to meet the idealistic standards they set.
for themselves. Consistent with Adler’s conceptualization of healthy and unhealthy perfectionism, several researchers categorized perfectionism as adaptive and maladaptive (e.g., Frost et al., 1993; Rice & Mirzadeh, 2000).

Adaptive Perfectionism

Although initial definitions of perfectionism only included maladaptive aspects, recent research shows the positive traits that are associated with perfectionism (e.g., Rice & Mirzadeh, 2000; Slaney, Rice, Mobley, Trippi, & Ashby, 2001). Hamachek (1978) differentiated normal perfectionists from neurotic perfectionists by their realistic high standards and flexibility to adjust to new situations. Slaney et al. examined the characteristics of adaptive perfectionists with a sample of 809 undergraduate students. Unlike maladaptive perfectionists, adaptive perfectionists did not perceive discrepancy between their actual performance and personal standards. Rice et al. (2011) conducted a study with a large sample of ninth grade adolescents (n =875) to explore Hamachek’s perfectionism classification and examine the differences between two categories. According to study results, adaptive adolescent perfectionists exhibited strong evidence for psychological adjustment and well-being.

There is limited literature on classification and definition of perfectionism in children. However, Ashby et al. (2004) reported their observations related to specific behaviors of adaptively perfectionist children at home and school settings. According to the authors, adaptive perfectionism promotes children’s psychological and social well-being in several areas, such as self-esteem, interpersonal relationships, and life satisfaction. In school environment, children may manifest adaptive perfectionism
through high standards and need for order without extreme self-criticism (Kottman & Ashby, 2000). If children’s high personal standards do not become unreasonable, they are more likely to have strong motivation to achieve their goals.

Maladaptive Perfectionism

Hamachek (1978) described neurotic perfectionists as individuals who possess unrealistic standards that are impossible to reach, show inability to enjoy achievements, and lack flexibility in their behaviors. According to Slaney et al. (2001), maladaptive perfectionists can be differentiated from adaptive perfectionists by their excessive level of concern over mistakes. Maladaptive perfectionism impacts individuals’ psychological and physical well-being throughout life span (Hewitt & Flett, 2001). Several researchers have shown the relationship between perfectionism and a variety of long-term psychological issues, such as anxiety, depression, low self-esteem, eating disorders, as well as interpersonal problems including marital difficulties, and personality disorders (Hewitt & Flett, 2002; Kenney-Benson & Pomerantz, 2005; Rice et al., 2011; Stoeber et al., 2009).

Maladaptive Perfectionism in Children

A growing body of research has revealed short-term and long-term mental health and adjustment issues that children with maladaptive perfectionism encounter. According to observations of Ashby et al. (2004), parents and teachers usually refer maladaptively perfectionist children to counseling because they look ‘‘overly serious’’ about their schoolwork or other endeavors (e.g., giving up recess or playtime to finish a
task or assignment); they are easily frustrated when things do not go just as they would like (e.g., drawings that do not meet their standards, resulting in numerous crumpled pieces of paper); or they may be hesitant to engage in activities that might result in a "mess" of some sort (e.g., baking or finger-painting)"(p.36). In addition, parents and teachers may identify maladaptively perfectionist children by their extremely self-critical behaviors and psychological symptoms such as anxiety and depression. Perfectionist children may see themselves as failures because they excessively focus on one less than perfect score and disregard all their past achievements.

In school settings, maladaptively perfectionist students may be discouraged from trying in school assignments (Kottman & Ashby, 2000). These children may avoid working on their school tasks and participating in class discussions in order to prevent less than perfect results that cause feelings of extreme disappointment, anger towards self and others, and sadness. With fear of having less than perfect scores on their homework, they may prefer not to turn in their assignments and earn zero. Adderholdt-Elliott (1989) suggested the term “paralyzed perfectionism” to explain discouragement of children to try new activities or start projects because of their excessive fear of failure. Maladaptively perfectionist children may also procrastinate in order to delay the negative feelings they anticipate having for imperfect outcomes.

Research on Maladaptive Perfectionism in Children

Several researchers focused on relationships between maladaptive perfectionism and mental health in children. The majority of the literature regarding child perfectionism spotlighted the impact of maladaptive perfectionism on internalizing problems,
specifically anxiety issues (Hewitt et al., 2002; McCreary et al., 2004; Rice et al., 2011; Tsui & Mazzocco, 2007). Compared to the nonperfectionist populations, perfectionist individuals are more likely to experience various types of stress in their daily lives, such as continuous pressure to reach high standards (Frost & DiBartolo, 2001). The relationship between perfectionism and stress comes with increased vulnerability to the disruptive impact of negative life situations. According to the vulnerability hypothesis, the interaction of perfectionism and life stress predicts anxiety, as perfectionist individuals tend to see stressful life events as possible failures. This hypothesis is consistent with the substantial number of research study focused on relationships between maladaptive perfectionism and anxiety.

McCreary et al. (2004) conducted a longitudinal study with 481 African American children with the mean age of 11.8 years ($SD = 0.35$ years) to explore the symptom correlates of perfectionism. They used two data sets collected early fall and spring, utilizing Child and Adolescent Perfectionism Scale (CAPS; Flett et al., 2000). The researchers concluded that maladaptive components of perfectionism were primarily associated with internalizing symptoms rather than externalizing symptoms. They indicated that adaptive components of perfectionism might protect against externalizing disorders. Consistent with the research findings of McCreary et al. that demonstrates correlation between maladaptive perfectionism and internalizing problems, anxiety has been one of the most studied psychological issues in relation to maladaptive perfectionism.

Hewitt et al. (2002) examined the association of self-oriented and socially prescribed perfectionism in children with depression, anger, anxiety, and stress related
to achievement. They investigated 114 children between ages 10 to 15. Self-oriented perfectionism was significantly correlated with anxiety and depression, and socially prescribed perfectionism had significant associations with depression, anxiety, and internalized and externalized anger. Rice et al. (2011) conducted a study with a large sample of adolescents ($n = 919$) with mean age of 14.60 years ($SD = 0.59$). Maladaptive perfectionists scored higher on social stress and anxiety compared to nonperfectionists and adaptive perfectionists. On the other hand, researchers did not find significant differences between maladaptive perfectionists and nonperfectionists in regards to levels of depression, sense of inadequacy, and levels of self-esteem.

Tsui and Mazzocco (2007) focused on the effects of math anxiety and perfectionism on math performance in mathematically gifted children, including 20 boys (mean age = 11.7 years, $SD = 0.42$) and 16 girls (mean age = 11.7, $SD = 0.33$). The authors investigated discrepancies in math performance when using untimed and timed testing. Levels of perfectionism and math-anxiety were positively correlated, specifically concern over mistakes, doubts about actions, and parental criticism were positively correlated with math anxiety. Authors concluded that worrying about making errors and doubting their own abilities might cause children to be preoccupied during tests.

Jacobs et al. (2009) conducted a study that explored the impact of perfectionism on treatment outcomes for clinical depression and suicidality. In a randomized controlled trial with 439 clinically depressed participants between ages 12 and 17, the researchers compared CBT, medication combined with CBT, and placebo effect. Across treatment conditions, adolescents who had higher perfectionism scores at baseline
continued to show high depression scores. Additionally, high levels of perfectionism impeded treatment effect for suicidality.

*Interventions for Maladaptive Perfectionism in Children*

Research focused specifically on the mental health treatment of perfectionism in children is limited. An exhaustive review of the literature revealed only two studies that explored the impact of maladaptive perfectionism on treatment outcomes for CBT on depression, suicidality, and anxiety (Essau et al., 2012; Jacobs et al., 2009) in older children and adolescents. Essau et al. studied mediators and moderators that predicted the effectiveness of a universal school-based cognitive behavioral prevention program to reduce childhood anxiety. The researchers compared anxiety levels of 9 to 12 years old children in the treatment ($n = 302$) and control ($n = 336$) groups before and after the 10-week program. Children in the treatment group attended the prevention program while the control group did not receive any interventions. There was no statistically significant difference between two groups at postintervention, but treatment group showed greater reduction in anxiety compared to control group after 12 months follow-up. According to the results, perfectionism was a mediator of pre- to post-intervention changes in anxiety level of children. Low levels of perfectionism were predictive of high treatment effectiveness. The authors concluded that less concern over one’s performance and openness to receive therapeutic confrontation were important factors to facilitate treatment effectiveness.

Mofield and Chakraborti-Ghosh (2010) investigated the impact of teacher-led classroom-based interventions on perfectionism in 153 gifted students in sixth, seventh,
and eighth grades. Using a quasi-experimental no-treatment control group design, the researchers provided the experimental group with affective curriculum that consisted of nine 45-50 minute courses. The curriculum included establishment of group guidelines, discussions on giftedness, self-assessment of perfectionism, activities about common experiences of gifted students, sources of perfectionism, and strategies to respond to unrealistically high expectations imposed by others. After completion of curriculum intervention, participants with moderate to high levels of maladaptive perfectionism reported lower scores on Concern over Mistakes, Doubts about Actions, and Personal Standards as compared to the control group.

Maladaptive Perfectionism in Adults

Several researchers recognized perfectionism as a personality variable that is associated with severe psychological disorders throughout the life span (Kenney-Benson & Pomerantz, 2005; McCreary et al., 2004). Descriptive case studies and correlational research with adult populations indicated that maladaptive perfectionism has a strong link to psychological problems (Flett & Hewitt, 2002). According to Flett and Hewitt, psychology and psychiatry literature provides evidence for persistence of maladaptive perfectionism in adult populations, demonstrating the importance of early assessment and intervention.

Research for Maladaptive Perfectionism in Adults

The relationship between perfectionism and eating disorders is one of the subjects of recent studies. Researchers conducted two sets of controlled case-studies
to compare 52 Korean women with lifetime Anorexia Nervosa (AN) with 108 Korean healthy controls and 42 women from United Kingdom who also exhibited lifetime AN (Kim et al., 2010). The authors used participants’ current age and age of onset to match Korean women with AN with a mean age of 23.19 years ($SD=6.33$) to British women with AN with a mean age of 24.10 years ($SD=6.39$). For comparison of the control group with the clinical sample, the researchers used age to match the Korean healthy women with a mean age of 22.31 years ($SD=3.62$) to Korean women with AN. Kim et al. compared the groups with regards to childhood risk factors that might have led to the development of eating disorders. The authors utilized Childhood Risk Factors Questionnaire that they derived from an extensive literature review. The questionnaire comprised of eight domains: parent’s or adult’s concern about thinness, parent’s or adult’s teasing about weight or shape, social support, anxiety, perfectionism, emotional overeating, emotional undereating, and picky eating. Results demonstrated that Korean and UK women with AN were more likely to report premorbid anxiety and perfectionism as compared to the control group. Kim et al. found childhood perfectionism as one of the most important conditions that contributed to the foundation for development of AN in adulthood. The authors suggested that the connection between childhood perfectionism and AN can be attributed to children’s exposure to parental criticism and judgment about their body shape and weight.

Peck and Lightsey (2008) investigated the relationship between eating disorders and perfectionism in undergraduate female students ($n=261$, mean age = 20.7 years). The authors used Multidimensional Perfectionism Scale (MPS; Frost et al., 1990) and Eating Disorder Inventory-Two (EDI-2; Garner, 1991). Research results demonstrated
that increased severity of eating disorders was significantly associated with increased perfectionism in female students ($p < .001$). In a 6 to 24 months follow up study, Sutandar-Pinnock, Woodside, Carter, Olmsted, and Kaplan (2003) examined the relationship between perfectionism and treatment outcomes of 73 inpatients (mean age = 27.2 years) diagnosed with AN. According to research results, participants with eating disorders had higher perfectionism scores than the healthy control group. The researchers demonstrated that perfectionism scores of individuals diagnosed with eating disorders remained high even when eating disorders were in remission. Additionally, participants with lower perfectionism scores at admission had better response to treatment and showed better outcomes at follow up. The researchers concluded that highly perfectionist patients might find it more difficult to engage in a program that is primarily focused on group therapy, in which they are expected to show imperfection by revealing their issues to the group.

The relationship between depression and perfectionism is another area that is the focus of several studies. Yoon and Lau (2008) conducted a research with a 104 Asian American university students with the mean age of 19.8 years ($SD=2.05$), investigating the contribution of interdependence concerns and parental relationship with maladaptive perfectionism and related depressive symptoms. According to the research results, maladaptive perfectionism, which comprised of doubting one’s actions and demonstrating excessive concern over mistakes, showed a strong correlation to depressive symptoms. In addition, the researchers suggested heightened cultural vulnerability and sensitization to maladaptive perfectionism in Asian American college
students, as demonstrated by high concern about making favorable impressions on others related to their interdependent orientation.

Rice and Arsdale (2010) investigated relationships among perfectionism, stress, and alcohol-related problems for 354 college students aged 18-27 years. Compared to adaptive perfectionists and non-perfectionists, participants with maladaptive perfectionism reported significantly higher stress levels and use of alcohol to cope. Additionally, the authors concluded that healthy levels of high standards might be a protective factor, as participants with adaptive perfectionism reported the fewest alcohol-related problems when compared to non-perfectionists.

Kawamura et al. (2001) examined the relationship between perfectionism and anxiety in 209 college students aged 18-38 years. Maladaptive aspects of perfectionism were associated with higher levels of anxiety symptoms as compared to adaptive aspects of perfectionism. In addition, the authors collected multiple measures of anxiety and conducted a factor analysis that resulted in three aspects of anxiety: Obsessive Compulsive Disorder (OCD), trait anxiety, and Post Traumatic Stress Disorder (PTSD). Kawamura et al. concluded that trait anxiety showed the strongest correlation with maladaptive perfectionism. Trait anxiety is a construct that reflects individual differences in the disposition for high anxiety in stressful situations (Rudaizky, Page, & MacLeod, 2011). Trait disposition to anxiety is assessed by the amount of time individuals spend experiencing an anxious emotional state. Kawamura et al. asserted that concern about evaluation related to maladaptive perfectionism was more central to trait anxiety than OCD. The authors also found that the relationships between maladaptive perfectionism, OCD, and PTSD were not independent of depression. However, when controlled for
depression, maladaptive perfectionism showed correlation with trait anxiety. The authors concluded that perfectionism might have an impact on the development and maintenance of anxiety associated with evaluative and more general fears that are common to trait anxiety. On the other hand, perfectionism did not seem to impact the development and maintenance of OCD or PTSD.

In a study of 475 university students with the mean age of 20.9 years, Klibert, Langhinrichsen-Rohling, and Saito (2005) explored the extent to which self-oriented versus socially prescribed perfectionism differed in correlations with adaptive and maladaptive constructs, such as self-esteem, perceived anxiety, suicidal ideation, shame, guilt, and procrastination. According to research results, socially prescribed perfectionism showed stronger correlations with maladaptive constructs as compared to self-oriented perfectionism. The authors concluded that achievement motivation and time management skills of individuals who exhibit only self-oriented perfectionism may be protective factors from depression, suicide proneness, shame, and procrastination.

Stoeber et al. (2009) explored the differential relationship between perfectionism, intrinsic-extrinsic motivation, and test anxiety in 105 university students with a mean age of 20 years. In terms of students’ motivation to study for an exam, self-oriented perfectionists showed positive correlations with intrinsic reasons for studying, unlike socially prescribed perfectionists who exhibited positive correlations with extrinsic reasons. Regarding test anxiety, there was only a positive correlation between perfectionism and total anxiety for the students, who exhibited socially prescribed perfectionism. Furthermore, interference and lack of confidence was positively correlated with socially prescribed perfectionism but negatively correlated with self-
oriented perfectionism. The researchers concluded that socially prescribed perfectionism is maladaptive regarding its association with higher anxiety in exams and extrinsic motivation for studying. On the other hand, Stoebert et al. asserted that the nature of self-oriented perfectionism is ambivalent, as it is associated with higher worry regarding the exam, but lower interference and higher confidence regarding achievement.

*Interventions for Maladaptive Perfectionism in Adults*

Although many authors agreed that maladaptive perfectionism requires the attention of mental health professionals in order to prevent related psychological problems, a literature review revealed a dearth of attempts to evaluate effectiveness of interventions targeting maladaptive perfectionism. One therapeutic approach that has been the focus of attention in the literature is cognitive behavioral therapy (CBT). CBT emphasized the examination of self-defeating behaviors and information processing through client education that includes giving information regarding the impact of perfectionism on one’s thoughts, emotions, and behaviors (Bieling, Israeli, & Antony, 2004). CBT therapists encourage clients to try alternative thoughts and behaviors that decrease intensity and frequency of negative emotions in order to demonstrate the strong relationship between perfectionism and distress. However, while cognitive behavioral approaches to treating perfectionism are emphasized in the literature (Shafran, Cooper, & Fairburn, 2002), controlled outcome studies to support the effects of CBT with this population is scarce.
As a response to limited proven treatments for perfectionism, Shafran et al. (2002) developed a CBT model for clinical perfectionism. They defined clinical perfectionism as “the overdependence of self-evaluation on the determined pursuit (and achievement) of self-imposed personally demanding standards of performance in at least one salient domain, despite the occurrence of adverse consequences” (p. 773). The authors suggested that mechanisms that cause individuals to maintain perfectionism include extreme standards, dysfunctional behaviors such as avoidance or constant performance assessment, cognitive biases such as dichotomous thinking and selective attention to failure, and increasing standards even after goals are achieved. However, Glover, Brown, Fairburn, and Shafran (2007) criticized this model, indicating that Shafran et al.’s definition of clinical perfectionism exclusively refers to self-oriented perfectionism, which is only one aspect of the multidimensional construct of perfectionism. Kearns, Forbes, and Gardiner (2007) proposed a new cognitive treatment model for perfectionism, cognitive behavioral coaching (CBC), which specifically targets nonclinical populations. The CBC model is focused on inaccurate thinking and assumptions that individuals with perfectionism exhibit. The researchers conducted on intense workshop series with 28 students pursuing master’s or doctoral research degrees. Small groups of participants attended a workshop series called “Getting Your Thesis Finished – Defeating Self-Sabotage.” The workshops followed the CBC model developed by the researchers. The CBC model included several techniques, such as behavioral experiments, reality testing, thought diaries, exposure, and relapse prevention strategies. According to the results of Kearns et al.’s single-group design study, participants’ perfectionism levels fell during the workshops and
reductions were sustained at four-week follow up. Changes in perfectionism were accounted by only two subscales of the Multidimensional Perfectionism Scale (Frost, Marten, Lahart, & Rosenblate, 1990): Concern over Mistakes and Personal Standards. The other four subscales, Parental Expectations, Parental Criticism, Doubts about Actions, and Organization, did not change through intervention.

Confronting the predominating existence of CBT interventions in the treatment of perfectionism compared to other approaches, Hewitt, Flett, Sherry, and McGee (2003) questioned the likelihood of obtaining meaningful and sustainable benefits from a brief intervention focused on factors that contribute to maintenance of the problem. The authors criticized treatments that focused solely on self-focused perfectionism, stating that they ignore interpersonal features, resulting in treatment models that aimed at short-term relief rather than long-lasting change. Hewitt et al. asserted that in order to effect lasting change in perfectionism, mental health professionals need to consider interpersonal aspects of perfectionism by addressing interpersonal patterns, developmental origins, and traumatic history in the therapy process.

Consistent with Hewitt et al.’s (2003) emphasis on self-related and interpersonal aspects of perfectionism, Greenspon (2008) criticized interventions that target perfectionistic thoughts and behaviors. According to Greenspon, attempts to directly change thoughts and behaviors may become burdensome and counterproductive, as perfectionist individuals are prone to experience them as personal critiques and become resistant to change. Thus, setting the stage to reduce perfectionist tendencies requires clients’ sense of acceptance by the therapist, as it may help clients to separate personal
values from behaviors and behavioral outcomes. Greenspon proposed several suggestions to effectively intervene with maladaptive perfectionism:

1) Perfectionism reflects the belief that one has to be perfect in order to be accepted by others. Thus, therapists need to create an atmosphere of acceptance to help clients feel accepted by who they are, rather than what they can do.

2) Relational developmental histories of perfectionist clients are reflective of their relational expectations. Thus, therapists need to explore the emotional convictions arising from clients’ developmental histories in order to help them gain insight into origins of their perfectionist strivings.

3) The process of helping clients to understand origins of their perfectionism facilitates insight, and it may create a sense of being understood and accepted by the therapist in deeper levels.

4) Therapists can use affirmation and validation of adaptive aspects of perfectionism that are separate from performance to strengthen clients’ sense of being accepted in therapy environment, such as sense of commitment, persistence, and sense of responsibility.

5) Therapists need to be cautious about approaching therapy from a perspective of who is right or what is normal behavior, as perfectionism is an attempt to repair a sense of defectiveness and lack of acceptance.

6) Self-reflection and self-disclosure regarding counselors’ own imperfections can play an important role in therapy, as they may contribute to clients’ acceptance of imperfection, as well as recognition of their own humanity and fallibility.

7) Cognitive and behavioral interventions may become more effective after therapists facilitate an atmosphere of understanding and acceptance in the therapeutic relationship. Clients are more likely to view such interventions as suggestions to improve than indicators of imperfection and demands for correction.

In summary, there have been limited attempts to develop treatments targeting perfectionism and evaluating effectiveness of existing interventions. Although researchers suggested CBT to change maladaptive perfectionistic thoughts and behaviors, there are contradicting views regarding its long-term impact. Researchers
who criticize CBT model suggested acceptance and relationship based approaches for perfectionists throughout the life span.

Perfectionism and Parenting Styles

Considering increasing number of studies regarding the link between perfectionism and mental health, researchers strive to have a better understanding of perfectionism as a personality construct. In order to gain insight into the nature of personality constructs, it is important to study factors and processes that play roles in the personality development (Flett, Hewitt, Oliver, & Mcdonald, 2002). Even though there are hypotheses regarding the impact of child development factors, such as parenting styles, on the development of adaptive and maladaptive perfectionism, empirical studies in the literature is limited. One model that explains the relationship between parenting and perfectionism is the Anxious Rearing Model. According to this model, children who are frequently exposed to parental worry about being imperfect and making mistakes develop perfectionistic tendencies (Flett et al., 2002). Parents with an anxious rearing parenting style tend to perceive mistakes as threats to physical and psychological well-being, and they continually remind their children that they need to be careful and not make mistakes. These reminders usually include statements related to being cautious of others judging them negatively for their flaws.

In one of the first empirical studies regarding developmental correlates of adaptive and maladaptive perfectionism, Enns et al. (2002) investigated the relationship between parenting experiences, and adaptive and maladaptive perfectionism in 261 college students with a mean age of 20.3 years ($SD=4.4$). Both adaptive and
maladaptive forms of perfectionism were correlated with harsh parenting and
perfectionist parenting. The authors defined perfectionist parenting as parents who
exhibit high expectations from themselves and their children. Although harsh parenting
styles defined by unrealistic expectations, lack of care, criticalness, and over-control
was significantly correlated with maladaptive perfectionism in children, results did not
hold for adaptive perfectionism. Researchers stated that harsh parenting style was
correlated with parents’ high expectations from children but not themselves.

Researchers suggested a relationship between the quality of the parent-child
relationship and development of perfectionist tendencies in children (Hamachek, 1978;
Yoon & Lau, 2008). Hamachek stated that critical parenting is associated with children’s
maladaptive perfectionism. Researchers also indicated a link between parents’
performance goals and unreasonably high standards for children, and development of
maladaptive perfectionism. These results demonstrate the significant role of parenting
attitudes and styles on the development of adaptive and maladaptive perfectionism and
indicate importance of involving parents in children's treatment process.

Play Therapy

Researchers have demonstrated play therapy as an effective intervention with a
broad range of problems and one that is particularly responsive to the unique
devolutional needs of young children (Bratton et al., 2005). According to Piaget
(1962), children under the age of 11 lack a fully developed capacity for abstract
reasoning or verbal thought processing, which is a prerequisite to meaningful verbal
communication and understanding of complex issues. Play is the natural language of
children (Landreth, 2012) that connects concrete experiences to abstract thoughts (Ray, 2012). Through play, children can make meaning of abstract life experiences, and find developmentally appropriate ways to express their thoughts and emotions.

Development of Play Therapy

Play was first introduced into child therapy in the early 1900s by psychoanalysts to facilitate children’s self-expression (Klein, 1932). Play therapy was popularized by Virginia Axline’s (1947) development of nondirective play therapy based on her belief that play was children’s natural mode of communication. Building on her work, Haim Ginott (1961), Clark Moustakas (1953), Louise Guerney (1983), and Garry Landreth (1991/2012) contributed significantly to the widespread acceptance and practice of play therapy, specifically child-centered play therapy (CCPT). While CCPT is recognized as the most practiced approach to play therapy in the United States (Lambert et al., 2005), the field of play therapy has grown dramatically over the past two decades to include various theoretical approaches to play therapy, such as Gestalt play therapy (Oaklander, 1994), Adlerian play therapy (Kottman, 1995), ecosystemic play therapy (O’Connor, 2000), cognitive behavioral play therapy (Knell, 1998), and prescriptive play therapy (Schaefer, 2001).

Rationale for Play Therapy

Landreth (2001) stated that, “Play is to children what verbalization is to adults” (p. 10). Because play is the most effective way for children to communicate, it is a unique medium that facilitates children’s developmental processes, such as expressive
language, emotional development, cognitive development, and social abilities (Ray, 2011). Thus, therapists of many theoretical orientations prefer to use play and activities in therapeutic interventions with children (Oaklander, 1994; O’Connor, 2000; Kottman, 2001; Landreth, 2001). According to Landreth (2012), children use toys and other materials in the play room to build a positive relationship with play therapists, express feelings, reenact and explore their experiences, strengthen self-concept, test limits, enhance self-understanding, and improve self-control. Landreth indicated that the essential part of the therapeutic process occurs as children express their feelings and thoughts nonverbally through the toys and materials in the presence of a caring and empathic adult.

Research Support for Play Therapy

In order to investigate the overall treatment effectiveness of play therapy, LeBlanc and Ritchie (2001) conducted a meta-analysis that included 42 play therapy outcome studies. According to the results, play therapy interventions demonstrated an overall moderate treatment effect compared to no treatment. Bratton et al. (2005) conducted the largest play therapy meta-analysis to date, with 93 controlled outcome studies. According to the results, play therapy demonstrated an overall treatment effect of .80, considered a large effect when compared to no treatment. The researchers also found that the mean effect size for play therapy with parent and teacher involvement was significantly greater than the effect size of play therapy only interventions conducted by professionals.
Historically, the majority of individual effectiveness research studies on play therapy focused on child-centered/nondirective methodology. Ray (2011) conducted a detailed search on effectiveness studies for nondirective play therapy and reported findings from 63 studies conducted over 60 years. Researchers showed nondirective play therapy as a viable treatment for a variety of emotional and behavioral issues, such as internalizing and externalizing problems (Bratton, Ceballos, Sheely-Moore, Meaney-Walen, Pronchenko, & Jones, in press; Garza & Bratton, 2005; Ray, 2008), self-esteem (Baggerly, 2004; Post, 1999), anxiety (Ray, Schottelkorb, & Tsai, 2007; Shen, 2002; Tyndall-Lind, Landreth, & Giordano, 2001), suicide risk (Shen, 2002), aggression (Dogra & Veraraghavan, 1994; Ray, Blanco, Sullivan, & Holliman, 2009), social problems (Fall, Navelski, & Welch, 2002), and Attention Deficit Hyperactivity Disorder (Muro, Ray, Schottelkorb, Smith, & Blanco, 2006; Ray et al., 2007).

In their meta-analysis, Bratton et al. (2005) explored the effectiveness of school-based interventions. The researchers concluded that although the average number of sessions in school settings was 8.4 as compared to 22.4 sessions in clinic-based intervention studies, school-based interventions showed a moderate treatment effect size of .69. Consistent with this finding, Ray (2011) asserted that play therapy is the preferred modality for treatment of elementary school-age children.

Although the extant research on play therapy effectiveness includes a large number of controlled play therapy outcome studies, the majority of these studies focused on CCPT/non-directive play therapy interventions. Baggerly (2004) suggested that researchers need to expand the literature in play therapy through conducting well-designed studies that explore a variety of theoretical approaches to play therapy.
Meany-Walen, Bratton, and Kottman (in press) conducted the only Adlerian Play Therapy (AdPT) effectiveness study to date. Using a randomized, controlled design, Meany-Walen et al. demonstrated the beneficial effects of AdPT on children’s ($n = 58$) disruptive behaviors and teaching stress. The researchers recommended further research to examine the effects of AdPT on other child mental health disorders.

Ashby and Noble (2011) suggested that Adlerian theory provides a useful framework to distinguish between adaptive and maladaptive perfectionism. Additionally, researchers supported Adlerian conceptualization of maladaptive perfectionism focused on the connection between inferiority feeling and neurotic striving for perfection (Ashby & Kottman, 1996). Considering conceptual fit of perfectionism with Adlerian theory, Ashby et al. (2004) proposed AdPT as a potentially effective treatment for maladaptive perfectionism.

Adlerian Play Therapy

Adler (1927) described individual psychology as “the science of living” (p. 1). He believed that life must be seen as a whole, and every single action and reaction must be considered to be the way individuals express their attitude towards life. Kottman (2003) integrated individual psychology concepts (Adler, 1956) with play therapy techniques to develop Adlerian play therapy (AdPT) as a therapeutic intervention for children. One of the goals of Adlerian play therapists is to encourage children to explore their goals of behaviors by acknowledging their efforts and progress and returning responsibility (Kottman, 2001). AdPT helps children to gain a deeper understanding of how they view themselves, others, and the world through play, art, and activities (Kottman, 2009).
Adlerian play therapists utilize a variety of playful interventions, such as art techniques, story-telling, and puppetry to help children gain self-awareness and learn useful ways to feel significant in their environments. In AdPT, a variety of toys from different categories, such as aggressive toys, expressive toys, family/nurturing toys, and pretend toys, are necessary for children to fully express their beliefs, feelings, and issues. Adlerian play therapists can include additional play materials to provide children with tools to express variety of ideas, emotions, relationships and life circumstances (Kottman, 2009). Play therapists consider therapeutic purposes of play materials before including them in the play room (Ray, 2009).

Adler emphasized children’s need for support from their caregivers to deal with difficulties of life. Adler (1956) suggested that the process of personality development is under the influence of environments surrounding children, especially family atmosphere. Healthy development of children is determined by their caregivers’ ability to provide a nurturing and egalitarian environment. Consistent with Adler’s emphasis on the family environment in healthy development of children, an essential component of AdPT is involvement of parents in the change process (Kottman, 2003). Kottman suggested that parental involvement increases the likelihood of making long-lasting changes in children’s attitudes. Play therapists need to have a clear understanding of family atmosphere in order to figure out the ways children see themselves, others, and the world. Furthermore, Kottman asserted that children become more willing to change their attitudes when they see their parents as active partners in the therapy process. In parent meetings, play therapists use consultation, teaching, and counseling techniques with parents to help them gain insight into the ways that they maintain their children’s
self-defeating behaviors. Additionally, therapists teach parents skills to modify their parenting strategies in order to facilitate modification in family atmosphere and support positive change in children’s thoughts and behaviors.

Kottman (2003) also suggested that teachers have significant influence on the lives of school-aged children, and that they can provide important information about children’s learning styles and interactional styles. According to Kottman, consulting with teachers is an important part of AdPT. Through consultations, play therapists can help teachers to understand the ways that they can support children to deal with their performance and relationship issues at school.

As school-age children improve in their ability to think logically, learn through conversing with others, and use learning strategies and memory, their cognitive flexibility and sophistication will allow them to use their cognitive skills in the therapy process (Kottman, 2001). Hence, developmentally appropriate therapies that are cognitively based, such as Adlerian play therapy, become important play interventions especially with children around age seven and older. In a randomized controlled study, Meany-Walen et al. (in press) examined the effectiveness of AdPT in children with clinical levels of disruptive behaviors in classroom. The researchers compared Adlerian play therapy to reading mentoring with 58 kindergarten through third grade students. Children received AdPT or an active control condition, reading mentoring, for 16 sessions twice a week. According to research results based on data from teachers and objective raters who were blinded to the study, children who received AdPT demonstrated statistically significant improvements on disruptive behaviors in the classroom and stress in the teacher-child relationship as compared to children in the
reading mentoring control group. Research results showed moderate to large treatment effect sizes on all measures of behavior, which indicated the practical significance of AdPT on reducing disruptive behaviors in young children. The researchers also demonstrated clinical significance of AdPT on children’s behavioral issues. According to the results, of the 21 children who presented in the clinical range for disruptive behavioral problems, 11 improved to normal functioning after receiving AdPT, four moved to borderline range, and six stayed at the clinical level.

Adlerian Play Therapy in Treatment of Perfectionism and Anxiety

Adler (1956) stated that, "the striving for perfection is innate in the sense that it is a part of life, a striving, an urge, a something without which life would be unthinkable" (p. 104). Individuals’ striving for superiority or perfection facilitates their movement towards self-preservation, procreation, and contact with the environment. Adler believed that every individual attempts the goal of perfection differently, and their approach can be differentiated by functional and dysfunctional behaviors towards superiority. Adler (1956) suggested that individuals striving for perfection aim to overcome obstacles and uncover their potential. Adler’s conceptualization of perfectionism is consistent with the studies that indicated the presence of a two-dimensional structure (Frost et al., 1993; Rice & Mirzadeh, 2000). According to Adler (1956), individuals with perfectionist tendencies can be categorized as healthy and neurotic perfectionists. Neurotic perfectionists have greater inferiority feelings compared to the healthy perfectionists, as they are less flexible and more accentuated in their movement towards superiority.
Ashby et al. (2004) suggested that Adlerian play therapists could help perfectionist children to develop strategies for “dealing more easily with life in all of its glorious imperfection” (p. 52). Adlerian play therapy offers unique ways to work with children who exhibit maladaptive perfectionism and high anxiety. According to observations of Ashby et al., children tend to show the maladaptive nature of their perfectionism through their anxiety level. Children with maladaptive perfectionism exhibit chronic anxiety that reveals itself by their constant expression of self-doubt and their excessive need to get approval of the therapist. In addition, they exhibit hyper-vigilance and a need for reassurance. On the other hand, adaptive perfectionism will manifest itself with a moderate level of anxiety in the playroom, such as frequent checking with the therapist to make sure that they do not break limits and are meeting the therapist’s expectations.

Ashby et al. (2004) defined goals for Adlerian play therapists as helping perfectionist children: (a) recognize self-defeating themes in their play and begin to shift their behaviors; (b) learn to moderate their reaction to perceived criticism from others; (c) restructure their distorted cognitions; (d) expand their choice of play materials; (e) readjust their attitudes toward and behavior related to orderliness in the play room; (f) learn strategies to recognize and cope with anxiety; and (g) accept greater responsibility for themselves by developing greater tolerance for risk and making mistakes (p. 48).

Kottman (2003) suggested that because therapeutic change becomes more systemic and long-lasting with involvement of adults in children’s lives, parent and teacher consultations are essential parts of Adlerian play therapy. Combining consultation and counseling from an Adlerian perspective allows Adlerian play
therapists to increase parents’ and teachers’ understanding of their roles in the maintenance of children’s maladaptive perfectionism. Additionally, Adlerian play therapists can make changes in parenting and teaching strategies by educating parents and teachers regarding strategies to modify maladaptive aspects of their children’s perfectionist tendencies (Ashby et al., 2004).

In summary, AdPT has potential to be an effective intervention to decrease maladaptive perfectionism and anxiety by facilitating children’s freedom to make mistakes, survive those experiences, and learn from them. Considering the lack of effectiveness studies in the literature, the proposed study explored the effectiveness of AdPT with children who exhibit maladaptive perfectionism and anxiety issues. Appendix E includes Kottman’s (2009) AdPT protocol.

Single-Case Design

Research methods courses primarily focus on group-designs for conducting effectiveness studies, which require researchers to group participants within different treatment conditions (Franklin, Allison, & Gorman, 1997). Many researchers have little exposure to an alternative paradigm, single case design, which allows researchers to demonstrate experimental control within a single participant (Kennedy, 2005). Rassafiani and Sahaf (2010) asserted the importance of single-case design for mental health professionals to decrease the gap between science and practice by allowing researchers to conduct studies with limited participants and funds.

Kazdin (2003) suggested that single-case research allows experimentation with individual participants in order to demonstrate causal relationships. Kennedy (2005)
suggested that using single case experimental design to test therapeutic interventions could provide strong empirical support for the efficacy of specific treatments. In line with growing literature suggesting the use of single-case design in effectiveness studies, counseling and play therapy research began to use single-case design to investigate treatment effects (McLeod, 2003; Ray, Barrio Minton, Schottelkorb, & Brown, 2010; Ray & Schottelkorb, 2010). According to Ray and Schottelkorb (2010) single-case studies are effective tools to promote effectiveness of play therapy interventions.

Ray and Schottelkorb (2010) described several difficulties that play therapists may encounter in designing single-case studies. According to the authors, one of the issues in single-case design is the challenge of implementing treatment in clinical settings because researchers rely on parents to bring children to therapy or fill out assessments. In order to deal with this problem, Ray and Schottelkorb suggested play therapists conduct studies in school settings.

Design and Data Analysis in Single-Case Research

In single-case study design, researchers demonstrate internal validity by establishing a functional relationship between dependent and independent variables (Kennedy, 2005). In order to demonstrate this functional relationship, researchers first need to establish a baseline (A) that serves as a background to explore the treatment effect. After establishing clear patterns of behavior in the baseline phase, researchers introduce the independent variable to observe the treatment effect during the intervention phase (B). According to Kennedy, the arrangement of an intervention (B) following the baseline (A) is a necessary but not sufficient condition to establish a
functional relationship. In order to control for the extraneous variables that may have influence on the onset of the independent variable, researchers need to return to the baseline condition (A).

There are two main procedures to analyze single-case study data: visual analysis and quantitative analysis (Rassafiani & Sahaf, 2010). Horner, Swaminathan, Sugai, and Smolkowski (2012) suggested that “Visual analysis of data involves the simultaneous assessment of the level, trend, and variability of the data within and across adjacent phases” (p. 276). According to Rassafiani and Sahaf, the first step of visual analysis is to convert the data into figures and graphs. Then, researchers look at the trends and changes in baseline, intervention, and maintenance phases in order to explore the influence of intervention on the outcome. Rassafiani and Sahaf suggested that quantitative analysis is more objective than visual analysis, as it provides standard methods to explore treatment effectiveness. Researchers use three methods for quantitative data analysis: (1) comparison of means between baseline and intervention phases, (2) comparison of trends between baseline and intervention phases, and (3) calculating two standard deviations of baseline phase and drawing it on the graph for comparison of lines with intervention phase.

Horner et al. (2012) emphasized the importance of computing effect sizes in order to compare or combine findings from single-case studies with other single-case studies or group-design. There are several ways to compute the magnitude of treatment, such as percentage of nonoverlapping data (PND; Scruggs et al., 1987), percentage of all nonoverlapping data (PAND; Parker, Hagan-Burke, & Vannest, 2007), and percentage of data points exceeding the median (PEM; Ma, 2006).
Single-Case Play Therapy Research

Research findings from a handful of well-designed single-case studies demonstrated beneficial treatment effects for child-centered/nondirective play therapy with emotional, behavioral, and developmental issues in children. Schottelkorb and Ray (2009) conducted a single-case research to explore the effectiveness of child-centered play therapy (CCPT) and person-centered teacher consultations to decrease the symptoms of attention deficit hyperactivity disorder (ADHD). Two out of four children participated in CCPT and their teachers received teacher consultation, and the other two children received CCPT and reading mentoring. According to the research results, two children significantly improved in their on-task behaviors after CCPT intervention. Additionally, the researchers concluded that the more sessions children had, the more improvement they demonstrated in their on-task behaviors. The results demonstrated ineffectiveness of reading-mentoring to improve on-task behaviors.

In another single-case play therapy study, Josefi and Ryan (2004) explored feasibility and effectiveness of non-directive play therapy interventions for children with autism. The researchers conducted qualitative and quantitative analysis of sixteen play therapy sessions with a 6-year-old boy who was diagnosed with autism. The child improved in his development of autonomy and his pretend play at the end of the treatment.

Swan (2011) conducted a single-case study to explore effectiveness of CCPT on problems of children with intellectual disabilities. Two children, ages 5 and 6, who were identified with an intellectual disability and behavioral problems participated in the study.
The researcher demonstrated the effectiveness of CCPT to reduce hyperactivity and irritability problems for both participants.

Using a single-case design, Brown (2007) investigated the impact of CCPT and CCPT combined with parent consultation on children’s developmental age. Participants included three children, ages 3, 4, and 5 years, who had developmental delays. The researcher demonstrated effectiveness of CCPT for improving children’s developmental ages. In addition, results demonstrated increased ability in cognitive, communicational, and social emotional functioning for each participant.

Summary

Perfectionism is an overlooked issue that impacts individuals’ psychological and physical well-being throughout the life span (Hewitt & Flett, 2001). A limited, but growing body of research reveals short-term and long-term mental health and adjustment issues that children with maladaptive perfectionism encounter. Anxiety is one of the most common emotional problems linked to maladaptive perfectionism (Hewitt et al., 2002; Kawamura et al., 2001; Klibert et al., 2005; Stoeber et al., 2009; Tsui & Mazzocco, 2007). Despite research findings that support the negative impact of maladaptive perfectionism and anxiety on children’s mental health and development, literature regarding effectiveness of play therapy interventions with this population is limited. Ashby et al. (2004) proposed the possible benefits of AdPT strategies to reduce maladaptive perfectionism and anxiety in children. Consistent with research that suggests the impact of parental attributes and behaviors on the development of maladaptive perfectionism (Hamachek, 1978; Clark & Coker, 2009), a key component of
AdPT is the inclusion of parents and teachers in the treatment process as active participants (Kottman, 2001).

Well-designed single case experimental design allows researchers to provide empirical support for effectiveness of treatments and techniques (Kennedy, 2005; Ray et al., 2010). Compared to group-design research, single-case design permits mental health researchers to use smaller numbers of participants to demonstrate effectiveness. There is a growing body of contemporary play therapy research studies using single-case designs that have demonstrated successful outcomes for the effectiveness of play therapy (Brown, 2007; Josefi & Ryan, 2004; Schottelkorb & Ray, 2009; Swan, 2011). Given the current state of research regarding developmentally appropriate interventions for children with maladaptive perfectionism and anxiety, and theoretical fit between Adlerian theory and perfectionism, I aimed to investigate the impact of AdPT to reduce maladaptive perfectionism and anxiety in children.
APPENDIX B

DETAILED METHODOLOGY
Single-case research allows experimentation with individual participants in order to show causal relationships (Kazdin, 2003). Using single case experimental design to test therapeutic interventions has the potential to present strong empirical support for the treatment efficacy (Kennedy, 2005). In line with growing literature promoting the use of single-case design in effectiveness studies, counseling and play therapy research began to use single-case design to investigate treatment effects (McLeod, 2003; Ray et al., 2010; Ray & Schottelkorb, 2010). According to Ray and Schottelkorb (2010) single-case studies are effective tools to promote the effectiveness of play therapy interventions.

In conducting this study, I hypothesized that AdPT, which includes parent and teacher consultations in conjunction with individual play sessions, would demonstrate a decrease in children’s maladaptive perfectionism and anxiety. I employed a single-case A-B-A experimental research design to investigate changes in children’s maladaptive perfectionism and anxiety levels across baseline, treatment, and maintenance conditions. A detailed description of the research question, definition of terms, instrumentation, participant selection, procedures, and data analysis follows.

Research Question

In the proposed study, the following research questions will be investigated: For children identified with maladaptive perfectionism, does Adlerian play therapy reduce (1) maladaptive perfectionism, and (2) anxiety.
Definition of Terms

For the purpose of this study, the following is a list of important concepts and their operational definitions:

*Maladaptive Perfectionism*

According to Hamachek (1978), and Rice and Mirzadeh (2000), both adaptive and maladaptive perfectionism are characterized by having high standards for accomplishments. Whereas, adaptive perfectionists are able to enjoy their accomplishments when they reach their goals, maladaptive perfectionism is characterized by high standards that never seem achievable. In addition, individuals with maladaptive perfectionism tend to have difficulties enjoying completed projects or achieved goals and exhibit excessive concerns over mistakes and self-criticism. For the purpose of this study, I operationally defined maladaptive perfectionism as high scores on the Child Adolescent Perfectionism Scale (CAPS; Flett, Hewitt, Boucher, Davidson, & Munro, 2002).

*Anxiety*

Spielberger (1966) defined trait anxiety as a relatively stable tendency to respond with anxiety when the individual perceives a threat in one's environment, as opposed to state anxiety which is defined as a transitory emotional state. Higher trait anxiety is associated with increased feelings of anxiety in situations perceived as threatening. For the purpose of this study, I operationalized anxiety as children’s clinical scores on the

Adlerian Play Therapy

Kottman (2001) defined AdPT as an integration of the Individual Psychology concepts of Alfred Adler with play therapy techniques. Kottman (2003) explained the main differences in AdPT compared to other play therapy approaches as the use of specific play and activity-based techniques to facilitate movement through the four phases of Adlerian therapy, the type of information gathered from children during the therapy process, and the strong emphasis on collaboration with children’s parents and teachers. According to Kottman (personal communication, June 2012), Adlerian play therapists conduct consultations with caregivers in addition to play sessions to ensure integrity of the AdPT protocol. For the purpose of this study, I operationally defined AdPT as adherence to Kottman’s (2009) manualized treatment protocol.

Instrumentation

For study purposes, I used the Revised Children’s Manifest Anxiety Scale: Second Edition (RCMAS-2; Reynolds & Richmond, 2008) Total Anxiety score as the twice-weekly repeated measure for anxiety, and the Child–Adolescent Perfectionism Scale (CAPS; Flett et al., 2002) Self-Oriented Perfectionism (SOP) and Socially-Prescribed Perfectionism (SPP) subscales as the twice-weekly repeated measure for maladaptive perfectionism. I utilized parent and teacher report on the CRS-R (Conners et al., 1998) Perfectionism and Anxious-Shy subscales to qualify children to the study
and as a measurement of children’s perfectionism and anxiety levels over 5 points of measurement throughout the study.

**Child–Adolescent Perfectionism Scale (CAPS)**

Flett et al. (2002) developed the CAPS as a 22-item self-report perfectionism scale for children and adolescents up to age 18 with a minimum Grade 3 reading level. The CAPS measures two dimensions of perfectionism: socially prescribed and self-oriented. The Socially Prescribed Perfectionism (SPP) subscale consists of 10 items (e.g., “My family expects me to be perfect”), and the Self-Oriented Perfectionism (SOP) subscale consists of 12 items (e.g., “I want to be the best at everything I do”). Children score each item on a 5-point Likert-type scale ranging from 1 (not at all true of me) to 5 (very true of me). Higher total scores on the CAPS demonstrate higher levels of perfectionism. Although the developers did not indicate cut-off scores for the subscales, their study findings demonstrated average SOP and SPP scores for 247 participants between grades 3 and 12. The mean scores were 34.27 (SD = 8.43) for SOP and 24.77 for SPP (SD = 8.42).

Several studies demonstrated the reliability of the CAPS in non-clinical populations of children between ages 8 and 19 (Castro, Gila, Gual, Lahortiga, Saura, & Tor, 2004; Flett, et al., 2002; Hewitt et al., 2002; Huggins, Davis, Rooney, & Kane, 2008). Flett et al. (2002) computed test-retest correlations for children and adolescents (n = 39) with a five-week interval. The test-retest correlation was .74 (p < .01) for SOP and .66 (p < .01) for SPP subscales. Castro et al. administered the CAPS to 68 participants between ages 11 and 19 years at a one-week interval and found alpha coefficients as
.82 for SPP and .75 for SOP subscales. Hewitt et al. conducted a study with 114 students with mean age of 12.3 (SD = 1.77) and reported internal consistency of .86 for SPP and .85 for SOP subscales. Huggins et al. used the CAPS to conduct a study with 786 students between ages 10 and 11, and found Cronbach α = .83 for SPP and α = .77 for SOP subscales. Additionally, researchers translated and used the CAPS in other countries (Bas & Siyez, 2010; Castro et al., 2004).

In order to establish validity of the CAPS, Flett et al. (2002) explored correlations between the CAPS subscales and Academic Reasons Survey (Ryan & Connell, 1989). According to the findings, SOP was significantly correlated with self-desire for perfection ($r = .60$), and SPP was significantly correlated with mother’s desire for perfection ($r = .50$) and father’s desire for perfection ($r = .62$) ($p < .05$). Flett et al. also found significant correlations between Eating Disorder Inventory Perfectionism Scale and SOP (-.41 for girls and -.72 for boys) and SPP (-.45 for girls and -.55 for boys) ($p < .01$). Although validity evidence for the CAPS is somewhat limited, Flett et al. (2002) developed the CAPS based on a valid maladaptive perfectionism instrument, MPS (Hewitt & Flett, 1989). P. L. Hewitt (personal communication, September 28, 2012) indicated appropriateness of the instrument for repeated measures.


The Revised Children’s Manifest Anxiety Scale: Second Edition (RCMAS-2; Reynolds & Richmond, 2008) is a 49-item self-report scale that assesses trait anxiety in children and adolescents between ages 6 and 19 years. The scale takes between 10 to 15 minutes to complete. Spielberger (1966) defined trait anxiety as a general tendency
to respond with anxiety when an individual perceives a threat in the environment. According to Spielberger, trait anxiety is a relatively stable characteristic, and higher trait anxiety is associated with an increased perception of threats in certain situations, situations that may not cause similar reactions for individuals with lower trait anxiety.

The RCMAS-2 provides a Total Anxiety score, as well as scores for the following subscales: Physiological Anxiety, Social Anxiety, Worry, and Defensiveness. Individuals give a ‘yes’ or ‘no’ answer to each question based on how they think and feel about themselves (Reynolds & Richmond, 2008). The Physiological Anxiety subscale (12 items) assesses the physiological responses that are associated with anxiety. The Social Anxiety subscale (12 items) measures anxiety in social situations and a concern about the self in relation to others and the Worry subscale (16 items) measures obsessive concerns, nervousness, and oversensitivity. The Defensiveness subscale (9 items) assesses willingness to admit common imperfections.

According to Reynolds and Richmond (2008), the alpha reliability internal consistency coefficients for the RCMAS-2 were .92 for Total Anxiety to .75 for Physiological Anxiety. At a one-week interval, test-retest reliability was highest for the Total Anxiety scale (.76). Lowe, Grumbein, and Raad (2011) established convergent validity (.70) for the RCMAS-2 with the Test Anxiety Scale for Elementary Students (TAS-E). C. Reynolds (personal communication, September 29, 2012) indicated appropriateness of the instrument for repeated measures.

*Conners Rating Scales-Revised (CRS-R)*

The Conners Rating Scales-Revised (CRS-R; Conners et al., 1998) includes 80-

For the CPRS-R, coefficient alphas ranged from .75 to .94 for males and .75 to .93 for females (Conners et al., 1998). Using Pearson product-moment correlations, Conners et al. found the following 6-week test-retest correlations: .60 (p< .05) for Oppositional, .78 (p< .05) for Cognitive Problems, .71 (p< .05) for Hyperactivity-Impulsivity, .42 (p< .05) for Anxious/Shy, .60 (p< .05) for Perfectionism, .13 (p = n.s.) for Social Problems, and .55 (p< .05) for Psychosomatic. The authors compared ADHD and non-ADHD groups for criterion validity. T-test results indicated that parents rated the ADHD group significantly higher than the non-ADHD group on the Oppositional, Cognitive Problems, Hyperactivity-Impulsivity, Anxious/Shy, Social Problems, and Psychosomatic scales. There was no significant difference between ADHD and non-ADHD groups on the Perfectionism scale.

For the CTRS-R, coefficient alphas ranged from .73 to .95 for males and .76 to .94 for females (Conners et al., 1998). Using Pearson product-moment correlations, Conners et al. found the following 6-week test-retest correlations: .86 (p< .05) for
Oppositional, .47 ($p < .05$) for Inattention/Cognitive Problems, .72 ($p < .05$) for Hyperactivity-Impulsivity, .88 ($p < .05$) for Anxious/Shy, .77 ($p < .05$) for Perfectionism, and .61 ($p < .05$) for Social Problems. Connors et al. established the discriminate validity of the CPRS-R by correctly classifying 85 percent of children identified with ADHD. The authors did not provide information regarding validity of the subscales.

Participants

The targeted sample included two children, ages 7 and 10, from two elementary schools in a suburban school district in the Southwestern region of the United States. Teachers and school counselors identified children with maladaptive perfectionism according to a checklist that I developed using the list of behaviors Ashby et al. (2004) and Adderholdt-Elliott (1989) defined. The checklist included the following behaviors and statements:

1. "Overly serious" about their schoolwork or other activities (i.e. giving up recess to finish school work)
2. Extreme concern over mistakes. (Concern over mistakes may prevent the student from trying to successfully complete assignments.)
3. Difficulty completing hand-writing assignments because of re-doing them over and over again.
4. Easily frustrated when things do not go just as he/she would like.
5. Hesitant to engage in activities that might result in a "mess" of some sort.
6. Avoidant of difficult projects, assignments, or tasks.
7. Negative self-statements when they do not live up to their standards (saying things like, "I knew I couldn't do that.").

8. Overly focused on negative qualities and on anything perceived to be less than perfect about themselves (e.g., their performance at school, athletic functions, and/or extracurricular activities; their appearance; their social interactions etc.).

9. Vigilant of external evidence to support their negative self-evaluation, often interpreting reactions from others as negative feedback that simply confirms their own self-critical views.

10. Feelings of extreme sadness, disappointment, or anger at themselves, at their peers, or at teachers when they turn in assignments and participate in class discussion with less than perfect results.

11. Perception of one or two errors as a complete failure.

12. Refusal to participate in class discussions, based on their fear that they could give a wrong answer.

I introduced the checklist to teachers as the Perfectionism Behavior Checklist (PBC). I developed the PBC for the purpose of this study as a 4-point Likert-type checklist ranging from 0 (no concern) to 4 (serious concern). For this study, I identified children who scored moderate to serious concern in more than 50% of the statements in PBC. Identified children who received the necessary parental consent qualified for the study based on clinical scores in Perfectionism subscale of the CRS-R (Conners et al., 1998). In order to reduce the likelihood that comorbid factors contributed to the identified children’s behaviors that might influence treatment outcome, I excluded
children who had clinical scores on any DSM subscales of the CRS-R other than the Total Anxiety subscale. Additional inclusion criterion included: 1) parents and children speaking and comprehending English, and 2) children reading at a third grade level (as identified by their teachers). Referred children who did not meet all criteria were eligible to receive play therapy services outside of the study.

Parents of five children consented to participate in the study and their children signed assent forms. Two children did not meet the inclusion criteria and one decided to drop out. Therefore, two out of five children participated in the research study. One of the participants was a 7-year-old Caucasian female and the other was a 10-year-old Hispanic-American male. The participants \( n = 2 \) met the inclusion criteria for the study by scoring in the clinical range for perfectionism on CTRS-R and/or CPRS-R. Teachers of both children agreed to attend teacher consultations. Only mothers of the participants consistently attended parent consultations.

Procedures

After establishing six data points for the baseline, I began AdPT sessions with the participants, which consisted of 30-minute individual sessions, twice per week. The children left their classrooms during school days to participate in the play sessions. The teachers selected times that did not interfere with instructional schedules. I conducted the play therapy sessions in specially-equipped playrooms at identified schools. The frequency of consultations depended on availability of the parents and teachers. The mothers were available to attend consultations once in every other week for 20 to 30
minutes. I met with the mothers at school and I met with the teachers during their planning periods or during times that were most convenient for them.

Treatment

I conducted play therapy sessions and teacher and parent consultations according to Kottman’s (2009) AdPT treatment protocol. In AdPT protocol, Kottman (2001) defined four phases: (a) building an egalitarian relationship with the child, (b) exploring the child’s life style, (c) facilitating the child’s insight related to his or her life style, and (d) providing reorientation. Schulman and Mosac (1988) defined life style as the organization of rules that individuals utilize as cognitive blueprint of their behaviors. Kottman suggested Adlerian play therapists to work on building relationships with children during the initial sessions, followed by exploration of their life styles, such as convictions about self, others, and the world. AdPT process follows by providing children with interpretations about their life styles in the form of hypotheses and metaphors. In the last phase of AdPT, play therapists help children to learn socially appropriate ways to feel significant in their family environments and other social settings.

In AdPT treatment protocol, Kottman (2009) suggested consistent use of specific skills throughout all phases, such as tracking behavior, restating content, reflecting feeling, encouraging, asking questions, metacommunication, giving explanations, and answering questions. Kottman also suggested to return responsibility to children, use their own metaphor, actively interact with them, clean the room together, and set limits depending on their unique needs. Furthermore, Kottman defined a variety of techniques
to use in each phase of AdPT. In the first phase, play therapists meet children and provide them with information about what play therapy is and what they can expect in play therapy sessions. During the second phase, therapists use questioning strategies, art techniques, metaphoric and storytelling techniques, and/or sandtray to explore children’s life style constructs, such as family atmosphere, family constellation, goals of misbehavior, personality priorities, and Crucial Cs. In the third phase, play therapists help children to gain insight about their relationship patterns, lifestyle convictions, and mistaken beliefs. Adlerian play therapists use metacommunication, metaphors, mutual storytelling, creative characters, and/or bibliotherapy. During the last phase, therapists use techniques such as metacommunication, metaphors, puppet play, didactic teaching, and modeling, in order to assist children in determining alternatives to their dysfunctional behaviors.

Adlerian parent and teacher consultations mirror the four phases in AdPT (Kottman, 2001). Kottman (2009) defined specific skills and techniques to utilize in parent and teacher consultations. During the first phase of Adlerian consultation, therapists give parents and teachers information regarding Adlerian play therapy, the importance of their involvement in the process, and logistics. Therapists also ask parents and teachers questions about children’s development, history of presenting problems, and previous attempts to resolve the problems. In the second phase, play therapists ask parents and teachers about their perceptions of the child’s assets, functioning at life style, birth order, goals of misbehavior, personality priorities, and mastery of Crucial Cs. Additionally, therapists use art techniques and/or sand tray to gather information, such as parents’ and teachers’ functioning at life tasks, attitudes
toward the child, parenting/teaching strategies, and philosophy of parenting/teaching. During the third phase, therapists help parents and teachers to gain insight into specific areas, such as how the child’s functioning at life tasks affect the child, how birth order and family constellation affect the child, how the child’s goals of misbehavior get played out in the family and other social environments, how the child’s Crucial Cs affect interactions in the family and other social environments, how the parenting/teaching strategies affect the child, and how the parent’s/teacher’s Crucial Cs affect the child. In the fourth phase, the therapist reeducates the parent/teacher by using brainstorming, discussions, metaphors, storytelling, art techniques, role-playing, and/or didactic teaching.

In order to ensure treatment fidelity for Adlerian play therapy, I video recorded all my sessions, received weekly supervision, and submitted video recordings of 10% of my sessions to an expert in AdPT who checked 15 minutes of randomly selected sessions for my adherence to the AdPT protocol. In order to check treatment fidelity, the AdPT expert used the Adlerian Play Therapy Skills Checklist (APTSC; Kottman, 2009) and Adlerian Play Therapy Parent Consultation Skills Checklist (APTPCSC). In this study, I, a doctoral candidate at the University of North Texas, specializing in play therapy, provided play therapy for both participants. I have received extensive supervised training in play therapy and participated in several Adlerian play therapy trainings and workshops with Terry Kottman, the developer of AdPT.

Data Collection

Upon receiving parental consent for identified children to participate in the study,
their teachers completed the CTRS-R and their parents completed the CPRS-R. In order to prevent assessment bias, a doctoral research assistant administered the CAPS and RCMAS-2 to all participants. The research assistant was a doctoral candidate at the University of North Texas, specializing in play therapy. She has received extensive supervised training in child and adolescent assessments. I also interviewed the mothers to gather detailed background information and support the qualification criterion of exhibiting maladaptive perfectionism.

Consistent with the single-case A-B-A experimental research design, the doctoral research assistant administered the CAPS and RCMAS-2 to participants twice per week during the three phases of the study: (a) baseline, (b) treatment, (c) and maintenance. Horner et al. (2005) suggested documentation of five or more data points to establish baseline patterns. In the present study, a research assistant collected baseline and maintenance data over three-week periods in the beginning and at the end of the study, resulting in six data points in each phase. The number of data points during the treatment phase for each participant varied upon the length of the treatment and circumstances that impacted data collection, such as spring break and the state mandated academic assessment. Teachers completed the CTRS-R and parents completed the CPRS-R five times: (1) prior to study, (2) following baseline/prior to treatment, (3) midpoint of treatment, (4) following treatment, and (5) following maintenance phase.

Data Analysis

Consistent with recommendations for analyzing data for single case design
(Kenedy, 2005; Ray et al., 2010), I performed visual analyses to analyze participants’ behavioral responses on the CAPS and RCMAS-2 across conditions. Visual analyses consisted of changes in level, trend, and variability within and across the baseline, intervention, and maintenance phases. Kennedy suggested that evidence of an effective intervention can be shown through meaningful differences between participants’ mean scores across conditions. Thus, I visually inspected each participant’s mean performance across each phase in respect to baseline to assess the changes in level during the intervention and maintenance phases.

According to Tankersley, Harjusala-Webb, and Landrum (2008), the change in trend is the best evidence to support a treatment effect in single case research designs. Thus, I evaluated the data both between and within conditions, and analyzed an ascending or descending trend in data across conditions. I calculated least-squares regression lines according to Kennedy’s (2005) description to provide an effect size statistic of $R^2$. Cohen (1988) provided guidelines to examine practical significance of research results: $R^2 = .25$ demonstrates a “large” effect, .09 demonstrates a “medium” effect, and .01 demonstrates a “small” effect.

In order to explore the effectiveness of AdPT, I also computed percent of data exceeding the median (PEM; Ma, 2006). PEM involves drawing a horizontal median line through baseline phase and extending it through intervention phase. Calculation of percentage of intervention phase data above that extended line yields effect size. According to Ma’s (2006) guidelines, 50% or less indicates no effect, 50-70% indicates a questionable effect, 70-90% indicates a moderate effect, and 90% and above indicates a strong effect. Furthermore, I analyzed the quantitative data collected from
parents and teachers via CPRS-R and CTRS-R Perfectionism and Anxious-Shy subscales over 5 points of measurement to examine the clinical significance of AdPT on each participant’s maladaptive perfectionism and anxiety. Clinical significance refers to the symptom reduction and the practical importance of an intervention’s impact on the client and/or the client’s social environment (Perdices & Tate, 2009).
APPENDIX C

UNABRIDGED RESULTS
Participant 1

Dillon was a 10-year-old Hispanic-American male. Since his parents' divorce in 2007, Dillon had lived in two households. He spent 4 days of the week in his mother's house and 3 days in his father's house. His mother, Heather (38) was in her second marriage. Dillon’s family on his mother’s side consisted of 5 members: stepfather, Daniel (38); mother, Heather; brother, Gary (7); and stepsister, Mary (4). Dillon’s biological father, William (37), lived by himself and his extended family lived in the same neighborhood. Dillon attended 21 play sessions. Dillon’s mother attended 6 parent consultations and Dillon’s biological father attended one. Dillon’s teacher attended 6 teacher consultations. Table C.1 demonstrates Dillon’s treatment process and data points.

Dillon's teacher referred him to play therapy for his extreme concern over mistakes, excessive frustration when things did not go the way he wanted, avoidance of difficult school work, negative self-statements when he did not live up to his standards, extreme focus on negative qualities about himself, vigilance to external evidence to support his negative self-evaluation, extreme sadness and disappointment when he has less than perfect results, perception of one or two errors as being complete failure, and unwillingness to participate in group discussions or activities based upon his fear of being wrong. Dillon qualified for this study because of his markedly atypical results in CTRS-R perfectionism subscales and his borderline score in the CPRS-R Perfectionism subscale.
Table C.1

*Dillon’s Treatment Process and Data Points*

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<th>Teacher Consultation</th>
<th>Child-Report</th>
<th>Parent Assessment</th>
<th>Teacher Assessment</th>
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</table>

* This session was conducted the day before the maintenance phase assessments started.
Additionally, initial parent and teacher meetings indicated that Dillon did not feel that he was significant in his home or school environments, as he verbalized believing that his parents were mostly paying attention to his brother and his teacher cared more about his classmates.

*Child-Adolescent Perfectionism Scale (CAPS)*

Figure C.1 represents Dillon’s scores on the CAPS across baseline, treatment, and maintenance phases. According to Dillon’s mean scores on the CAPS, the level of phases did not demonstrate improvement in SOP or SPP as a result of AdPT. The level (mean) for SOP was 41.33 in the baseline phase, 49.44 in the intervention phase, and 44.33 in the follow up phase. The level for SPP was 35.33 in the baseline phase; 43.39 in the intervention phase, and 46.33 in the follow up phase. Through visual analysis, the trend line indicated slight upward trend for SOP and moderate upward trend for SPP. When analyzing the data across all phases, Dillon’s perfectionism scores demonstrated a moderate amount of variability, making data difficult to interpret.

Because visual analysis alone does not make clear the effectiveness of the interventions, PEM statistics and least square regressions were calculated. According to PEM statistics, for self-oriented perfectionism scores, median of the baseline phase was 41.5 and none of the data points in intervention phase was below the median. For socially-prescribed perfectionism scores, median of the baseline phase was 36.5 and none of the data points in intervention phase was below the median. PEM statistics indicated that AdPT was ineffective in reducing maladaptive perfectionism. According to Cohen’s (1988) guidelines, there was a slight negative relationship for SOP ($R^2 = .05$)
and large negative relationship for SPP ($R^2 = .32$) between the treatment phases and data points, indicating worsening of maladaptive perfectionism over time.

**Figure C.1.** Dillon’s perfectionism scores on the CAPS throughout the three study phases. Decrease in the CAPS scores demonstrates improvement in perfectionism. The highest (ceiling) score on SOP is 60, and the highest score on SPP is 50.

In addition to analyzing Dillon’s scores on the CAPS across all phases, I analyzed the level, trend, and variability of the phases separately. Figure C.2 demonstrates the data points and linear regression lines for the SOP and SPP subscales during the baseline phase. The six data points for the SOP subscale indicated a moderate variability, a moderate upward trend, a mean of 41.33, and a trend line with a large negative effect of $R^2 = .38$. For the SPP subscale, the six data points indicated a large variability, a moderate upward trend, a mean of 35.33, and a trend line with a large negative effect of $R^2 = .42$. Trend lines for the SOP and SPP subscales during the baseline phase indicated that Dillon’s maladaptive perfectionism was getting worse over time without intervention.
Figure C.2. Dillon’s SOP and SPP subscale scores for the baseline phase. Decrease in the CAPS scores demonstrates improvement in maladaptive perfectionism. The highest (ceiling) score in SOP is 60, and the highest score in SPP is 50.

During the intervention phase, the 16 data points for the SOP subscale revealed a large variability, a mean of 49.44, a slight upward trend, and a trend line with a small negative effect of $R^2 = .06$. The results for the SPP subscale revealed moderate variability, a mean of 43.39, a small downward trend, and a trend line with a moderate positive effect of $R^2 = .14$. These results indicate small negative effect on SOP and a moderate improvement in SPP. Figure C.3 illustrates the data and trend lines for this phase.

Figure 4 demonstrates the maintenance phase. The six data points for SOP revealed a moderate variability, a mean of 44.33, a moderate downward trend, and a least squares regression line of $R^2 = .59$. The results for the SPP subscale revealed a moderate variability, a mean of 46.33, a small upward trend, and a trend line with a large negative effect of $R^2 = .28$. These results demonstrated an improvement in SOP and a worsening in SPP during the maintenance phase.
Figure C.3. Dillon’s SOP and SPP subscale scores for the intervention phase. Decrease in the CAPS scores demonstrates improvement in maladaptive perfectionism. The highest (ceiling) score in SOP is 60, and the highest score in SPP is 50.

Figure C.4. Dillon’s SOP and SPP scores in the maintenance phase. Decrease in the CAPS scores demonstrates improvement in maladaptive perfectionism. The highest (ceiling) score in SOP is 60, and the highest score in SPP is 50.
According to Dillon’s mean score on the RCMAS-2 Total Anxiety subscale, the level of phases indicated a minor decrease in anxiety from baseline to maintenance. Figure C.5 shows Dillon’s RCMAS-2 Total Anxiety scores. The level was 38.83 in the baseline phase, 37.94 in the intervention phase, and 35.16 in the follow up phase. Visual analysis demonstrated a slight downward trend, which indicated small improvement in his anxiety as a result of AdPT. When analyzing the data across all phases, Dillon’s anxiety scores demonstrated a mild amount of variability.

![Diagram of RCMAS-2 scores](image)

**Figure C.5.** Dillon’s anxiety scores on the RCMAS-2 throughout the three study phases. Decrease in the RCMAS-2 scores demonstrates improvement in anxiety. The scores higher than 60 demonstrate clinical anxiety.

According to Cohen’s (1988) guidelines, there was a moderate relationship for anxiety ($R^2 = .12$) between the treatment phases and data points. PEM statistic was
also calculated for the Total Anxiety subscale. Median of the baseline for the Total Score was 37.5, and 8 out of 16 data points in the intervention phase were below the mean. PEM statistic result for the RCMAS-2 Total Anxiety score was 50%, indicating no effect of AdPT on anxiety.

In addition to analyzing the RCMAS-2 results across all phases, I analyzed the level, trend, and variability of the phases separately. Figure C.6 demonstrates the baseline phase. The six data points for the RCMAS-2 Total Anxiety subscale revealed a large variability, a mean of 38.83, a moderate downward trend, and a least squares regression line of $R^2 = .22$. The results of the Total Anxiety subscale revealed moderate effect size, indicating a moderate decrease in Dillon’s anxiety over time without intervention.

*Figure C.6.* Dillon’s anxiety scores on the RCMAS-2 through the baseline phase. Decrease in the RCMAS-2 scores demonstrates improvement in anxiety. The scores above 60 show clinical anxiety.
During the intervention phase, the eight data points of the RCMAS-2 Total Anxiety subscale revealed a moderate variability, a mean of 37.94, a small downward trend, and a trend line with a small effect of $R^2 = .05$. These results indicated a slight improvement in Dillon’s anxiety during the intervention phase. Figure C.7 illustrates the data and trend line for this phase.

Figure C.8 demonstrates the linear regression line and the data points for the RCMAS-2 Total Anxiety subscale in the maintenance phase. The six data points indicated a large variability, a moderate downward trend, a mean of 35.17, and a trend line with a moderate effect of $R^2 = .15$, indicating a moderate decrease in Dillon’s anxiety.

*Figure C.7.* Dillon’s anxiety scores on the RCMAS-2 through the intervention phase. Decrease in the RCMAS-2 scores demonstrates improvement in anxiety. The scores above 60 show clinical anxiety.
Figure C.8. Dillon’s anxiety scores on the RCMAS-2 through the baseline phase. Decrease in the RCMAS-2 scores demonstrates improvement in anxiety. The scores above 60 show clinical anxiety.

Conners Rating Scales-Revised (CRS-R)

I explored the clinical significance of AdPT on each child’s daily functioning via Perfectionism and Anxious-Shy subscales in the CRS-R for parents (CPRS-R) and teachers (CTRS-R). Figure C.9 represents Dillon’s CPRS-R and CTRS-R scores. According to parent report on the CPRS-R Perfectionism subscale, Dillon demonstrated borderline perfectionism prior to the study and following baseline. Dillon’s perfectionism scores decreased to the normative range at the midpoint of treatment and stayed in the normal range following the end of treatment and following the maintenance phase. Dillon’s CPRS-R Anxious-Shy subscale scores were on low end of the normal range prior to the study. At the midpoint of treatment, his anxiety scores showed a decrease and remained constant from mid-point to end of treatment and through the maintenance phase.
Figure C.9. Dillon’s perfectionism and anxiety scores on the CRS-R throughout the three study phases. 70+ markedly atypical, 66-70 moderately atypical, 61-65 mildly atypical, 56-60 borderline. Decrease in the CPRS-R and CTRS-R scores demonstrate improvement in maladaptive perfectionism and anxiety.

According to CTRS-R results, Dillon’s Perfectionism subscale scores were at the markedly atypical range prior to the study and following baseline. His score decreased to the mildly atypical range at the midpoint of intervention. Dillon’s perfectionism scores declined to the normative range following the end of treatment and stayed in the normal range following the maintenance phase. Dillon’s CTRS-R Anxious-Shy subscale scores
were at the markedly atypical range prior to and after the baseline. His scores decreased to the mildly atypical range at the midpoint of the intervention. Dillon’s anxiety score declined to the normal range following the end of treatment and stayed at the normal range following the maintenance phase. In summary, AdPT demonstrated clinically significant reduction in Dillon’s maladaptive perfectionism and anxiety.

Participant 2

Jasmine was a 7-year-old Caucasian female. Jasmine’s parents divorced when she was 6 years old. She lived with her mother, Gloria (37); twin brother, Jason (7); sister, Suzy (5); and grandfather, James (65). Jasmine’s father, Jonathan (35), had lived in a different city since the fall of 2011. Jasmine, her mother, sister, and brother had moved in with her grandfather eight months prior to the study. Jasmine attended 16 play sessions and Gloria attended 5 parent consultations. Jasmine’s teacher attended 3 teacher consultations. Table C.2 demonstrates Jasmine’s treatment process and data points.

Jasmine’s teacher referred her to play therapy for her excessive seriousness about schoolwork, extreme concern over mistakes, difficulty completing hand-writing assignments because of re-doing them, excessive frustration when things do not go the way she would like, extreme sadness and disappointment when she had less than perfect results, and perception of one or two errors as complete failure. Jasmine qualified for this study because her CTRS-R score indicated borderline perfectionism and her CPRS-R score indicated mildly atypical perfectionism.
Table C.2

Jasmine’s Treatment Process and Data Points

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<th>Phase</th>
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<th>Teacher Consultation</th>
<th>Child-Report</th>
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</table>

* One data point was collected before and one was collected after the first intervention.

** One data point was collected before and one was collected after the last intervention.
Furthermore, according to the informal reports during initial parent and teacher consultations, Jasmine was shy and withdrawn in social environments, and she did not perceive herself as good enough to count at home or school. Both her parent and teacher reported that Jasmine was a competent and smart child who was underachieving as a result of her concerns over making mistakes.

**Child-Adolescent Perfectionism Scale (CAPS)**

According to Jasmine's mean scores on the CAPS, the level of phases did not demonstrate improvement in SOP or SPP as a result of AdPT. Figure C.10 shows Jasmine’s SOP and SPP scores. The level for SOP was 40.66 in the baseline phase; 46.75 in the intervention phase, and 45.67 in the follow up phase. The level for SPP was 35.67 in the baseline phase; 40.78 in the intervention phase, and 44.67 in the follow up phase. Visual analysis showed moderate upward trends, indicating worsening of both self-oriented and socially prescribed perfectionism. When analyzing the data across all phases, Jasmine’s perfectionism scores demonstrated a moderate to large variability for SOP baseline and SPP intervention phases, as well as large variability throughout the study, except for the SPP baseline phase, making data difficult to interpret.

According to Cohen’s (1988) guidelines, there was a small negative relationship for SOP ($R^2 = .08$) and a moderate negative relationship for SPP ($R^2 = .10$) between the treatment phases and data points. PEM statistics were also calculated. For SPP, median of the baseline phase was 40.66 and there were no data points in intervention phase below the median. For socially-prescribed perfectionism scores, median of the
baseline phase was 35.66 and none of the data points in intervention phase was below the median. PEM statistics indicated that AdPT was ineffective in reducing maladaptive perfectionism.

**Figure C.10.** Jasmine’s perfectionism scores on the CAPS throughout the three study phases. Decrease in the CAPS scores demonstrates improvement in maladaptive perfectionism. The highest (ceiling) score in SOP is 60, and the highest score in SPP is 50.

In addition to analyzing the CAPS results across all phases, I analyzed the level, trend, and variability of the phases separately. Figure C.11 demonstrates the linear regression lines for SOP and SPP subscales in the baseline phase. The six data points of the baseline phase for SOP subscale indicated moderate variability, a small upward trend, a mean of 40.67, and a trend line with a moderate negative effect of $R^2 = .19$. For the SPP subscale, the six data points indicated a small variability, a small upward trend, a mean of 35.67, and a trend line with a large negative effect of $R^2 = .85$. Trend lines for
SOP and SPP subscales during the baseline phase indicated that Jasmine’s maladaptive perfectionism was getting worse over time without intervention.

Figure C.11. Jasmine’s SOP and SPP subscale scores for the baseline phase. Decrease in the CAPS scores demonstrates improvement in maladaptive perfectionism. The highest (ceiling) score in SOP is 60, and the highest score in SPP is 50.

During the intervention phase, the 12 data points of the SOP subscale revealed small variability, a mean of 46.75, and a small upward trend, and a trend line with a large negative effect of $R^2 = .43$. The results of SPP subscale revealed moderate variability, a mean of 40.75, a small upward trend, and a trend line with a small negative effect of $R^2 = .06$. These results indicated a decline in worsening of maladaptive perfectionism during the intervention phase. Figure C.12 illustrates the data and trend lines for this phase.

Figure C.13 demonstrates the maintenance phase. The six data points for SOP revealed low variability, a mean of 45.67, a slight downward trend, and a least squares regression line of $R^2 = .01$. The results of SPP subscale revealed moderate variability, a mean of 41.67, a moderate downward trend, and a trend line with a small positive effect
of $R^2 = .06$. Although these results indicated improvement in SOP and SPP during the maintenance phase, the outlier data (4th data point) had a potential impact on the validity of effect size calculation.

Figure C.12. Jasmine’s SOP and SPP subscale scores for the intervention phase. Decrease in the CAPS scores demonstrates improvement in maladaptive perfectionism. The highest (ceiling) score in SOP is 60, and the highest score in SPP is 50.

Figure C.13. Jasmine’s SOP and SPP scores in the maintenance phase. Decrease in the CAPS scores demonstrates improvement in maladaptive perfectionism. The highest (ceiling) score in SOP is 60, and the highest score in SPP is 50.
Revised Children’s Manifest Anxiety Scale: Second Edition (RCMAS-2)

Figure C.14 represents Jasmine’s RCMAS-2 Total Anxiety scores. According to the mean scores of Jasmine’s RCMAS-2 Total Anxiety subscale, the level of phases indicated a slight increase in anxiety from baseline to maintenance phase. The level was 61 in the baseline phase, 64.25 in the intervention phase, and 68.5 in the follow up phase. Visual analysis showed a slight upward trend, indicating worsening of anxiety. Jasmine’s anxiety scores demonstrated a moderate amount of variability, making data difficult to interpret.

![Graph showing Jasmine's anxiety scores on the RCMAS-2 throughout the three study phases. Decrease in the RCMAS-2 scores demonstrates improvement in anxiety. The scores above 60 show clinical anxiety.]

According to Cohen’s (1988) guidelines, there was a moderate negative relationship for anxiety ($R^2 = .13$) between the treatment phases and data points. Consistently, individual phase analyses indicated worsening of Jasmine’s anxiety. The
PEM statistic was calculated for the RCMAS-2 Total Anxiety score. The median of the baseline for the Total Anxiety score was 60.5, and 1 out of 12 data points during the intervention phase were below the median. The result for the PEM statistic was 8%, indicating that AdPT was ineffective in improving anxiety.

In addition to analyzing the RCMAS-2 results across all phases, I analyzed the level, trend, and variability of the phases separately. Figure C.15 demonstrates the linear regression line and data points for the RCMAS-2 Total Anxiety subscale in the baseline phase. The six data points of the baseline phase indicated moderate variability, a large upward trend, a mean of 61, and a trend line with a large negative effect of $R^2 = 0.95$, indicating Jasmine’s highly increased anxiety over time without intervention.

![Figure C.15. Jasmine’s anxiety scores on the RCMAS-2 through the baseline phase. Decrease in the RCMAS-2 scores demonstrates improvement in anxiety. The scores above 60 show clinical anxiety.](image)

During the intervention phase, the 12 data points for the RCMAS-2 Total Anxiety subscale revealed a moderate variability, a mean of 64.25, a slight downward trend, and a trend line with a negligible effect of $R^2 = .008$. These results indicated a minor
improvement in Jasmine’s anxiety during the intervention phase. Figure C.16 illustrates the data and trend line for this phase.

Figure C.16. Jasmine’s anxiety scores on the RCMAS-2 through the intervention phase. Decrease in the RCMAS-2 scores demonstrates improvement in anxiety. The scores above 60 show clinical anxiety.

Figure C.17. Jasmine’s anxiety scores on the RCMAS-2 through the maintenance phase. Decrease in the RCMAS-2 scores demonstrates improvement in anxiety. The scores above 60 show clinical anxiety.
Figure C.17 demonstrates the maintenance phase. The six data points for the RCMAS-2 Total Anxiety subscale revealed a large variability, a mean of 68.5, a moderate downward trend, and a least squares regression line of $R^2 = .05$. The results of the Total Anxiety subscale revealed moderate effect size, indicating a moderate decrease in Jasmine’s anxiety. Although this result indicated an improvement during the maintenance phase, the outlier data (5th data point) had a potential impact on the validity of effect size calculation.

**Conners Rating Scales-Revised (CRS-R)**

I explored the clinical effectiveness of AdPT via Perfectionism and Anxious-Shy subscales in CRS-R for parents (CPRS-R) and teachers (CTRS-R). Figure C.18 shows Jasmine’s CPRS-R and CTRS-R scores. Jasmine’s CPRS-R perfectionism scores were in the mildly atypical range prior to study and in the markedly atypical range following baseline. Jasmine’s perfectionism scores stayed in the markedly atypical range at the midpoint of treatment, and decreased to the moderately atypical range following treatment. The perfectionism score decreased to the normative range following maintenance phase. According to CPRS-R Anxious-Shy subscale results, Jasmine’s anxiety scores were in the markedly atypical range prior to study, following baseline, and at the midpoint of treatment. Her anxiety scores decreased to the moderately atypical range following treatment and decreased to the normal range following maintenance phase.
Figure C.18. Jasmine’s perfectionism and anxiety scores on the CRS-R throughout the three study phases. 70+ markedly atypical, 66-70 moderately atypical, 61-65 mildly atypical, 56-60 borderline. Decrease in the CPRS-R and CTRS-R scores demonstrate improvement in maladaptive perfectionism and anxiety.

According to the CTRS-R results, Jasmine’s Perfectionism subscale scores were in the borderline range prior to study and following baseline. Her perfectionism score increased to the markedly atypical range at the midpoint of treatment, and it declined to the normal range following treatment. Jasmine’ perfectionism score decreased to the normative range following maintenance phase. Jasmine’s CTRS-R Anxious-Shy subscale scores were moderately atypical prior to the study and markedly atypical following baseline. Her anxiety scores stayed in the markedly atypical range at the
midpoint of treatment. Her scores declined to the normal range following treatment and stayed in that range following maintenance phase. In summary, AdPT demonstrated clinically significant reduction in Jasmine's maladaptive perfectionism and anxiety.
APPENDIX D

DISCUSSION
Review of the Results

According to PEM results on the CAPS and RCMAS-2 self-report, AdPT did not demonstrate effectiveness on decreasing maladaptive perfectionism or anxiety for either child in the study. On the other hand, according to Cohen’s guidelines, effect size calculations for individual phases showed improvement in Dillon’s SPP during the intervention phase. Additionally, parent and teacher reports on the CRS-R demonstrated Dillon and Jasmine’s improvement from clinical to normal range in maladaptive perfectionism and anxiety, indicating the clinical significance of the findings regarding the effect of AdPT on Dillon and Jasmine’s day to day functioning at home and school.

Although the results of the individual phase analyses, which indicated improvement in Dillon’s SPP score, were encouraging, the majority of child self-report results were inconsistent with parent and teacher reports. One explanation for the discrepancy between children’s self-report and reports of parents and teachers is social desirability bias. Given the potential for perfectionists to be sensitive about reporting their own imperfections, children’s self-report might have resulted in invalid findings (Rice et al., 2011). This reasoning is supported by Dillon’s moderately problematic defensiveness scores on the RCMAS-2, as well as his lower than normal anxiety subscale scores. Additionally, Barnette (2000) suggested that using negative items in instruments is one of the main factors that reduce reliability and validity. The presence of reverse items in the CAPS that were not capitalized or boldface might have impacted reliability and validity of the results in the present study. The research assistant who administered the self-reports instruments interview style supported possible existence of
this specific issue by stating that in particular Jasmine seemed to be confused by the items that included the words “do not” or “cannot.” Additionally, less than adequate psychometrics of the CAPS might have influenced accuracy of the results.

Another explanation for the discrepancy between Dillon and Jasmine’s self-assessment results and the reports of their parents and teachers is resistance of perfectionistic beliefs to change. According to Flett and Hewitt (2007), perfectionist individuals often have difficulties to give up their perfectionism because their need to be perfect is an important part of their identities. Furthermore, Ellis (1996) suggested that counselors need to address clients’ anxiety about making mistakes to be able to combat their perfectionism, indicating that improved courage to take risks occurs prior to decrease in cognitive aspects of maladaptive perfectionism. Although Jasmine and Dillon’s maladaptively perfectionist behaviors decreased throughout the therapy process, more time might be necessary for the cognitive aspects of perfectionism to show clear improvement.

Although the overall findings for the child self-report were not promising regarding AdPT’s effectiveness, the results from parent and teacher report, along with parent and teacher comments and my observations, suggest that AdPT demonstrated beneficial effects on the children’s maladaptive perfectionism and anxiety. It is plausible that Adlerian techniques and strategies, such as facilitation of insight into problematic thoughts and attitudes, attention to Crucial Cs, and encouragement of functional behaviors facilitated Dillon and Jasmine’s behavioral change reported by teachers and parents. In this study, I focused on the Crucial Cs in explaining the participating children’s change process. According to Adler (1929), individuals who come to therapy
lack the courage to deal with life’s difficulties. Encouraging clients to overcome their hesitant attitudes towards life is the main road to improvement and change. The use of encouragement throughout the four phases of AdPT (Kottman, 2003) facilitated the children’s “courage” to take risks and learn from their mistakes, which resulted in decreased maladaptive perfectionism and anxiety. According to the informal reports during parent and teacher consultations, throughout the therapy process, Dillon and Jasmine showed increased effort to work on difficult assignments, try new behaviors, and complete tasks on time. Additionally, parents and teachers verbally reported continued improvement throughout the maintenance phase. It seems reasonable to believe that the change in parent and teacher attitudes after receiving Adlerian consultations contributed to the children’s improvement during the intervention phase and extended the effects of their overall improvement during intervention through the maintenance. Dillon’s and Jasmine’s mothers and Dillon’s teacher stated that encouragement was the skill that they found most helpful because both children seemed to respond to encouragement with increased cooperation and effort on challenging tasks. Consistently in one of the later play therapy sessions, Dillon stated that his mother was more patient with him about completing his homework. Furthermore, Dillon’s teacher reported that Dillon was able to perform close to his potential during the state mandated academic assessment, whereas Dillon was not able to finish the preparation exam two months prior to the real exam, as a result of his high anxiety.

According to Adler (1929), perceived imperfection can be a burden for children and cause excessive feeling of inferiority, which may generate lack of interest in the
world and others. Adler believed that striving for adaptive perfectionism requires a sense of social interest, which he defined as the concern for others’ wellbeing as well as one’s own welfare. Adler stated that every individual has the potential for social interest. However, he suggested that the social interest needs to be nourished by caregivers and significant others in order to develop. Prior to the intervention phase, parents and teachers reported that the participants were preoccupied with avoiding imperfect outcomes, resulting in isolation from their classmates. These statements indicated that both children had limited ability to “connect” and feel “capable” (Lew & Bettner, 1998). In the teacher consultation following the intervention phase, Jasmine’s teacher stated that Jasmine reported a reduction in Jasmine’s worry about receiving less than perfect results in class assignments. Consequently, she finished her tasks early and demonstrated increased social interest and ability to connect through helping her peers who struggled with assignments. Similarly, Dillon’s mother reported his increased willingness to help his brother with challenging homework and school related tasks. Dillon’s mother also stated that Dillon began to use encouragement statements with his brother when his brother felt discouraged. Based on these anecdotal reports, Dillon and Jasmine’s reduction in maladaptive perfectionism and improved courage resulted in increased social interest and ability to connect with others.

During the reorientation phase, Jasmine and Dillon began to express their negative feelings more openly rather than shutting down and withdrawing. During parent consultations, both parents expressed concern over their children’s expression of negative emotions. I worked with the mothers to accept and encourage their children’s verbalization of negative feelings and understand their children’s underlying concerns.
As they felt more accepted and encouraged, Jasmine and Dillon demonstrated more self-enhancing ways to “count” in their environments. In the final phase, I worked with the mothers to help them change their family atmosphere with high-standards into a democratic family environment, in which parents communicate love and respect in ways that encourage Crucial Cs (Kottman, 2001). Consistently, during a later play therapy session, Jasmine reported feeling more understood by her mother when she got frustrated. I was also able to observe Jasmine having increased encouragement to connect with me and express her emotions, such as letting me know that she didn’t like an activity that I brought into the session. These observations and informal reports are consistent with Kottman and Ashby’s (2000) suggestion that play therapists can encourage adaptive aspects of perfectionism as they facilitate reduction in self-criticism and fear over mistakes.

According to the individual phase analyses results for the CAPS, Dillon’s socially oriented perfectionism scores showed moderate improvement during the intervention phase and worsened during maintenance. Assuming the effectiveness of AdPT in reducing Dillon’s maladaptive perfectionism during treatment, the worsening in his behavior after treatment ended may indicate Dillon’s termination was premature. The loss of support and acceptance might have contributed to his regression to high SPP during maintenance.

In their study to examine the relationship between parenting styles and perfectionism, Enns et al. (2002) demonstrated that perfectionist parenting style is correlated with perfectionism in children. The result is consistent with Kottman’s (2001) suggestion to work with the parents and other significant caregivers, such as teachers,
to alter their perceptions and behaviors that maintain children’s maladaptive perfectionism. In the beginning of the study, both Dillon and Jasmine’s mothers reported struggling with their own perfectionist tendencies. During the intervention phase, as a result of gaining insight into own perfectionist tendencies during parent consultations, Jasmine’s mother decided to seek personal counseling to work on maladaptive aspects of her own perfectionism. At the end of the study, both mothers reported improved understanding of their roles in maintaining the participants’ maladaptive perfectionism and anxiety through having high expectations for themselves and modeling fear of being perceived as imperfect by others. Consistent with Kottman’s suggestion to work with the system, teacher consultations seemed to impact the therapeutic process. Dillon’s and Jasmine’s teachers indicated increased use of encouragement rather than negative consequences when Dillon and Jasmine failed to complete their class assignments. Furthermore, Bratton and Landreth (1995) suggested that new parenting skills combined with improved acceptance of children’s feelings and behaviors may result in improved findings in behavioral assessments. In the present study, in addition to the impact of new skills that they learned, improvement in the reports of parents and teachers may also be connected to change in their perceptions of Dillon and Jasmine’s dysfunctional behaviors.

In summary, although there is discrepancy in the findings, parent and teacher reports were consistent in indicating the clinical significance of AdPT on Dillon and Jasmine’s day to day functioning at home and school. For both children, AdPT demonstrated a beneficial effect on reducing maladaptive perfectionism and anxiety. This finding of AdPT’s beneficial effect on children’s daily lives is consistent with Meany-
Walen et al.’s (in press) results regarding the beneficial effect of school-based AdPT on children’s classroom behavior. Furthermore, parent and teacher statements were consistent with the Adlerian view of the therapeutic change process, specifically the importance of encouragement, facilitating Crucial Cs, and nurturing social interest. Consistent with the emphasis of AdPT on systemic change, parent and teacher consultations were integral to the treatment process.

**Limitations and Recommendations for Future Research**

One of the challenges in single case research with children is identification of assessments to objectively measure behavior (Ray et al., 2010). Ray et al. suggested the use of behavioral observations to reduce assessment bias in single case research. However, the lack of instruments to measure maladaptive perfectionism and anxiety in children resulted in reliance on child self-report measures as weekly assessments. The only perfectionism instrument found that was suitable for young children, the CAPS, had questionable reliability and validity. Heppner, Wampold, and Kivlighan (2008) stated that one of the limitations of single case studies occurs when data is collected using instruments with weak psychometrics, which obscures the interpretation of findings. Thus, it is possible that the effect size calculation using weekly data yielded invalid results because of issues related to child self-report. Rigorous single case research studies on perfectionism and anxiety may be possible with development of objective instruments with strong psychometrics.

Another limitation was the design of the present study. Establishing a stable baseline is an essential requirement in single-case studies in order to demonstrate
experimental control within a single participant (Kennedy, 2005). Although a major strength of the present study is applicability of AdPT to school settings where all children have access to services, it was challenging to establish stable baselines, in particular with Dillon, due to school schedules and time limitations. A rigorous study with stable baseline would provide more reliable and valid results, offering potential implications for informing effective practices with children who exhibit maladaptive perfectionism and anxiety.

A major limitation in single-case design research is the inability to generalize findings (Heppner et al., 2008). According to Kazdin (2003), replication of single case research with a variety of participants is required to show generalizability. Another limitation of this study is significant time requirement for the treatment. Although it may be possible for researchers to replicate the present study, school counselors and clinicians may not have adequate time and resources to implement the protocol as presented. School counselors may benefit from utilizing counseling interns or independent counselors from community to reduce their caseloads. It is also important to note that clinicians and school counselors need extensive training and supervision in the protocol in order to conduct AdPT effectively.

Experimenter bias was another limitation of the present study. According to Heppner et al. (2008), one disadvantage of intensive single-case design is that researchers may overlook the information that contradicts the results that they expect to find. Expectations of the researcher may cause the contrary data to be undetected during analysis of the data. As the lead researcher, I was heavily involved in carrying out the intervention and the study. I utilized a research assistant to administer self-
report assessments to decrease researcher bias. However, my involvement in conducting AdPT sessions, providing parent and teacher consultations, analyzing data, and my strong belief in the value of play therapy might have influenced the treatment and data analysis processes. Future researchers would benefit from utilizing additional research team members or blinded raters to provide treatment in order to further remove themselves from the treatment and research activities.

Implications for Practice

There are several implications of the present research for clinical practice. The present study is the first of its kind to use AdPT as a play therapy intervention for children presenting with maladaptive perfectionism and anxiety. Given the limitations of present findings, the following are tentative implications for practice.

Parent and teacher reports demonstrated initial support for Ashby et al.’s (2004) claim that AdPT can provide beneficial outcomes on children’s maladaptive perfectionism and anxiety. Despite the findings from child self-report assessments indicating no improvement on target behaviors as a result of AdPT, the parent and teacher reports demonstrated that practitioners should consider utilizing AdPT with children who exhibit maladaptive perfectionism and anxiety.

The results give credence to Kottman’s (2001) recommendations of including parents and teachers in treatment. Conducting play therapy sessions in school settings presents opportunities for counselors to facilitate the change process by easy access to teachers. Although parent involvement may be more feasible in clinical settings, the school environment allows counselors to include both parents and teachers in therapy
process. Additionally, school-based AdPT shortens the duration of therapy by allowing counselors to see children more than once a week. Jones and Landreth (2002) suggested that intensive play therapy provides the opportunity for more immediate and long-lasting change in children. Ray et al. (2008) compared short term (8 weeks) and long term (16 weeks) play therapy interventions for 16 sessions and concluded that short term intensive play therapy was more effective in reducing overall teacher-student relationship stress. Considering the limited time to facilitate improvement in children’s dysfunctional behaviors in order to prevent long-term academic and social impacts, the relevance of intensive AdPT for school counselors to work with children exhibiting maladaptive perfectionism and anxiety is promising.

The results indicated that number of AdPT sessions to show improvement in maladaptive perfectionism and anxiety may vary. According to parent and teacher assessments, Dillon showed improvement before session number 10. Dillon’s teacher reports demonstrated decrease in maladaptive perfectionism and anxiety from the markedly atypical to mildly atypical range, and his mother reports showed a reduction in maladaptive perfectionism from borderline to the normal range. On the other hand, Jasmine needed more than 14 sessions to demonstrate a clinically significant decrease in her maladaptive perfectionism and anxiety. In the final meeting, Jasmine’s mother stated that her own emotional issues impacted her ability to fully implement parenting strategies that she learned during consultations. Also during play therapy process, Jasmine reported recent history of parental divorce and change of social environment that might have contributed to the increase in number of sessions to demonstrate improvement. Researchers, clinicians, and school counselors may need to consider
factors that impact therapeutic change, such as history and background, stability of their support system, parent and teacher involvement, and severity of maladaptive perfectionism and anxiety, in order to tailor intensity and duration of AdPT according to unique needs of children. Additionally, considering children’s different needs and backgrounds, clinicians and school counselors will benefit from utilizing measurement throughout the therapy process to assess improvement.

In the present study, both parents and teachers showed relative consistency in attending consultations. However, involvement in the therapy process is a significant commitment for parents and teachers. Researchers, clinicians, and school counselors may benefit from providing flexible consultation schedules and educating parents and teachers regarding importance of their roles in the therapeutic process. Considering that delivery of counseling services is only one of the several responsibilities of school counselors (ASCA, 2005), they may also benefit from conducting group consultations for parents and teachers rather than scheduling individual meetings.

Conclusion

Perfectionism is an overlooked trait that has short and long term impacts on children’s psychological well-being. With its focus on encouragement and modification of maladaptive thoughts and behaviors, as well as its strong emphasis on systemic change, AdPT offers potential as a treatment for children with maladaptive perfectionism and anxiety (Ashby et al., 2004). Adlerian theory has historically been used in the school environment to create an atmosphere that facilitates healthy development in children (Kottman, 2003; Nelsen, 2000; Watts, 2006). Kottman and
Ashby (2000) suggested the use of AdPT to facilitate a shift from maladaptive to adaptive perfectionism in children. However, there is only one study to date that explored and demonstrated effectiveness of AdPT on behavioral problems (Meany-Walen et al., in press). Prior to the present study, the claim of AdPT’s impact on maladaptive perfectionism and anxiety (Ashby et al., 2004) was an assumption without any research support. Although there is discrepancy in the present findings between the children’s self-report and reports of the parents and teachers, AdPT demonstrates initial promise as an intervention for children with maladaptive perfectionism and anxiety that warrants future research.
APPENDIX E

ADDITIONAL MATERIALS
University of North Texas Institutional Review Board
Informed Consent Form

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

**Title of Study:** Effectiveness of play therapy to reduce anxiety in children who are exhibiting high levels of perfectionism.

**Investigator:** Sinem Akay, University of North Texas (UNT) Department of Counseling and Higher Education.

**Supervising Investigator:** Dr. Sue Bratton

**Purpose of the Study:** You are being asked to allow your child to participate in a research study which investigates the effectiveness of play therapy to reduce anxiety in children who are exhibiting high levels of perfectionism. A high level of perfectionism is characterized by the child setting excessive standards for himself/herself that never seem achievable, self-criticism, excessive worry over mistakes, and anxiety about performance such as test taking. Additionally, children who are overly perfectionist may have difficulty completing projects and assignments for fear of failure, and may have difficulties relating to peers. Research shows a relationship between perfectionism and a variety of difficulties that can worsen as children mature including anxiety, eating disorders, and social problems. Research supports that early intervention may reduce the impact of perfectionism on children’s future well-being.

**Study Procedures:** If your child qualifies for the study, your child will be asked to participate in play therapy twice per week for 30-minutes over 12 weeks, as well as complete forms to assess perfectionism and anxiety before, during, and after the study. Your child will fill out assessments two times a week for 20 weeks, which includes 4 weeks prior to starting play therapy and 4 weeks after play therapy to assess your child’s progress. Assessments take approximately 25-30 minutes to complete. Times of the assessments and play therapy sessions will be determined by the teacher in order to minimize any impact on your child’s school achievement. Play therapy sessions will be video-recorded for the purpose of my supervisor overseeing the quality of services that your child receives. Only my supervisor and I will have access to the videos in order to assure your child’s confidentiality.

If you decide for your child to participate in the study you will be asked to complete a 20-minute assessment before, during, and after the play therapy intervention, for a total of 6 times. I believe that collaborative efforts between parent, teacher, and therapist are the most effective way to help children. So, I will invite you to participate in short meetings with me once a week to discuss best ways to help your child. Meetings are not required, but if you choose to meet with me, meetings will be set around your schedule.

**Foreseeable Risks:** This study poses few potential risks. As with any counseling intervention, your child may become more aware of emotional difficulties. In the event
your child has a difficult time adjusting to emotional insight, you will be contacted and if you prefer, a referral will be made to a local counseling center.

**Benefits to the Subjects or Others:** We expect the project to benefit your child by reducing his/her perfectionism and related anxiety to a healthier level.

**Compensation for Participants:** None

**Procedures for Maintaining Confidentiality of Research Records:** Participant files and assessment results and will be locked in a file cabinet in the supervising investigator’s counseling office at UNT. The confidentiality of your child’s individual information will be maintained at all times.

**Questions about the Study:** If you have any questions about the study, you may contact Sinem Akay at 940-808-6542 or Dr. Sue Bratton, director of the Center for Play Therapy at UNT, at 940-565-3864.

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

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

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

______________________________             __________________
Printed Name of Parent or Guardian               Printed Name of Child

______________________________             ____________________  Signature of
Parent or Guardian                      Date
Child Assent Form

You are being asked to be part of a research project being done by the University of North Texas Department of Counseling and Higher Education.

This study looks at a way to help children who worry a lot about meeting high standards or making mistakes on such things as tests, assignments, and projects.

You will be asked to attend play therapy sessions that will take about 30 minutes each week. Your sessions will be video-recorded so my teacher can help me do my best job as a counselor. You will also be asked to take assessments two times a week that will take about 30 minutes each.

If you decide to be part of this study, please remember you can stop participating any time you want to.

If you would like to be part of this study, please sign your name below.

__________________________             _______________
Printed Name of Child      Date

__________________________             _______________
Signature of Child            Date

__________________________             _______________
Signature of Student Investigator            Date
Perfectionism Behavior Checklist

*Please complete the checklist for children about whom you have concerns regarding perfectionistic behavior that seems to interfere with child’s learning, achievement, or happiness.*

**Student’s Name:**______________________________    **Age:**  _________

**Reads at third-grade level or above:**    **Y**   **N**

For each item below please mark the box that best describes your level of concern for this child compared with other children of the same age.

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<thead>
<tr>
<th></th>
<th>No Concern 0</th>
<th>Mild Concern 1</th>
<th>Moderate Concern 2</th>
<th>Serious Concern 3</th>
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<tr>
<td>Looks “overly serious” about schoolwork or other activities (i.e. giving up recess to finish school work)</td>
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<td>Has extreme concern over mistakes. (Concern over mistakes may prevent the student from trying to complete assignments or taking excessive amount of time to complete assignments.)</td>
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<td>Has difficulty completing hand-writing assignments because of re-doing them over and over again.</td>
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<td>Gets easily frustrated when things do not go just as he/she would like.</td>
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<td>Is hesitant to engage in activities that might result in a “mess” of some sort.</td>
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<td>Avoids difficult projects, assignments, or tasks.</td>
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<td>Makes negative self-statements when he/she does not live up to his/her standards (saying things like, “I knew I couldn't do that” or “that was stupid of me”).</td>
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<td>Overly focused on negative or “less than perfect” qualities about himself/herself (e.g., task performance, sports, extracurricular activities, physical appearance, social interactions etc.).</td>
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<td>Looks for external evidence to support his/her negative self-evaluation, often interpreting reactions from others as negative feedback that simply confirms their own self-critical views.</td>
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<td>Reacts with feelings of extreme sadness, disappointment, or anger at himself/herself, at their peers, or at teachers when they turn in assignments and participate in class discussion with less than perfect results.</td>
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<td>Sees one or two errors as a complete failure.</td>
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<td>Unwilling to participate in class discussions, based on his/her fear that he/she could give a wrong answer.</td>
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COMPREHENSIVE REFERENCE LIST


